

2016

# Low-income African American parents' perception and influence on childhood obesity

Vickie Sims-Johnson  
*Walden University*

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# Walden University

College of Health Sciences

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Vickie Sims-Johnson

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2016

Abstract

Low-Income African American Parents' Perception and Influence on  
Childhood Obesity

by

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MSA, Central Michigan University, 2000

BS, Clayton State College, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

November 2016

## Abstract

Childhood obesity affects children from every socioeconomic level, but there is a higher prevalence of obesity among preschool-age children from low-income families. Some obese children are experiencing symptoms (e.g., high cholesterol and diabetes) generally experienced by adults. As a result, healthcare costs have increased. The purpose of this qualitative phenomenological study was to understand how low-income African American parents contribute to the prevalence of obesity in preschoolers. The conceptual framework and constructs from the health belief model (HBM) guided this study. Interview data were gathered from 8 participants who met the inclusion criteria of being a low-income African American parent with an overweight/obese child living in the Atlanta Region. Creswell's simplified version of Stevick-Colaizzi-Keen's data analysis led to the following themes among the participants. The themes were time restraints for preparing a healthy meal and limited activities-playtime, family time, America's childhood obesity, inappropriate diet, and lack of knowledge. Results demonstrated that parents might not understand that a lack of adequate sleep, physical activity, and healthy meals (consumed with parents) contribute to the prevalence of childhood obesity. Positive social change can be achieved through decreased healthcare costs associated with obesity related diseases by implementing the recommended 60 minutes of structured and unstructured playtime activities at learning centers and parents introducing small dietary changes, with healthy choices, which can start preschoolers eating healthier at a young age.

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## Dedication

I dedicate this dissertation to Mrs. Vivian D. Sims, my mother, (deceased but never forgotten), who I loved and cherished stated I could finish this dissertation; I know your spirit is with me. To Sylvester Sims, Sr., my father, (deceased also never forgotten,) who I loved. I have aspired to bring forth the intellect that was given to me from both of my parents. To Preston Johnson (deceased) who always knew this time would come.

To Sherry Sims Martin (deceased), my sister, gifted writer, colleague, and friend who I felt was around during this entire journey, especially when a black butterfly comes so close to me. To “My Dancers”, Alexandria Arèal and August Jasèy, my most wonderful granddaughters whom I believe will become very positive social change agents. Finally yet importantly, to my daughters, Pomdrest, “P.J.”, and Amethyst, “Boonkie”, who has listened attentively as I discussed my dissertation over the last few years. I wish each of you continued success in your business and future educational aspirations.

I love each of you immensely!

## Acknowledgments

First, I want to acknowledge God for his present help and for preparing me to endure to the end of this journey. To Dr. John Oswald (My Chair and Content Expert) thank you for your patience, support, and noteworthy responses. I also want to thank my committee members Dr. Kimberly Dixon-Lawson (Methods Expert) for your willingness to join the committee during a crucial time on this journey and for your guidance and encouragement. To Dr. Agboto (University Review Representative) thank you for your insight and suggestions. It has been my pleasure to have each of you as a member of my dissertation committee.

I am appreciative to Sylvia, my sister, for her readiness to assist me and other family members who offered words of encouragement. In addition, thank you to the Walden Community, and some fantastic friends I met along the way who were always available.

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## Chapter 1: Introduction to the Study

### **Introduction**

The obesity phenomenon among children and adolescents continues to be a health problem in the United States. Obesity has increased over 50% in the last 3 decades, from 5.0% to 12.4% (National Collaborative on Childhood Obesity Research [NCCOR], n.d.). The rate of obesity for African American children aged 2- to 5- years-old is over 11% (Let's Move, n.d.). In 2008, obesity cost an estimated \$147 billion for medical treatment (Children's Defense Fund [CDF], 2012). The medical cost for prescriptions, emergency room visits, and outpatient services were over \$14 billion, and inpatient services estimates were \$238 million (CDF, 2012; NCCOR, n.d.). Health care cost for treating an obese individual are \$1,429 more than the cost of treating a nonobese person (Centers for Disease Control and Prevention [CDC], 2012). These costs are an economic burden to the country. Understanding how African American parents influence the prevalence of obesity in preschoolers might help to reduce the cost of treating childhood obesity and improve the overall health of the nation.

Obese children are at risk for health complications traditionally seen in adulthood. These complications are Type 2 diabetes, risk factors for heart disease, hypertension, high cholesterol, cancer, and abnormal glucose tolerance test (Let's Move, n.d.; NCCOR, n.d.). Obese 4-year-olds have a 20% chance of becoming an obese adult (NCCOR, n.d.). The Let's Move project, initiated by the first Lady Michelle Obama, has increased



awareness of childhood obesity. First Lady Michelle Obama stated that the emotional and physical health of a generation was at stake due to childhood obesity as well as the economic health and security of the nation (Let's Move, n.d.). President Barack Obama initiated the first Task Force on Childhood Obesity with an objective to reduce the rate of obesity by 5% by the year 2030 (Let's Move, n.d.). Through understanding, how parents influence obesity in children, health care professionals and parents can develop appropriate strategies to reduce the rate of obesity. This would be one step toward meeting the objective.

### **Background**

Childhood obesity, a public health problem, affects not only high-income countries but also low and moderate-income countries (The World Health Organization [WHO], 2014). The WHO (2014) stated that childhood obesity is one of the most serious health problems encountered in the 21<sup>st</sup> century, and it should be a high priority. The rate of childhood obesity has doubled over the last 2 decades with more than 40 million children under the age of 5 overweight or obese globally (Moore & Bailey, 2013; WHO, 2014). It is projected that, should the current trend continue, more than 70 million young children and infants will be overweight or obese by 2025 (WHO, 2014). Without further research to understand how African American parents might influence obesity in children, based on the projection of the WHO (2014), the prevalence rate of obesity for low-income African American preschoolers would continue to increase.

In the United States, 17 % of children 2-19 years-old are overweight or obese (CDC, 2012). Southern states have a high rate of obesity (Moore & Bailey, 2013). From 1998 to 2008, the overall prevalence of obesity among low-income children increased from 12.4% to 14.5% respectively (CDC, 2009; Moore & Bailey, 2013). Scholars have shown a positive correlation between low socioeconomic households and obesity (Bellows et al., 2011; Trust for Americas Health [TFAH] and Robert Wood Johnson Foundation [RWJF], 2014a). In addition, there is a correlation between obesity increase and decreased education for women. However, there is no significance in the prevalence of obesity in men related to income or educational level (TFAH and RWJF, 2014a).

The African American community is disproportionately affected by obesity. African American women have an obesity rate of 56.6% compared to 29.7% in 1974 (TFAH and RWJF, 2014b). African American children have an obesity rate of 20.2% and Latino children have an obesity rate of 22.4% compared to the obesity rate of 14.3% for European American children (TFAH and RWJF, 2014a). Georgia ranks 18<sup>th</sup> in the obesity rate with African Americans' obesity rate 37.2% and Latino 28.1% (TFAH and RWJF, 2014a). Comparatively, European Americans have an obesity rate of 26.2% (TFAH and RWJF, 2014a). The obesity rate for adults in Georgia remains high. However, preschoolers age 2 to 4 have a significant difference in their obesity rate (TFAH & RWJF, 2014a). In 1989, Georgia's obesity rate for 2- to 4-year-olds from low-income families was 6.8% and continued to rise to 14.8% over 2 decades (TFAH and

RWJF, 2014a). The obesity trend has started to decline in preschool age children from 14.2% in 2009 to 13.2% in 2011 (TFAH and RWJF, 2014a).

Childhood obesity is a phenomenon that many parents of preschool-age children do not see as a health risk that will cause their child medical complications linked to obesity (Towns & D'Aura, 2009).

### **Problem Statement**

Childhood obesity, a public health issue, affects one in seven low-income preschoolers and it exists in all socioeconomic groups (CDC, 2014). According to the WHO, (2011), approximately 43 million children under the age of 5 years are overweight or obese. The Pediatric Nutrition Surveillance System (PedNSS), surveyed 3.7 million 2- to 4-year-olds and found that nearly one-third surveyed were obese (as cited in CDC, 2014). The PedNSS described the nutritional status of low-income children who attend maternal and child health and nutrition programs supported by federal funds. The medical costs associated with childhood obesity are over \$14 billion for prescriptions, outpatient visits and emergency room visits (CDF, 2012; NCCOR, n.d.). In addition, \$238 million are spent for inpatient services (CDF, 2012; NCCOR, n.d.).

In the United States, 16.9% of all children are obese. Twenty point two percent of African American children are obese, 22.4% of Latino children are obese, and 14.3% of European American children are obese (CDF, 2012; TFAH and RWJF, 2014a). All populations are experiencing an increase in childhood obesity. No cultural or ethnic group is exempt from the health consequences that are associated with childhood obesity.

Obese children have a greater likelihood of being obese adolescents and young adults. In addition, obese children have a higher probability of experiencing health outcomes seen in obese adults. A significant health consequence of obesity is cardiovascular disease which is associated with high blood pressure and high cholesterol (CDC, 2014; CDF, 2012; Let's Move, n.d.; NCCOR, n.d.). The amelioration of childhood obesity is paramount. For the first time in history a generation is at risk of being out lived by their parents (CDF, 2012; Kime, 2009; NCCOR, n.d; United States Department of Agriculture, 2004).

Childhood obesity appears to be a bellwether in the African American population. The rate of obesity for African American children is nearly 40% of preschool- age children 2- to 4- years old having an obesity rate of 11 % (Let's Move, n.d.). According to TFAH and RWJF, (2014a) there has been a decline in the obesity rate for low-income preschool age children in Georgia from 14.8% in 2008 to 13.2% in 2011. However, there is a lack of data on the decline of obesity in low-income African American preschool age children. Moreover, there are minimal qualitative studies on the perception of low-income African American parents and their influence on childhood obesity.

### **Purpose of Study**

The purpose of this qualitative phenomenological study was to understand better the perception of low-income African American parents concerning childhood obesity in preschool age children, specifically preschoolers attending a prekindergarten (pre-k) program in a learning center in the Atlanta Region. Additionally, examined how low-

income parents may influence the prevalence of childhood obesity in preschool age children. The participants were able to describe their experience with childhood obesity as it relates to their preschool child who is overweight or obese (Creswell, 2009).

Huffman, Kanikireddy and Patel (2010) evaluated the parental status and childhood obesity and found that children from single parent households had a higher rate of obesity than dual family households do. In addition, children from dual family households had a significantly lower body mass index (BMI) than children from single families (Huffman et al., 2010). Additionally children from single family homes were less likely to eat together as a family (Huffman et al., 2010). Likewise, they watch television during mealtime (Huffman et al., 2010). In the study, African American women headed 47% of the single-family households compared to 14.4% European American women who are heads of the household (Huffman et al., 2010).

Various researchers have examined the continuous rise in childhood obesity. Researchers have found an association between parental perception of childhood obesity and the increase in childhood obesity (Jimenez-Cruz, Bacardi-Gascon, Castillo-Ruiz, Mandujano-Trujillo, & Pichardo-Osuna, 2010; Nsiah-Kumi, Ariza, Mikhail, Feinglass, & Binns, 2009; Spivack, Swietlik, Alessandrini, & Faith, 2010). A multivariate issue requires an understanding of the population affected. Therefore, gaining insight into the perception of childhood obesity as experienced by low-income African American parents can add to the knowledge base. Other researchers and health care practitioners can use

the results of the study to assist with health care interventions and preventive measures to address obesity.

### **Research Questions**

RQ1 – How does the perception of low-income African American parents, relating to childhood obesity, influence obesity among preschool age children?

RQ2 – How does the work schedule, or lack of work, of low-income African American parents influence childhood obesity in preschool age children?

RQ3 – How does the mealtime routine of low-income African American parents influence childhood obesity in preschool age children?

Although researchers have shown that children are more likely to be overweight in families where the mother works, there are additional variables to consider (Lee et al., 2012). In the literature review, I will delve more into parental employment and childhood obesity.

### **Conceptual Framework**

There has been debate about using the term theoretical framework and conceptual framework interchangeably. Green (2014) suggested that there should be clarification of the terms for novice researchers. A conceptual framework is used to explain the main topic of study. In addition, a conceptual framework is used to show how key variables, concepts or factors may be interrelated. The conceptual framework can be in the graphical or narrative form (Miles, Huberman & Saldana, 2014). Maxwell (2013) posited that the conceptual framework is a part of the research problem, and it

helps to guide the researcher. The conceptual framework also includes the beliefs and actual ideas the researcher has about the phenomena studied. In addition, Maxwell state an essential part of the design that supports and informs the research is the system of concepts, beliefs, theories, expectations, and assumptions (p.39). I will discuss the conceptual framework in further details in Chapter 2.

The theoretical framework used as the basis of this study was the health belief model (HBM). The HBM was developed by Hochbaum, Kegels, and Rosenstock (Glanz, Rimer, & Viswanath, 2008; Nahar et al., 2013). The HBM was developed to address the reasons why individuals refused to test for tuberculosis, a preventive measure, when the screening was free (Glanz et al., 2008; Roden, 2004). The model includes four primary constructs to predict why people would respond to prevent illness, screen for, or control a disease.

According to the HBM people's actions stems from their perceived susceptibility, perceived severity, perceived benefits, and perceived barriers to a perceived threat and net benefit (University of Twente, 2014). The HBM includes two additional constructs: cues to action and self-efficacy (Glanz et al., 2008; University of Twente, 2014). Lewin proposed that an individual's behavior is the result of the environment and the individual's behavior is the underpinning of the HBM (as cited in Cherry, n.d.; as cited in Glanz et al., 2008).

The conceptual framework, two concepts from the HBM (perceived susceptibility and perceived severity), and the research questions are intertwined and requires dialogue

with the parent to understand her/his perception of the phenomenon and how it is affecting or will affect the child.. A transcendental phenomenological approach allows the parent to describe their experience with childhood obesity

### **Nature of the Study**

A qualitative approach was the nature of this study. Qualitative research provides an opportunity for exploring and understanding the meaning that individuals and groups attribute to a social issue (Creswell, 2009). To assist the researcher in gaining a deeper understanding of the experience as told by the participants, Patton (2002) suggested that the researcher become as close to the phenomenon as possible. I chose a qualitative phenomenological design because it focuses on understanding the essence of the lived experience of the participants (Creswell, 2007; Rudestam & Newton, 1992). Using a phenomenological approach places the researcher close to the phenomenon through interviewing in the natural setting of the participant. Gaining a deeper understanding of the meaning of human beings everyday experiences is the aim of phenomenology.

Husserl introduced phenomenology as a rigorous science and first philosophy as (as cited in Patton, 2002; as cited in van Manen, 2011). The phenomenology approach chosen for this inquiry was transcendental phenomenology. In this approach, Moustakas (as cited in Creswell, 2007) recommended that the researcher set aside all personal experiences and presuppositions as much as possible in order to view the phenomenon with a fresh perspective. Equally important, researchers have argued for more qualitative



research methods with African Americans specifically childhood obesity (Kumanyika et al., 2007). George, Freedman, Norfleet, Feldman and Apter, (2003) posited that qualitative research is the best method to understand better African Americans. There has been a lack of participation by African Americans in quantitative studies. Therefore, the results may be appropriate for the overall population or majority and not generalized to the African American population (Corbie-Smith et al., 1999). For those reasons, I used a transcendental phenomenological approach.

### **Definition of Terms**

*Body mass index (BMI):* A tool used to screen children and teens to determine if a child is underweight, normal weight, overweight or obese. However, BMI does not determine if a child has excessive body fat. The formula used to determine BMI is, weight in pounds / [height in inches]<sup>2</sup> x 703; example 100<sub>lbs</sub> / (48<sub>in</sub> x 48<sub>in</sub>) x 703 (CDC, 2014).

*Child obesity:* A (BMI) at or above the 95th percentile of the sex-specific CDC BMI-for-age growth charts (CDC, 2014).

*Child overweight:* A BMI at or above the 85<sup>th</sup> percentile but below the 95<sup>th</sup> percentile (CDC, 2014).

*Low-income:* For the purpose of this research, low-income is defined as an annual salary not to exceed a total income of \$47,700 based on the Federal Poverty Guidelines at 200% above the poverty level threshold (Families USA, 2014; U.S. Department of Health & Human Services, 2014).

*Perception:* “The way you think about or understand someone or something”

(Retrieved October 23<sup>rd</sup>, 2014 from <http://www.merriam-webster.com/dictionary/perception>).

### **Assumptions**

I assumed that because participation in the study was voluntary, the participants would provide detail information about their experience caring for an obese or overweight child. Because there were no identifying information (e.g., name, social security number, etc.), I assumed that veracious answers were given to each question. I believe that parents were interested in providing data to improve their child’s quality of life. I further assumed that parents were willing to make behavioral changes that will affect their child’s health now and in the future.

### **Scope**

The purpose of this phenomenology study was to understand the essence of childhood obesity as experienced by low-income African American parents who live in one of the counties surrounding the Atlanta Region in Georgia. In addition, I wished to understand the perception of low-income African American parents in relation to childhood obesity and how their understanding has caused or may influence an increase in the prevalence of obesity for preschool age children. Researchers have shown a higher prevalence of childhood obesity among preschool age children from low-income families (CDC, 2014; Ogden, Carroll, Kit & Flegal, 2012). Results from this study can be added

to the knowledge base and used by other researchers to further explore African American parents' understanding of childhood obesity and the health consequences.

### **Delimitations**

There were delimitations for this study. The participants consisted of only low-income African American parents (fathers or mothers) and one guardian with preschool age children (4-5- year-olds). Total household income did not exceed \$47,700 for a family of four. Participants in the study had at least one child (obese or overweight) attending a preschool/ pre-k program. The population was from one of the counties surrounding the Atlanta Region. Participants in the study were 18 years of age and above. The study consisted of face-to-face interviews with parents, fathers/mothers, or guardians and telephone interviews. Hence, mail interviews were not a part of this study.

### **Limitations**

The population of the study did not include all low-income African American parents living within one of the counties surrounding the Atlanta Region with a preschool age child who is obese or overweight. Low-income African American parents whose annual income exceeds \$47,700 for a family of four were not included in this study. Further, all participants in the study lived in a county in the Atlanta Region and had at least one child (overweight or obese) who attended a preschool/pre-k program within one of the counties. Lastly, data collected from the sample were not representative of all low-income African American families. Data on the child's weight came from the parent or

guardian; therefore, accuracy of the data was not guaranteed. To address this limitation, parents self-selected if their child was overweight or obese.

### **Significance of the Study**

Qualitative research is used to understand the phenomenon as experienced by a group, community or individual (Creswell, 2009). Childhood obesity has affected all racial and ethnic groups. It is important to understand the factors that have and continue to influence childhood obesity in order to ameliorate this epidemic. In this study, I allowed low-income African American parents the opportunity to provide information on their experiences with childhood obesity. Data from the study can complement quantitative studies and add to the knowledge base, as well as provide a better understanding of low-income African American parents. In addition, African Americans can discuss how their socioeconomic status influences their decisions regarding nutrition, physical activities, or health behaviors that affect childhood obesity.

Other researchers could use findings from this study to initiate qualitative studies to increase clarity of low-income African Americans' understanding of childhood obesity. When people get the opportunity to make positive changes that affects the health of their children, some of the people will make lifestyle changes. Providing information to parents in a setting where they can be comfortable and ask questions without feeling alienated will foster collaboration between parent and health care providers, parents and educators, parents and their peers, and parents and other family members. Through collaboration, parents can become empowered to engage in conversations with

stakeholders that advocate for environmental changes. The results of this qualitative study are another step toward positive social change.

### **Social Change**

In order to bring about positive social change in the United States, there must be a representation of all races and socioeconomic status of people. Obesity and overweight affects children and teens throughout the United States. Researchers have shown that African-American children have a higher rate of obesity than European American children do (CDF, 2012). Researchers suggested that qualitative studies be undertaken to understand the African American population and childhood obesity (Kumanyika et al., 2007). George et al. (2003) posited that understanding African Americans through a qualitative research approach is best. In quantitative studies, African Americans are underrepresented, and the results cannot be generalized to that population (Corbie-Smith et al, 1999).

Understanding African American parents' perception of childhood obesity, and how their attitude may contribute to their child being overweight or obese, can cause a domino effect on the population. First, the health care provider will be able to discuss with parents healthy alternatives thus developing preventive measures appropriate for the African American population. Second, in collaboration with parents, healthy lifestyle changes can be developed that can reduce the number of African American children from being at risk of developing health issues associated with obesity. Third, making lifestyle changes can prevent some children from becoming obese adults. Lastly, healthy choices

introduced to children at an early age can decrease health care cost associated with childhood obesity and increase the likelihood of having a more vigorous society.

### **Summary**

Childhood obesity continues to be a health problem, and it is present in all socioeconomic groups with a greater prevalence in some racial and ethnic groups. The incidence rate for obesity significantly decreased for 2- to 5-year-olds from 13.9% in 2003-2004 to 8.4% in 2011–2012 in the United States (CDC, 2013). Globally over 40 million children under 5 years of age are overweight or obese (CDC, 2014; WHO, 2014). The rate of obesity for all children was 16.9%, and the rate for African American children was 20.2% (TFAH and RWJF, 2014a). Obesity disproportionately affects African American children. Georgia once had the second most obese children population. However, Georgia now ranks 17<sup>th</sup> among states with a 1.6% decline in the obesity rate for 2-4-year-old children from low-income families (Georgia Department of Public Health, n.d.). The decline in obesity for 2-4-year-olds is a positive step toward reaching the objective set by President Obama of reducing obesity by 5% by 2030. However, the data does not state if there was a decline in the prevalence of obesity in low-income African American preschool age children.

The cause of childhood obesity is multifactorial. Parental perception of their child's weight, physical inactivity, and perception of safety are among those factors (Datar, Nicosia & Shier, 2012; Garrett-Wright, 2011; TFAH and RWJF, 2014).

Quantitative study results do not generalize to the African American population due to a

lack of participation (Corbin-Smith et al., 1999). According to George, et al. (2003), qualitative studies are better to understand African Americans. One of the delimitations of the study was only low-income African Americans residing in one of the counties surrounding Metro Atlanta were included in the study.

Chapter 2 the literature review, includes factors contributing to childhood obesity such as parental influences, nutrition, inadequate sleep and other contributing factors. In Chapter 3, I will describe the design of the research study. In Chapter 4, I will outline the results of data collected from participants, and in Chapter 5, I will present a summation, conclusions, and recommendations of the overall findings.

## Chapter 2: Literature Review

### **Introduction**

In the United States the obesity rate for all populations have increased over the last 25 years (TFAH and RWJF, 2014). The national childhood obesity rate has leveled off, and some groups have shown a decline in some states; however, there is a substantially higher rate of overweight and obesity among African American youths and Latino youths than European youths (CDF, 2012; TFAH and RWJF, 2014). In addition, the majority of the children who are overweight or obese come from developing countries (Let's Move, n.d.; WHO, 2014). However, there is a higher rate of obesity in children from low-income families (TFAH and RWJF, 2014).

High blood pressure and high cholesterol are two risk factors for cardiovascular disease. The results from one study found that 70% of obese children have at least one cardiovascular risk factor and 39% have at least two risk factors (CDC, 2012). In addition, obese children are at risk for type 2 diabetes, joint problems, sleep apnea, asthma, and various cancers (CDC, 2014; CDF, 2012; Let's Move, n.d.; NCCOR, n.d.; WHO, 2014). There have been many conjectures on the reasons for children being overweight and obese. While many of the conjectures by society, political leaders, and even within the family structure, are true on the surface, there is a lack of research evidence to support all of them. In this section, I will focus on aspects of childhood obesity including, the origin of childhood obesity, prevalence of childhood obesity, risk



factors, health consequences and health care cost, nutrition, other risk factors, inadequate sleep, parental influences, and obesity in Georgia.

### **Literature Search Strategy**

I used the following electronic databases to find sources related to childhood obesity and parents' influence/perception: ProQuest Central full text, ProQuest Family Health, EBSCO (Academic Search Premier), CINAHL, Medline, WorldCat, and Galileo.

Google Scholar, also a public library and reference sections of reviewed articles.

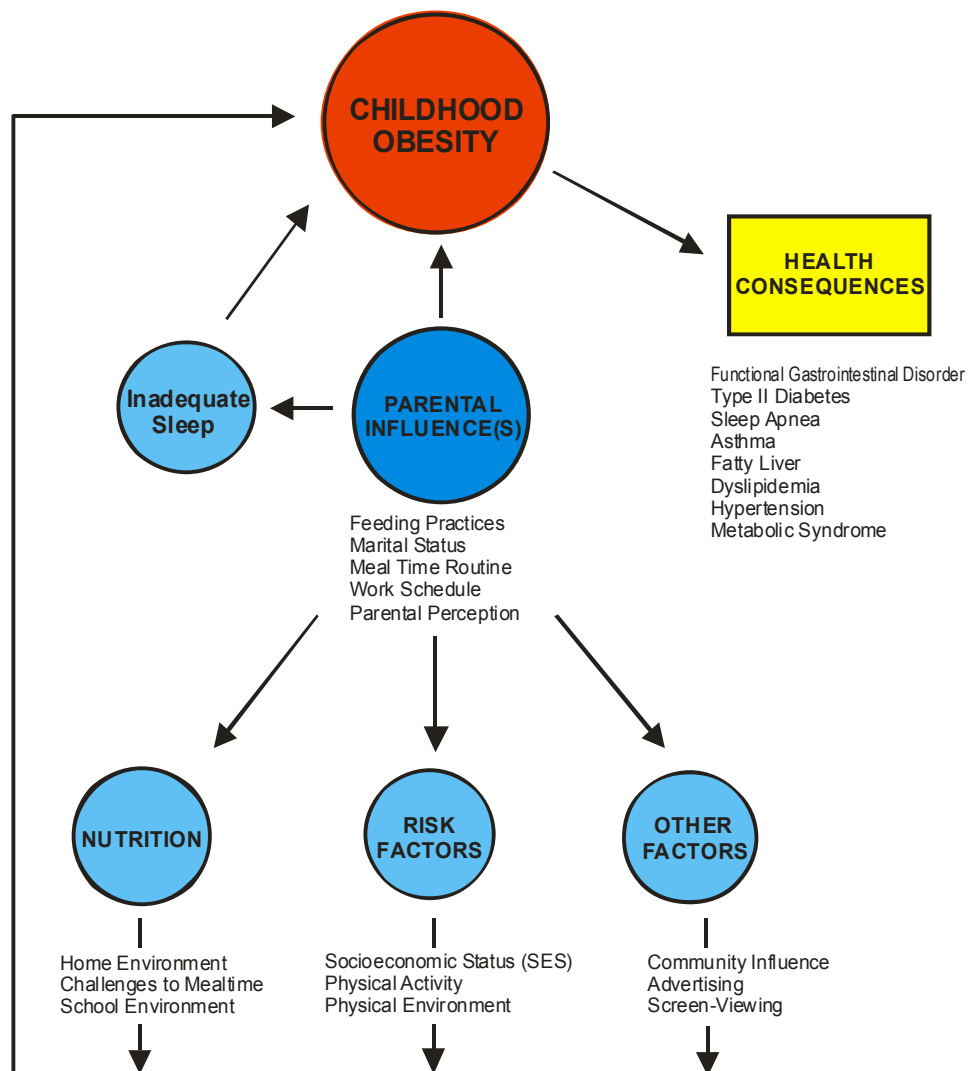
The following search terms were used: *parental perception and childhood obesity, parental values, parent's influence, childhood eating behavior, African American parents' perception, African American influence on childhood obesity, preschool and childhood obesity, low-income preschoolers, low-income and childhood obesity, preschool age children, obesity prevalence in preschool, work and childhood obesity, fathers and childhood obesity, childhood obesity prevalence, Blacks and obesity, poverty and obesity and obesity in the state of Georgia*. The literature review included journal articles, books, and personal communication primarily ranging from 2010 to 2015 also seminal literature.

Many studies were conducted on the perception of parents relating to childhood obesity; however, I found little research on the perception of low-income African American parents and their influence on childhood. Hence, the finding from this study may be used by learning center directors for developing strategies to incorporate physical/playtime activities and healthy food choices for preschoolers. In addition, health

care professionals and parents can develop strategies for making small dietary changes and more physical activity time for preschoolers.

### **Conceptual Framework**

The researcher uses the conceptual framework as a guide to keep focused, it determines what, and who will be studied (Rudestam & Newton, 1992). The conceptual framework is in narrative, tabular or graphical form (Miles et al., 2014). Figure 1 provides a diagram of the relationship between the constructs and the phenomenon (childhood obesity).



*Figure 1. Conceptual Framework*

The conceptual framework consists of concepts directly related to the phenomenon under study, childhood obesity and two constructs from the HBM; perceived susceptibility and perceived severity guided this transcendental phenomenology study.

### **Origin of Childhood Obesity**

Childhood obesity (CHO) is a chronic disease, and its effects can be multifaceted. Bezuchka (2005) posited that the maternal grandmother determines the quality of people's health. External factors could also have an impact on health prior to or during conception (Christoffel, Wang, & Binns, 2012). However, Gillman, suggested that researchers should use multiple designs to determine lifelong health trajectories due to the differences in the dose of nutrition, hormones or placentation in animals and humans (as cited in Christoffel et al., 2012). Barker (as cited by Thornburg, 2011) showed a correlation between birth weight, 5 – 9 pounds, and death due to heart disease. Subsequently, a new field of medicine was initiated known as the developmental origins of health and disease (DOHAD).

Mothers are faced with day to day challenges that causes stress; the stress experienced during pregnancy affects the fetus and the structure of organs can be altered (Thornburg, 2011). Because of these stressors, there are changes in the regulatory genes throughout an individual's lifetime (Thornburg, 2011). Whitaker and Dietz (as cited by Ebbeling, Pawlak & Ludwig, 2002) hypothesized that a maternal prenatal nutrition could be a risk factor for obesity throughout life. During certain stages of fetal development, undernourishment affect physiological changes that result in obesity (Ebbeling et al., 2002).

Children can experience being overweight or obese at any age. Gillman et al. (2008), found there was a 6%-9% chance that 3- year-olds will be overweight based on any combination of four modifiable variables. Mothers smoking during pregnancy, gestational weight gain, infant sleep pattern, and breastfeeding duration are modifiable variables. Each variable independently can cause obesity. The social environment and the internal environment of mothers continue to influence obesity. Thornburg (2011) posited that without change in the social environment that will affect mothers of the future, obesity and other chronic diseases will continue to rise.

### **Prevalence of Obesity**

The emergent rise in obesity among children requires due diligence to ameliorate this social health problem. The prevalence of obesity in children under 5-year-old is over 43 million globally (WHO, 2014). Obesity, once considered a high income problem, is now an issue for developing countries with low or moderate income as defined by the World Bank (WHO, 2014). The rate of obesity for developing countries is 30% higher than developed countries (WHO, 2014); in 1990, the rate for overweight and obese children was 31 million, in 2012, the rate was nearly 44 million (WHO, 2014). It is estimated that, should the current trend continue, by 2025, there will be 70 million children who are overweight or obese globally (WHO, 2014).

Obesity in the African American population continue to be high. In 2009-2010, the obesity prevalence of African American children was 24.3% compared to Hispanics Americans and non-Hispanic European American children obesity prevalence of 21.1%

and 14.0% respectively (Ogden et al., 2012). In addition, 16.9% of children and adolescents were obese with 31.8% being overweight or obese (Ogden et al., 2012). Body fat and BMI is highly correlated when the BMI level is higher or in the, 97 percentile (Ogden et al., 2012). However, at the same BMI level, African American children do not have a higher standard of body fat; it is significantly lower than Mexican American or non-Hispanic European American children (Ogden et al., 2012). It is not clear if body fatness would be a better predictor than BMI for obesity-related health issues (Ogden et al., 2012).

### **Risk Factors Linked to Obesity**

There are multiple risk factors associated with childhood obesity. According to Huffman et al. (2010), the causes of childhood overweight are modifiable risk factors such as physical inactivity, low socioeconomic status (SES), and environmental factors. Additionally, unhealthy eating habits, an increase in fast food consumption and sugar-sweetened beverages are also risk factors for obesity (Huffman et al., 2010; Kalinowski et al., 2012; Pena, Dixon, & Taveras, 2012). Further, Huffman et al. (2010) found that the BMI of African American children was significantly higher in single-parent households. Equally important is the fact that “significantly higher cholesterol levels and lower HDL (more elevated LDL) levels” were identified in the findings for children from single parent households (Huffman et al., 2010, p. 2807).

**Low Socioeconomic Status**

The obesity prevalence for children 2-5 years old have declined overall; however, the obesity prevalence for children from low SES households continues to rise. Children from low SES are 1.6 times more likely to be overweight or obese than children from higher SES (Lee, Andrew, Gebremariam, Lumeng & Lee, 2014). Lee et al., (2014) found that children who were in poverty prior to 2-years of age were 2.3 times more likely to become obese by 15.5-years old. Whether a child experiences poverty, before 2-years old or after 2-years, they are at risk for obesity (Lee et al., 2014). Although SES was associated with overweight and obesity among European American children, Asians Americans and Hispanic Americans, African Americans showed no apparent association between overweight/obesity and SES during early childhood (Jones-Smith, Dieckmann, Gottlieb, Chow & Fernald, 2014).

**Physical Activity**

A lack of physical activity was identified as a risk factor for childhood obesity. Regardless of the SES of children, the national guidelines for physical activity state that preschoolers should have 60 minutes of structured physical activity as well as 60 minutes of unstructured physical activity (Shape America, n.d.). Only when preschoolers are sleeping should they be inactive for more than 60 minutes (Shape America, n.d.). Because children mimic what they see by observing their parents' behavior, as well as other family members, a child's physical activity level is associated with the parents' modeling of physical activity (Bellows et al., 2011). Parental perception of unsafe

neighborhoods has an impact on a child's ability to meet the recommended guidelines for physical activity and the use of parks and recreation centers. Consequently, when a parent's perception of neighborhood safety or weather limits children's outdoor playtime there is a tendency for children to have increased screen time (Bellows et al., 2011). Screen-viewing leads to sedentary behavior that is a risk factor for childhood obesity (Bellows et al., 2011).

### **Physical Environment**

Outside activities are the most efficient way for children to meet the national guidelines for physical activity as well as unstructured playtime. However, before children can engage in any activity outside parents must assess the safety of the surrounding environment. Parental perception of neighborhood safety is influenced by events such as actual crime level in the community, economic conditions, physical disorder and social incivilities (Bellows et al., 2011). Also, SES status and victimization experience will impact parents' attitude toward neighborhood safety (Bellows et al., 2011; Datar et al., 2013; Pena et al., 2012). Scholars have found a correlate between physical activity and perception of safety. According to Datar et al. (2013), perceived neighborhood safety and children's physical activity was based primarily on cross-sectional studies as well as most studies using a small sample (p. 1066). Datar et al. found "neighborhood safety was not a significant risk factor for obesity in young children" (p. 1069).



Neighborhood safety is a primary concern for many parents. Crimes are shown on the local news with emphasis on the number and type of crimes committed in local communities. For many parents, safety is their first concern and play activities will take place in the home.

### **Consequences of Obesity**

Overweight and obesity is the result of various risk factors. Children who are overweight or obese have a greater likelihood of becoming an obese adult (CDC, 2012). Combining risk factors have the potential of placing children at risk for exhibiting symptoms of diseases routinely seen in obese adult, (e.g., cardiovascular disease and certain types of cancers; WHO, 2012). Because of the obesity epidemic, the health care costs for treating obese children have escalated.

### **Health Consequences**

Consequences of obesity in children can be overwhelming for parents. Researchers have identified a plethora of health complications associated with childhood obesity. These include functional gastrointestinal complaints, (e.g., constipation, irritable bowel syndrome, gastroesophageal reflux disease and encopresis; Huang et al., 2013). Poor dietary habits of children and adolescents are linked to constipation and encopresis (Huang et al., 2013). Additionally, Type 2 diabetes, sleep apnea, asthma, fatty liver disease, dyslipidemia, hypertension and metabolic syndrome are negative consequences for overweight and obese children (Huang et al., 2013; Mayo Clinic, 2014; Obesity Society, 2014; Sundaram, 2012; Treviño, 2015). Low-income families have difficulty-

accessing health care for their overweight or obese child, even with health care insurance. Also, some low-income families cannot access health care due to cost and limited financial resources (Haboush, Phebus, Ashby, Zaikina-Montgomery & Kindig, 2010). The lack of access to health care professionals places low-income families at a disadvantage for receiving guidance on making healthy food choices and lifestyle changes.

### **Health Care Costs**

Childhood obesity is a financial burden for families as well as the nation. First Lady Michelle Obama declared that childhood obesity affects the economic health of the nation (The White House, 2010). Cawley (2008), categorized the economic consequences of obesity as direct costs (e.g., medical costs), and indirect cost (e.g., loss of productivity). In 2008, treating obesity-related illnesses in adults cost an estimated \$147 billion (Cawley, 2008; CDC, 2012; Hammond & Levine, 2010). Additionally, childhood obesity cost \$14 billion; this includes prescription drugs and, emergency room and outpatient visits (Cawley; 2008; CDF, 2012). In addition, inpatient services cost \$238 million (CDF, 2012). The indirect cost of obesity for organizations due to loss productivity through job absenteeism costs \$4.3 billion annually (Cawley, 2010; Hammond & Levine, 2010). Understanding a parent's knowledge of obesity is paramount to curtail the indirect cost associated with obesity.

### **Nutrition**

Scholars have suggested that dietary intake is a modifiable, contributing factor for overweight and obesity in preschool age children (Kime, 2013; Treviño et al., 2011).

Decreasing the consequences of obesity will reduce health care cost. Parents' understanding the effects of obesity and making behavioral modifications are a positive step toward reducing the prevalence of obesity in preschool age children.

### **Home Environment**

Family dynamics has changed over the last 4 decades. Most households require both parents to work full time to maintain the status quo. With the advent of mergers and acquisitions, along with many organizations outsourcing a significant part of the company, many families no longer have the financial resources to support the family with one income. Mothers no longer can afford to be homemakers and ensure that the family will have an appropriate diet. Today, meal choices are based on the amount of time a parent feels she/he has for planning and preparing a meal and how fatigued they may feel (Malhotra et al., 2013; Storfer-Isser & Musher-Eizenman, 2013). Time scarcity and fatigue may influence the dinner meal, however, mothers can use the mealtime to set rules and limits on what their children should eat and how much they can eat (Herman, Malhotra, Wright, Fisher & Whitaker, 2012; Malhotra et al., 2013).

### **Challenges to Mealtime**

Preparing meals and feeding children can be challenging for many parents. In a qualitative study of predominantly African American mothers, Malhotra et al., (2013)

identified three areas that were challenging for parents related to feeding their children. First, parents found difficulty with saying no to their children when the child always asks them for a snack or sweets. In frustration, parents will give in and allow the preschooler to have a snack or sweets even when a meal was being prepared. Second, children like many adolescents and adults can be intelligent. Children will ask another adult in the household for a snack or sweets even when their mother has said no. Despite the mother's objection, other family members will give in to the child. Lastly, childhood memories challenge parents (Malhotra et al., 2013). Some parents do not want to say "no" to their child because they did not have a choice growing up. Consequently, parents' desire to give their children what they could not have as a child has made it challenging to set limits on portion size and providing nutritious meals (Herman et al., 2012; Malhotra et al., 2013).

### **School Environment**

For many parents, childhood obesity has reached the crisis stage, and it is difficult for some parents to manage dietary intake. As well, parents need a better understanding of the role dietary intake, and physical activity has on obesity. The school environment plays a significant role in providing children with the proper nutrition required to be healthy and a safe environment for children to be physically active. Some parents see the school's meal as a way for their child to receive the missing food groups that is not supplied at home (Sealy, 2010). To assist in providing schools with the resources for purchasing nutritious foods, the United States Department of Agriculture, Food and

Nutrition Service (USDA), has established the Child and Adult Care Food Program (CACFP). Children who attend day care, head start, or, any other licensed preschool program are also eligible for CACFP (USDA, 2014).

### **Other Risk Factors for Childhood Obesity**

#### **Community Influence**

Low-income families often live in communities that lack the resources (e.g., local food markets or green space) needed to enable parents to provide their children with nutritious meals and a safe place for physical activity. Convenient stores are more prevalent in African American neighborhoods, offering energy dense foods, sugar-sweetened beverages, and snacks for children, than grocery stores that offer fresh fruits and vegetables, and fresh meats (Hudson, 2008). Familiar fast food restaurants that offer toys, playground equipment, and talking characters are child friendly and convenient for parents

#### **Advertising**

Poor dietary habits are associated with the use of media (Strausburger, 2011). Malhotra et al. (2013) found that low-income parents used TV viewing to pacify their child or as a distraction during the dinner meal. TV viewing during mealtime exposes children to multiple advertisements (e.g., fast foods, snacks, or sugar-sweetened beverages). Children see an estimated 11 food commercials for every hour of TV viewing (Strausburger, 2011). Also fast food advertisements caters to adolescents. Most

of the products advertised are foods high in sugar, salt, fat content and have a tiny nutritional value (Strausburger, 2011). With the use of technology, advertisers can reach children via any media platform. The food industry spends over \$100 million monthly in advertising (Strausburger). Teenagers receive fast food coupon offers via cell phones (Strausburger, 2011).

### **Screen viewing**

Today screen viewing is not limited to TV-viewing. It includes smartphones, video gaming, and the internet. TV viewing is a risk factor for childhood obesity (Huffman, 2010; Jago et al., 2011; Koleilat et al., 2012; Strasburger, 2011). Jago et al. (2011) found over 75% of 750 parents TV-viewing time was greater than 2 hours per weekday and 62% of children TV-viewing time was higher than 2 hours. Also, parents and children multi-screen viewing was greater than one hour daily. Multi-screen viewing can be watching TV and using the computer at the same time (Jago et al., 2011). Although the American Academy of Pediatrics (2014) suggests children's TV-viewing time should be from 1-2 hours per day. Koleilat et al. (2012) found the risk of obesity increased by 71% for every hour a child spends with videos or TV-viewing. The likelihood of children watching more than 2 hours of the television increased by 7.8 times, when the parent watches more than two hours of TV (Jago, 2013).

### **Inadequate Sleep**

Screen viewing and other media not only affects dietary intake, but it is also associated with inadequate sleep (Jago et al., 2013; Strausburger, 2011). In the last few

decades, sleep duration has decreased by one hour (Strausburger, 2011). There are several sleep disorders, (e.g., insomnia, sleep apnea, and narcolepsy), that are responsible for people not getting enough sleep and, there are other reasons for not getting enough sleep (e.g., extended work schedules, jet lag, shift work that causes irregular sleep patterns, lifestyle choices, late night TV, internet use, caffeine, and other stimulants; Bell & Zimmerman, 2010).

Difficulty falling asleep doubles for adolescents who watch more than 3 hours of television in comparison to teens who view less than one hour per day (Strausburger, 2011). How much sleep a child needs depends on the child, however, the recommendation for preschool-age children are 11-12 hours a day (CDC, 2013)? Sleep duration is one of three significant risk factors for overweight/obesity for preschool children. Also children who slept 8 hours or less risk factor was 2.2 times higher than for preschoolers who slept 9 hours or more (Dev, McBride, Fiese, Jones & Cho, 2013).

Research findings have also shown short sleep duration has an effect on metabolic and endocrine functions. There is a decrease in leptin and increased ghrelin levels, pro-inflammatory cytokines levels are elevated, decreased glucose tolerance, and elevated cortisol concentration (Chaput, Klingenberg, Astrup, & Sjodin, 2011). Bell and Zimmerman (2010) found an association between the amount of sleep for 3-4- year-olds and the increased odds of being overweight at 9.5-years-old. Also, shorten sleep duration at 3-years-old correlates with obesity at 7- years-old. There is no association between taking a nap during the day and obesity at any age (Bell & Zimmerman, 2010). Getting a

good night's sleep has a regulating effect on metabolism and hormones. Observations during sleep shows a decrease in cerebral glucose, decreased heart rate, core body temperature falls, sympathetic nerve activity decreases, decreased blood pressure, and sympathetic nerve activity decreases (Chaput et al., 2011).

Making sure preschoolers are getting adequate sleep can be challenging for some parents. Some children attend before care and aftercare. For many children, this means going to the daycare/learning center before the pre-k program begins and staying after the pre-k program ends. The arrival time can be as early as 6 am for some children and departure time as late as 6 pm for others. Some working parents have no choice as to how early their child must begin the day.

### **Parental Influence on Childhood Obesity**

Lewin postulated that our behavior is the result of the individual and the environment based on the situation now of the behavior (as cited by, The Tavistock Institute, n.d.). In the last 3 decades, the obesity rate for children in the United States has tripled (The White House, 2010). The literature states that the African American population has a higher obesity rate than the non- Hispanic European American population, and a family's income to poverty ration determines the obesity prevalence of preschool age children from low-income families (CDC, 2015). With changes in the economy over the last decade, many jobs have been lost and, the role of family members has changed.



## **Parental Feeding Practices**

Many households are supported by working mothers and a number of barriers interfere with their feeding practices. Hernandez, Thompson, Cheng, and Serwint (2012) surveyed 150 mothers and found that 37.6% rated purchasing and preparing unhealthy foods as the top risk factor for obesity. In addition, mothers consider rewarding children with food and asking the child to finish all the food on their plate as important risk factors for obesity. Parents with an at-risk child and parents with a healthy weight child identified the top barrier that prevented the child from achieving a healthy weight as other caregivers who offer the child food (Hernandez et al., 2012). Other perceived barriers were having somewhere for the child to play, and parents of at-risk children identified preparation of healthy foods was a top hindrance (Hernandez et al., 2012). Whether a child is an average weight or at risk for overweight, nearly all parents want their child to be healthy. Over 80% of the parents reported having a healthy weight was the motivator for having a healthy child (Hernandez et al., 2012).

Although Hernandez et al. (2012) ranking of risk factors by low-income mothers identified having children to finish all of the food on their plate as a high-risk factor for obesity, Lumeng et al. (2012) study on maternal feeding found mothers of 15 months to 36 months old children gave multiple prompts to the child to eat. The prompts are assertive and intrusive. The prompts could be: 1) verbal encouragements such as suggesting, commanding or directing the child to eat; 2) physical supports such as feeding the child or putting the food in the child's hand; or 3) verbal offers such as asking

the child if he/she would like more food. The results of the study found that assertive prompts and intrusiveness was associated with child adiposity (Lumeng et al., 2012).

The feeding behavior of parents is associated with the risk of childhood obesity. Murashima, Hoerr, Hughes and Kaplowitz (2012) found that parents who use a non-directive control in their feeding practices were associated with children choosing nutrient dense foods rather than energy dense foods. For children to make healthier choices relies on the premise that the parent will have nutrient dense foods in the home for the child to choose. Low-income families who do not live near food supermarkets choose to purchase food from the local community stores that do not always carry fresh vegetables and fruits. Additionally the cost of food items are higher and, therefore, the family dollar will not stretch as far as it could if low-income parents had access to supermarkets. Hence, low-income parents must purchase higher-fat foods for the family (Leff, 2002). While middle-income parents are forcing their children to eat because they do not want them to be underweight, low-income African American and Hispanic American parents want their children to be generous (Murashima et al., 2012).

### **Marital Status**

Parents play a significant role in the development of their children. Bronfenbrenner (1966) posited the development of the child is dependent upon their surrounding environment (microsystem, e.g. family, school and community). The ideal home environment would consist of father, head of household, mother, and children. However, family households have migrated from couples (mother and father) to singles,

cohabitation, and same-sex couples. Single-parent families have increased over the last few decades in the United States (U.S.). In 2003, there were 2 million single-mother families (Huffman et al., 2010). Forty-seven percent of the single-parent households were African American females compared to 14.4% non-Hispanic European American female and 8.6% African American male compared to 5.1% non-Hispanic European American men. Of all households, 26% were single-parent families with 76% women head of the household (Huffman et al., 2010).

Consequently, children from dual family households BMI was significantly lower than children from single-parent families. Overall, children from single-parent households have higher BMI, total caloric intake, LDL, and total fat compared to children from dual parent families (Huffman et al., 2010). Additionally, African American children are more overweight, and their BMI is higher than European American. Lastly, the likelihood of being obese is greater for children in single parent households (Huffman et al., 2010). In order to lower the BMI and improve the health of children from single family households, as well as children from dual family households, it will require parents to make lifestyle changes.

### **Mealtime Routine**

Family meals were once considered a time to enjoy family, food, and occasionally friends. It was during mealtime that children received table etiquette, learn what to eat, when to eat, and the family communicated regarding events of the day (Malhotra et al., 2013). Meals were the same time during the week, and each family member was

expected to be present. Kime (2014) found that grandparents had a definite routine to eating during their generation. Parents reported there was a set routine to eating during their generation and that their fathers' generation was influential during that timeframe. However, children from the current generation do not regard food or eating in the same manner as their parents or grandparents in previous generations. Kime (2014) also found that children age 11 and 12, expressed having autonomy, and they are "regarded as citizens" (p. 8) in this context, making their own choices are encouraged. The current generation of children found eating fast foods, processed foods, and foreign foods as the norm (Kime, 2014). Even grandparents' perception of order has changed, and they recognize there is no routine/order to eating (Kime, 2014).

Today preschoolers are making decisions regarding their food consumption. Although Nicklas, Neil, Stuff, Hughes, and Liu, (2012) posited there is no agreement on portion size for preschoolers, Herman et al., (2012) found that parents allowed their child to determine their portion size. This finding along with the fact that many families do not consume meals together could explain why preschoolers only consumed 70% of the dinner meal (Kime, 2014; Niklas et al., 2012). In fact, Niklas et al. (2012) found that only 52% of (n=214) mothers surveyed consumed the dinner meal with their child. Also preschoolers wasted 43% of the lunch meal at daycare.

In spite of these data, the prevalence of obesity amongst low-income preschoolers remains high. A large number of risk factors have been associated with childhood obesity. Household routines are associated with reducing the odds of obesity in children

(Anderson & Whitaker, 2010). Anderson and Whitaker (2010) found the association of three household routines significantly reduced the likelihood of obesity. The sample consisted of (8,550) 4-year-olds. Anderson and Whitaker found that children who slept at least 10.5 hours per day, consumed the dinner meal regularly with family, and reduced screen viewing (video, TV, DVD) to less than 2 hours per day, obesity prevalence was 14.3% compared to children who were not exposed to any household routine was 24.5% (Anderson & Whitaker, 2010). Additionally, the odds of obesity for children exposed to one routine, was 23%-25% lower than children exposed to no routine (Anderson & Whitaker, 2010).

### **Working Parents**

The role of parents that is mothers goes further than preparing meals, and ensuring that children get an adequate amount of sleep, and minimum screen viewing time. Because of the socioeconomic status of many families, it is necessary for mothers to work part-time or full-time. In many cases, the mother is the sole provider for the family in a dual parent household. For the working mother, her responsibilities may also include caring for the home, outside commitments (e.g., school activities or community meetings), shopping for groceries, and assisting with homework.

A number of researchers have found time restraints and fatigue as barriers to planning or preparing a meal for working parents (Koulouglioti, Cole, & Moskow, 2011; Sealy, 2010; Storfer-Isser & Musher-Eizenman, 2013). Many times parents choose between working late and preparing dinner for their family. As a result, the dinner meal

may be a prepared meal from a take-out restaurant and or something microwaveable (Storfer-Isser & Musher-Eizenman, 2013). Some parents use the school meal to supply the food groups missing from the dinner meal (Sealy, 2010). Storfer-Isser and Musher-Eizenman, (2013) study of single mothers' view on everyday routines found although parents may have established a routine for the child dinner meal, screen viewing time, and bedtime, there is a disruption in the routine when children transition between two homes. Acclimating children back to the home routine can be challenging for mothers as well as cause children to become irritable.

Likewise, adolescent girls whose mothers work full-time are more likely to gain weight than girls whose mothers stay at home or work part-time. However, fathers' work schedule is not associated with weight gain for girls (Lee et al., 2012). Children of working mothers spend less quality time and eating with their mothers than children of non-working mothers (Crawley, 2010). Although previous studies imply mothers working, full-time jobs contribute to childhood obesity, Anderson (2013) makes the point that overweight is more calories consumed than calories expended. Therefore, what is the significance of mothers working and a child gaining weight? Households that have a set routine for the breakfast meal with the parents and child, television viewing time, and bedtime influence children in a positive way (Anderson). Anderson's (2013) correlation of mothers' employment, diet, family routine, and activity behavior found no evidence of maternal employment being a risk factor for childhood. Understanding how a mother's

work schedule may be a risk factor for childhood obesity in the low-income African American population, requires dialogue with the population at risk.

### **Parental Perception**

Without asking, it is difficult to know if low-income parents clearly understand information provided to them during health care visits. Minority populations have been disproportionately affected by health disparities and SES (May, Freedman, Sherry, & Blanck, 2013). The attitudes of parents with low health literacy may not understand the consequences of childhood obesity (Garrett-Wright, 2011). Parental knowledge of childhood obesity in and of itself can be one of the greatest influences on overweight/obesity. Researchers have found that parents do not perceive their child as overweight although the child may be obese (Garrett-Wright, 2011; Goodall, Pierce, Bravo, & Ferris, 2008; Hughes, Sherman, & Whitaker, 2010; Jones et al., 2011). In the African American community, the perception of a healthy baby is a baby with plump rosy cheeks and fat thighs. Those characteristics do not imply that African-American parents want babies or children that are overweight or obese. A grandmother commented previous generations knew babies would become active as they grew and subsequently “thin out”, become smaller (R. Lewis, personal communication, February 8, 2014).

Although obesity is defined based on BMI (Ogden, et al., 2012), some parents determine overweight/obesity based on visual observation e.g. clothing size and if the child “looks” too fat (Goodell et al., 2008; Hughes et al., 2010). In addition to judging

whether a child is overweight or obese through observation, some parents (overweight or normal weight parents) judge the parenting style of other mothers with an obese child. Kalinowski's et al. (2012) found that a majority of mothers believed that obesity was the result of inept or lazy mothers. Mothers of normal weight, overweight, and obese children expressed this sentiment; however, Kalinowski et al. (2012) noted, parents who were overweight or obese did not perceive their parenting style as inept or lazy.

Mothers are the protector of their children and as such, parents may be hesitant about addressing weight issues with their child. This hesitation has stemmed from various sources such as the media's ability to over emphasize extreme cases of obesity and its' lack of communicating to the consumer in a friendly manner (Jones et al., 2011). As well, conflicting information from clinicians on how much weight infants and children should gain (Jones et al., 2011). Additionally, parents are also concerned about the stigmatization that comes with being an obese child. Also, parents are likely to have feelings of ambivalence when trying to decrease the likelihood of their child developing low self-esteem from setting limits on eating behavior (Haugstvedt, Graff-Iversen, Bechensteen, & Hallberg, 2011). These reasons may be why mothers are not quick to make healthy dietary or lifestyle changes.

### **Georgia's Role in Obesity**

Georgia's obesity rate for children 2-4-years-old from low-income families has declined. CDC's annual report in 2011 shows the obesity rate for Georgia was statistically significant as well as 17 other states. The current obesity rate is 13.2% down



from 14.8% (TFAH & RWJF, 2014). With this positive trend, Georgia is in the right position for ameliorating the prevalence of childhood obesity in low-income families.

To join the fight against childhood obesity, the National Association for the Advancement of Colored People (NAACP) has published a manual specifically for the African American Population. The Childhood Obesity Advocacy Manual is a tool to be used by individual units (local NAACP) throughout the United States to ‘implement education, awareness and advocacy in the Black community’ (Anonymous, 2013). In addition, the manual contain information for promoting healthy behaviors as well as best practices for fighting childhood obesity. With an obesity rate of 35% for African American children, promoting healthy behaviors in the Black community is essential (Anonymous, 2013).

An initiative to improve the health of Georgia’s young people, thus improving Georgia’s future, called Georgia Student Health and Physical Education (SHAPE) was launched by the Department of Public Health in 2012 (Association of State and Territorial Health Officials [ASTHO], 2013). A number of influential organizations and state and local agencies support Georgia SHAPE. These partners include Children’s Health care of Atlanta, the Atlanta Braves Foundation, Georgia Chapter of the American Association of Pediatrics, Arthur M. Blank Family Foundation, Georgia Department of Early Care and Learning, etc. The population focus is children up to 18 years of age and their parents or caregivers, also birthing hospitals, schools administrators, childcare facilities, teachers, local schools, and businesses (ASTHO, 2013, p. 3). Georgia SHAPE

strategies for childhood obesity prevention “cover birth to adolescence and include working with childcare centers, schools, business community, and hospitals to implement policies and programs designed to improve nutrition and decrease sedentary lifestyle” (ASTHO, 2013, p. 1). Core strategies: Increasing breastfeeding, Governor’s Georgia SHAPE award initiative for childcare facilities, and school initiatives for children and adolescents ages 6-18 (ASTHO, 2013).

In addition to Georgia SHAPE, Georgia provides a free pre-k program to all 4-year-old students living in the state of Georgia. Georgia pre-k program began in 1992 initially as a state funded program for “at-risk” students. “At-risk” is any child and/or family who receive/participate in Food Stamps, Peach Care for Kids, Temporary Assistance to Needy Family (TANF), SSI, Medicaid, Child and Parent Services (CAPS) program. Over the last decade, the percentage of economically disadvantaged students increased (State of Georgia, 2013). The “at-risk” population increased by 14.6% from 43.2% to 57.8% (State of Georgia, 2013). In 1995, pre-k became a Georgia lottery-funded program and open to all Georgia students.

Pre-k programs are available in private learning centers, childcare centers, and public schools. Space is limited and to be fair to all students filling seats are by a lottery process. Atlanta Public Schools’ (APS) pre-k program is funded by the Georgia State Lottery, and open to parents living in Atlanta. APS serve approximately 920 pre-k children yearly. Students attend school for 6.5 hours (8 am-2:30 pm). Breakfast and lunch is available and parents have the option of bringing their child’s lunch however, the

school requests that parents bring a healthy lunch and no sugary snacks or soda (Atlanta Public Schools, 2008). As parents acknowledge the rules and regulations regarding pre-k, parents can encourage healthy eating habits at home as well as physical activity for the family.

Over a million children entered Georgia's pre-k program. In 2010-2011, there were 82,000 pre-k students from every county in the state. Georgia's pre-k program is a voluntary universal program, in 2011-2012 there were (10,652) 4-year-olds on the waiting list across the state (State of Georgia, 2013). A child's development takes place over time through the interactions of the child and the immediate environment. Bronfenbrenner, (1994) refer to these interactions as proximal processes. Therefore, a child entering a pre-k program will be able to develop relationships with other preschoolers and teachers as well as interact through group play, reading time, and eating (Bronfenbrenner, 1994). Georgia's pre-k program is setting a model for a healthy lifestyle for the next generation.

### **Summary**

Childhood obesity continues to be a health issue and the African American population has a higher obesity rate than non-Hispanic European American population (CDC, 2015). The consequences of childhood obesity are varied. Children who are overweight or obese are at risk for any number of health issues. The medical cost (direct cost) associated with childhood obesity is over \$14 billion (Cawley; CDF, 2012) and

organizations incur a \$4.3 billion cost in loss productivity due to job absenteeism (Cawley, 2010; Hammond & Levine, 2010).

Researchers have identified a number of risk factors associated with childhood obesity for example, marital status, time restraints, TV-viewing, parental perceptions and others. Children are at risk for obesity as early as conception because stress experienced by mothers has an effect on the fetus (Thornburg, 2011). Job losses through changes in the economy have brought about changes in the family structure. Single- family households are now 26% with 76% having women as head of household (Huffman et al., 2010). In addition, 47% African American females compared to 14.0% non-Hispanic European American females are head of household. In addition, 8.6% single African American males compared to 5.1% European American males are head of household (Huffman et al., 2010).

Mothers' becoming head of household have increased their responsibilities and decreased the time once used for planning and preparing meals for the family. Some mothers have become part-time workers and others full time employees. Because of this, time restraints and fatigue have been associated with children eating more prepackaged meals and eating out at fast food restaurants thus, increasing the likelihood of obesity (Malhotra et al., 2013; Storfer-Isser & Musher-Eizenman, 2013).

Lewin posited, "To understand or predict behavior, the person and his environment have to be considered as one constellation of interdependent factors" (as cited by The Tavistock Institute, n.d. para. 4). Based on Lewin's theory of predicting and

understanding behavior, this phenomenological inquiry was the best approach to gain a better understanding of how low-income African American parents' environment influence their perception of childhood obesity. Through collaboration with the parent and health care provider, appropriate interventions and preventive measures will result in healthy lifestyle changes.

In Chapter 3, I provided the research design and rationale for this transcendental phenomenological study. I discuss my role as the researcher, methodology, participant selection logic, instrumentation, procedures for the pilot study, recruitment, participation, data collection, data analysis, issues of trustworthiness, and ethical procedures. Once IRB approval was given, data collection began. Chapter 4 provides data analysis, and results. Chapter 5 provides the discussion, conclusions and recommendations.

## Chapter 3: Methodology

### **Introduction**

There are three research designs from which to choose: qualitative, quantitative and mixed methods. The research method chosen to investigate a phenomenon is determined by the researcher's worldviews that will determine the strategy for inquiry, research methods, and the problem being addressed (Creswell, 2009). A qualitative research method was chosen for this study. Qualitative research allows the researcher to explore, in-depth, a phenomenon in order to understand the meaning an individual or group attributes to a problem (Creswell, 2009). Childhood obesity is a perpetual problem influenced by a number of risk factors. Better understanding of how low-income parents' perception impact obesity is essential for curtailing the prevalence of obesity in preschoolers. I chose a qualitative phenomenology approach for this study to gain an understanding of the participants' perceptions relating to childhood obesity. In this chapter, I describe the research design, rationale for the research design, strategy of inquiry, role of the researcher, the sample population, data collection method and data analysis, trustworthiness and ethical procedures for participant protection.

### **Research Design and Rationale**

A qualitative research design employing a phenomenology approach was chosen for this research inquiry. Qualitative research takes place in a real world setting without the manipulation of the phenomenon by the researcher. Multiple sources of data are collected in qualitative research such as face-to-face interviews, observations, and

documents. With the constant use of social networking by many people, researchers may collect data via text messaging, pictures and e-mails (Creswell, 2007).

A qualitative research design using a phenomenology strategy was chosen because phenomenology focuses on how people describe their experience with the phenomena and how they make sense of it (Creswell, 2007; Patton, 2002). In order to gaining a better understanding of low-income African American parents' influence on childhood obesity, it was necessary to understand the nature of their experience with childhood obesity. A phenomenology approach also allows the researcher to expound on the experiences of several participants related to the same phenomenon (Creswell, 2007). Studying several participants allows the researcher to capture the essence of the experience (Patton, 2002). Patton (2002) posited that, the researcher become as close to the phenomenon as possible to understand the participant's experience. Close observation and in-depth interviewing will allow the researcher to describe the nature of the experience Patton, 2002, p. 106).

There are other approaches used in qualitative inquiry, but these approaches were rejected. For example, narrative researchers focus on having one individual tell stories of his or her experiences and create a story of the participant's life. Grounded theorists focus on generating a theory from the data collected in the field (Creswell, 2007). Ethnographers focus on describing and interpreting how a cultural group works. The case study is best suited for presenting an understanding of a case; its focus is developing and analysis of a case (Creswell, 2007).

I chose phenomenology because I wished to describe and clarify the meaning of the lived experiences of several individuals related to a phenomenon or concept. I tried to go beneath understanding the experiences resulting from a phenomenon to the basis of the experience (Creswell, 2007; Rudestam and Newton, 1992). Husserl, distinguishes between “phenomenological psychology as the foundational science for all psychological disciplines and transcendental phenomenology as first philosophy” (as cited by van Manen, 2011, para. 2).

In transcendental phenomenology, Husserl’s concept of “epoche”, meaning bracketing, allows the researcher to set aside all presuppositions in order to take a fresh look at the phenomenon under study (Creswell, 2007). In addition, Moustakas, (as cited in Creswell, 2007) posited that transcendental means “in which everything is perceived freshly, as if for the first time” (p. 60). To answer the research questions, it was necessary to explore the meaning that participants ascribed to the phenomenon under study. Using a transcendental phenomenology approach allowed me to engage in dialogue with the participants that will answer the following research questions.

RQ1 – How does the perception of low-income African American parents, related to childhood obesity, influence obesity among preschool age children?

RQ2 – How does a low-income African American parent’s work schedule or lack of work influence childhood obesity?

RQ3 – How does the mealtime routine of low-income African American parents influence childhood obesity?



### **Role of the Researcher**

The role of the researcher is varied. As the key instrument in a qualitative study, the researcher collects all data and, determines what data will be collected and by what method. The data can be collected via interviewing, observations, document review, pictures, and audiovisual material (Creswell, 2007; Patton, 2002). In addition, many people are using social networking as a method of communicating their personal views on social issues, as well as their personal problems. Social networking sites used by participants may provide the researcher with valuable data (van Manen, 2013). It is the researcher's responsibility to gain access to the research site and gain approval from an institutional review board (IRB) prior to starting any research (Creswell, 2007).

The researcher is responsible for controlling the bias that she/he brings to the research site. The researcher should bracket personal experiences as much as possible to minimize bias (Creswell, 2007). Miles et al., (2014) suggested ways to avoid biases from the effects the site can have on the researcher such as triangulation of data collection methods, allowing another researcher to view field notes, (which can identify if the researcher is misled), and by keeping the research questions in mind (Miles et al., 2014). The researcher can also have an effect on the research site. Biases from the researcher on the site can be avoided by being clear about intentions, informing potential participants about the study, staying on site longer than required, and asking a participant to make the researcher aware of any influences that he or she may have on the participants or site (Miles et al., p. 298). As the researcher, I do not have any personal or professional

relationships with any of the potential participants nor am I familiar with the environment where the research will take place

## **Methodology**

### **Population Selection Logic**

Prior to drawing a sample, which is the group of people that will be in the research study, it is necessary for the researcher to identify the theoretical population, study population and to create a sampling frame (Trochim, 2006). The researcher should draw a sample from the theoretical population; however, the population that is accessible to the researcher will be the study population. The sampling frame is a list of the accessible group from which the researcher can draw her or his sample (Trochim, 2006). Because not every eligible person in the sampling frame will participate in the study, the sampling frame should include enough people to provide the sample size.

The population for this qualitative phenomenology study was low-income African American parents with a child or children 4-to 5- years-old attending a pre-k program in one of the surrounding counties of the Atlanta Region. A purposeful sampling strategy I used to solicit information rich cases. In addition, the criterion sampling strategy and predetermined criteria determined the selection of the participants. The criterion sampling worked best for this qualitative phenomenology study because each participant had experienced the same phenomenon (Creswell, 2007).

### **Participant Criteria**

The following predetermined criteria were for participation. Participants lived in one of the surrounding counties in the Atlanta Region and were considered a low-income African American parent (father/mother) or guardian with at least one preschool age child (4-5-years-old). Participants were married, single, or cohabitating. Participants were 18 years of age or older. The household income could not exceed \$47,700 annually for a family of four. Participants could be a guardian of the preschooler, however; the income limits and age still applied. The participants spoke English fluently and were willing to sign an informed consent. Each prospective participant completed a demographic survey. I used the survey to determine if the participants had met the inclusion criteria.

Although there is no set rule on sample size in a qualitative study, the number of participants chosen for this qualitative phenomenology study was eight. Because qualitative research is not focused on generalizing but to elucidate the meaning the participants ascribe to a phenomenon, sample size in a qualitative studies are much smaller (Creswell, 2007; Mason, 2010). Sample size in qualitative inquiries is dependent upon several factors, the purpose of the research, what the researcher wants to know, and the amount of time and resources available to the researcher. There are no set rules as to the sample size for qualitative research (Patton, 2002). Creswell (2007) recommended five to-25 participants for a qualitative phenomenological study.

The recruiting of the participants could not begin prior to approval from Walden's IRB. Upon Walden University IRB approval number 01-12-16-0309823 with expiration

date 01-11-2017, I contacted the privately owned learning centers where I attempted to recruit the participants. Each of the perspective learning centers participates in Georgia's pre-k program. I received approval from the appropriate individual at the perspective learning centers to initiate my research study. Flyers were placed in the learning centers and worship facility prior to recruiting participants. The flyer provided pertinent information so the prospective participants could make an informed decision. Each participant received an informed consent to sign if she/he had agreed to participate in the study. Identification of participants was a code, available to me only. The participants were provided contact information (i.e., telephone number and email) to reach me if there are any additional questions not addressed prior to the interviewing process.

The number of participants was eight. There has been some debate on saturation in a qualitative study. According to Mason (2010), saturation determines the sample size for a majority of qualitative studies. Creswell (2007) recommended five to-25 participants for a phenomenology study, which will be sufficient to meet saturation. My study had eight participants, which was sufficient to reach saturation.

### **Instrumentation and Data Collection**

For this study, as the researcher, I was the primary instrument. The data collection instruments were semi structured interview protocol and a demographic survey. In addition, an audiotape recorder was utilized during vis-a`-vis interviews with one participant. I produced the interview guide, and demographic survey. In qualitative phenomenology studies, the researcher is concerned with understanding the experiences

of the participants (Rudestam & Newton, 1992). By producing the data collection instruments, I maintained the focus of the study also, posed interview questions that answered research questions, and minimize time and cost. Furthermore, I was able to capture the essence and understand the experiences of the participants by asking open-ended questions that allowed participants to describe their understanding of childhood obesity (Creswell, 2007; Patton, 2002). The interview questions, reviewed by a panel of experts in the field of obesity and nutrition, were found to be valid and in alignment with the research questions.

Following approval from Walden's IRB, the recruitment of participants began. To reduce the likelihood of perspective participants feeling threatened or pressured to participate in this study, flyers were available for all perspective participants to participate in this qualitative phenomenology study. This included, flyers being placed in the worship facility childcare center for recruiting perspective participants. Participants for the study came from the counties surrounding the Atlanta Region.

Each participant was required to sign an informed consent and each participant was informed the interview would be audio recorded with his/her permission. Only the first participant was willing to be audio recorded during the face-to-face interview. Interview notes were taken on the remaining participants. To ensure accuracy of the data written during the interview, member checks were performed throughout the interview for each participant. An interview protocol (see Appendix D) ensures that each participant receives the same questions in the same order. The interview protocol guide

served as a contingency plan to take field notes in the event there were any problems with the audio recorder. In addition, it assisted in terminating the interview. Onwuegbuzie, Leech, and Collins, (2010) posited that nonverbal communication is a part of qualitative research; however, few qualitative researchers provide details on the topic in qualitative studies; and qualitative textbooks do not elaborate on nonverbal communication.

Every participant may not communicate verbally, some subjects make use nonverbal communication. Gorden (as cited in Onwuegbuzie et al., 2010) recognized four basic types of nonverbal communication: (a) chronemic (i.e., amount of silence between conversation); (b) paralinguistic (i.e., voice quality, pitch, and volume variations); (c) proxemics (i.e., how personal space is used to communicate); and (d) kinetics (i.e., body motion, gestures and posture, p. 700). Nonverbal communication includes an observation protocol guide, if required, with a shorthand code to reduce the time spent taking notes and giving more time to the participant being interviewed (Onwuegbuzie et al., 2010). Member checks ensured the validity of data collection and data analysis. Table 1 illustrates the alignment of the research questions and interview questions for this qualitative phenomenological study.

Table 1  
*Alignment of Interview Questions and Research Questions*

Interview Questions	Research Questions
1, 2, 3, 4	RQ1
5, 6, 7	RQ2
8, 9, 10, 11	RQ3

### **Procedures for Pilot Study**

Pilot studies serve several purposes in qualitative studies. A pilot study helps the researcher to develop or refine data instruments and questions (Creswell, 2007). Equally important, is the researcher's opportunity to apply epoche, a central concept in a transcendental phenomenology approach, during the pilot study (Kim, 2011). Additionally the pilot study can be used determine if the verbiage of the interview questions needs further clarity for the participants. Because this was my first qualitative research study, the pilot study also helped me to enhance my listening skills.

The pilot study consisted of the first two participants recruited for the main study. There was no deviating from the protocol for the pilot study participants. The first participant came from one of the learning centers. Flyers (see Appendix E) were placed in trays at learning centers and worship facility childcare center. Data collection and data analysis followed the same procedures as the main study. The results of the pilot study were included in the data analysis of the main study because no changes or clarification

required related to the interview questions was required. In addition, the results of the pilot study were disseminated and helped me to identify any issue, barrier or biased associated with the formulation of the interview questionnaire (Kim, 2011).

### **Procedures for Recruitment, Participation, and Data Collection**

I recruited participants following approval from the IRB. The recruitment of low-income African American parents began with a purposeful sampling strategy. Potential participants had at least one 4-to-five-year-old attending a pre-k program in one of the counties surrounding the Atlanta Region. Participants were 18 years of age or older. I collected data using face-to-face semi-structured (audio-recorded) interviews and demographic survey. The interviews consisted of self-generated open-ended questions, with prompts as required, validated by the pilot study. Each participant received an informed consent prior to beginning the interview session with an opportunity to have all concerns addressed prior to signing. I explained to participants, his/her right to withdraw from the study at any time during the interview. Equally important, I ensured that each of the participants was protected by giving each participant a code name.

Recruitment of participants continued until the sample size (eight), that includes two for the pilot study, was complete. Sample size was achieved, and no one withdrew. The interview time was 30 to 45 minutes per participant. The participant and I agreed upon the location for data collection. I audio recorded one interview and transcribed it verbatim. Following the interview, I acknowledged the participants for their participation



in the study and informed each one when a report of the interview was available for their review and validation of data received.

### **Data Analysis Plan**

According to Creswell (2007), there are specific structured methods for data analysis using phenomenology. Creswell posited, Moustakas modification of Stevick-Colaizzi-Keen data analysis method as the most feasible and advantageous approach (p. 159). I used Creswell's simplified version of Stevick-Colaizzi-Keen's phenomenology data analysis for this study. The data analysis had six steps that proceeded as follows: 1) I described my personal experience (presuppositions) with the phenomenon. 2) I developed a list of significant statements from the data (interviews) in relation to participants' experience with phenomenon (horizontalization) and a list of statements that was not repetitive and overlapping. 3) I organized significant statements into larger units of information, themes. 4) Written descriptions of what participants experienced (textural description) including verbatim examples. 5) Next written descriptions of how experience happened (structural description), and the context and setting the experience happened. 6) Finally, a written composite description of the "essence" of the phenomenon from the syntheses of the textual and structural descriptions of the phenomenon (Creswell, 2007, p. 159). Table 2 summarizes the steps in Creswell's method of analysis I used for this phenomenology study. According to Miles et al. (2014), the researcher has an obligation to report all perspectives encountered doing a

research study. Therefore, any discrepant case will be a part of the data analysis and reported for this phenomenology study (Patton, 2002).

In addition, to assist in data analysis I manually coded the data for organization as I looked for similarities in participant's responses. Through data analysis, from face-to-face interviews, the essence of low-income African American parents experience with childhood obesity is better understood.

Table 2

*Summary of Creswell's Method of Analysis*

<i>Step 1 Epoche-Bracketing</i>	Set aside personal experience and assumptions
<i>Step 2 Horizontalization</i>	Develop a list of important statements from interview data.
<i>Step 3 Themes-Cluster meaning</i>	Group statements into themes
<i>Step 4 Textual Description</i>	Write a description of what parents experienced
<i>Step 5 Structural Description</i>	Write a description of how the experience happened.
<i>Step 6 Essence</i>	Combine the structural and textural descriptions to understand the nature of the problem, childhood obesity.

### **Issues of Trustworthiness**

Trustworthiness in qualitative research is equivalent to rigor in quantitative research (Patton, 2002). Various perspectives on how to validate qualitative research was proposed. Authenticity and trustworthiness are terms used to judge the quality of qualitative inquiries (Miles et al., 2014) To establish trustworthiness Lincoln and Guba (as cited by Creswell, 2007) proposed terms such as credibility, transferability, dependability, and confirmability. Member checks established credibility. The data collection method for this phenomenology study employed face-to-face interviews. One interview was audio recorded and transcribed verbatim. Participant received a copy of the transcript to review for accuracy. In addition, triangulation of data collection methods, interviews, observations, and reflexivity further established credibility (Deal, 2010).

Thick descriptions that have the potential for results to be applicable to similar situations established transferability (Miles et al., 2014). Triangulation of methods, and audit trail can establish dependability. I will maintain all data collected which include audio tapes, journals, transcripts, notes, and protocol guides in a secured filing cabinet. Computer generated data is password protected. Lastly, confirmability maintains that the findings go back to methods and procedures (Deal, 2010; Miles et al., 2014).

### **Ethical Consideration**

Just as qualitative researchers seek to validate their studies by incorporating strategies that will establish trustworthiness, equally important is to follow ethical

procedures to ensure humane treatment for participants. According to Miles et al. (2014), *first do no Harm*, is a classic principle for humane conduct all researchers should follow. As a professional registered nurse, I adhere to a code of ethics that governs my conduct to all people. Currently, I foresee minimal to no risk of harm to participants. In undertaking this qualitative transcendental phenomenology study, I complied with all of Walden's IRB policies and procedures. All required documentation for Walden's IRB is included in the IRB application. As well, the appropriate documents have the IRB's approval number. In addition, upon approval from the IRB, I began the process of recruiting participants for the pilot study and the main research study. A flyer explaining the purpose and benefits of the study was available for participants to read. Participants received a \$5 gift card for his/her participation in this research study. In addition, participants can benefit by knowing their participation in this research study can enlighten health care providers and stakeholders of their experience with childhood obesity. Consequently, collaboration between health care providers and low-income African American parents can develop interventions and preventive strategies to help reduce the prevalence of childhood obesity in preschool age children. All prospective participants had an opportunity to ask questions prior to deciding to partake in the research study. I explained to all participants that participation in the study was voluntary and they had the right to withdraw from the study prior to the start or anytime during the interview.

No participant withdrew from the study prior to answering any interview questions and no participant withdraws from the study prior to completing the interview, the data collected followed the data analysis process. I informed each participant that the interview was audio recorded with his/her permission and the interview process would take between 45 to 60 minutes. However, only the first participant agreed to be audio recorded. The audio recording of the first participant transcribed verbatim. In addition, a copy of the transcript was given to participant to check for accuracy. The last seven participants' data was hand written. Member checks performed throughout the data collection process.

I explained to each participant, in order to protect his/her identity, a number was assigned (e.g., 001, 002, 003, etc.) as their identifier and there were no personal identifiers associated with participants. In addition, I explained confidentiality to the participants and assured each one that only I, as the researcher, and my supervisory committee had access to his/her data. There were no foreseeable risk associated with this research study and no participant verbalized any complaint during or following his/her participation in this phenomenological study.

I maintain all the data from the study for five years (per Walden's IRB policy) in a secure filing cabinet. Data stored on any electronic device is password protected. Dissemination of results followed completion of the research study and is available for participants and partners. I have initiating the publication of the research.

### **Summary**

Chapter 3 provided the methodology for this research study starting with the research design and rationale. This qualitative inquiry used a transcendental phenomenology approach. This method allowed the researcher to approach the issue with a fresh perspective by putting aside all presuppositions to gain a deeper understanding of the participant's experience with the phenomenon. The role of the researcher in qualitative research can be that of a participant, observer, or observer participant. As well, the researcher was the main instrument in this qualitative research.

In addition to ensuring humane treatment for participants, the researcher is also the gatekeeper of the data received. The selection of participants and the criteria used is part of the research problem. There is a discussion on the self-developed instrumentation and the data collection method. The procedure for the pilot study and the main study are discussed along with the procedure and criteria for the selection and recruitment of participants. Data analysis plan, issues of trustworthiness, and ethical considerations concludes Chapter 3. Within Chapter 4, I provide the data analysis results from the data collected from the pilot study and the main study interviews. Chapter 5 provides a summation of the data with recommendations and conclusion.

## Chapter 4: Results

### **Introduction**

The intent of this transcendental phenomenological study was to better understand how low-income parents' perceptions might influence obesity in preschool age children. The population chosen was low-income African American parents living in one of the nine counties surrounding the Metropolitan Atlanta Region in Georgia. The following research questions (RQ) guided this study:

RQ1: How does the perception of low-income African American parents, in regards to childhood obesity, influence obesity in preschool age children?

RQ2: How does a parent's work schedule or lack of work influence childhood obesity?

RQ3: How does the mealtime routine of low-income African American parents

In this chapter, I describe the pilot study, population sample, and methods utilized for data collection, evidence of quality and summation of interview questions

### **Pilot Study**

As asserted in Chapter 3, upon approval from Walden University's IRB approval # 01-12-16-0309823, I conducted a pilot study using the first two participants in this study. In order to recruit participants, I left flyers (Appendix E) at the learning center. The pilot study was conducted to test the clarity of the interview questions and to ensure that the interview questions would answer the research questions. Each pilot study

participant gave appropriate responses for all interview questions. In addition, responses to Interview Questions 1, 2, 3, and 4 answered RQ1; responses to Interview Questions 5, 6 and 7 answered RQ2; and responses to Interview Questions 8, 9, 10, and 11 answered RQ3.

After analyzing the data, I determined that no changes or refinement of the interview questions was required. Also, no changes were needed in the data analysis strategy. The pilot study did not guarantee the success of the main study; however, the pilot study was successful. I continued to recruit participants for the main study. The results of the pilot study were included in the results of the main study.

### **Research Setting**

The research setting for this study was face-to-face interviews and over-the-phone interviews. There was some difficulty in setting a time to interview several of the participants. It was necessary for me, as the researcher, to be flexible in order to recruit participants for this study. Several participants worked evenings and the night shift. Only one participant was willing to be audio recorded. I assured all participants that it would not be necessary to audio record the interview. No other personal or organizational conditions appeared to influence the participants that would affect the interpretation of the study results.

### **Demographics**

The demographics and characteristics of the eight participants included their parental status, household income, household size and county of residence. Table 2 lists



these characteristics. All participants were African American and over 18 with one parent stating he was over 60. Seventy-five percent of the participants were fathers and the remaining 25% was one grandmother and one mother. Each participant had a preschooler 4 or 5-years old, and one participant had twins.

Table 3

*Characteristics of Participants*

Parental Status	Household Income	Household Size	County of Residence
Father	<\$40,000	5	Fulton
Grandmother	<\$40,000	3	Fulton
Mother	<\$47,800	5	Fulton
Father	<\$25,000	4	Fulton
Father	<\$47,800	4	Fayette
Father	<\$35,000	4	Gwinnett
Father	<\$25,000	3	Clayton
Father	<\$35,000	6	Dekalb

### Protection of Participants

As the researcher, I had a responsibility to protect the identity of the participants and the confidentiality of data collected. As shown in Table 4, a unique identifier was

given to each participant, including the pilot study participants, that was used throughout this study. No participant's identity was disclosed.

Table 4

*Participant's Identifier*

Participant	Identifier
1	FA-0114
2	GMO-0123
3	MO-0130
4	FA-0204
5	FA-0219
6	FA0321
7	FA-0419
8	FA0415

### **Data Collection**

As the primary instrument for this transcendental phenomenological research study, it was necessary for me to first bracket my presuppositions and experiences relating to the causes of overweight and obesity in children as much as possible. I was able to set aside my experiences and biases to approach this study with a fresh perspective as suggested by Moustakas (as cited in Creswell, 2007). I began the process of recruiting participants for this study January 13, 2016 through invitation by flyer. Initially, Candy Cane

Learning Center (located in DeKalb County) was chosen to advertise for potential research participants. The assistant director granted permission and flyers were made available for potential participants.

The first potential participant, not a parent from Candy Cane Learning Center, overheard me talking about the research and asked if he could be in the study. After further conversation, it was clear that he met the criteria for being a participant.

Following the completion of the demographic profile, a time was set for the interview. I informed the potential participant that his interview was the pilot study for the main research study. After explaining the purpose of the pilot study and reading the informed consent (Appendix G-2), he acknowledged an understanding of the pilot study and stated that an audio recording was okay. At the conclusion of the interview, I informed the participant I would give him a call once I receive the audio transcription to check for accuracy of information (member checking).

As I was leaving, the participant told me of another potential participant. I gave him a flyer with my contact information to pass on to the potential participant. After 9 days, there was no response from the learning center. Three days after giving out the flyer to my first participant, I received a call from the referred potential participant. After further conversation, I concluded that the caller was eligible to be a participant. I informed the potential participant that she would be the second person in the pilot study. I explained the purpose of the study and gave the potential participant that a copy of the informed consent. She acknowledged an understanding and agreed to be in the study

without audio recording. I explained that there would be no recording device and I would take notes. A day and time was set for the interview. After successfully completing the pilot study, I continued recruiting six more participants. To improve my recruitment chances, I made contact with three additional learning centers, one center located in Henry County, another in Fulton County and the third center located in DeKalb County. With permission granted, I left flyers for distribution to potential participants.

The recruitment of participants took place from January 14, 2016 to April 19, 2016. Once in the field it became evident that my recruitment strategy needed to change. Flyers remained in the learning centers, while the referral of potential participants increased. I decided to use opportunistic and snowball sampling strategies in this research. I recruited eight participants for this research study using the first two participants for the pilot study. Six fathers participated in the study with one mother and one grandmother. No participant, other than the first participant, wanted to be audio recorded. The interview process took between 20-25 minutes to complete with additional time to clarify answers, ask any questions and perform member checks.

### **Interviews**

All participants completed a demographic profile questionnaire to confirm that he or she met the criteria for being in the study. The eight participants recruited completed the interview process. It was my plan as outlined in Chapter 3, to perform face-to-face interviews with all potential participants. However, during recruitment several potential participants asked if the interview could be over the phone. In the field, qualitative

researchers must be flexible and able to adapt to change as necessary. Four participants' interviews were via telephone per the participant's request, and four interviews were face-to-face. I used an interview protocol (Appendix D) to ensure that each participant's questions were in the same order. No audio recording took place after the first participant. All information written and answers clarified with participants (member checking) following completion of the interview.

### **Data Analysis**

I used Creswell's strategy, as outlined in Table 2 for the data analysis process. In addition, I used hand coding to develop themes. I began the process of data analysis immediately following the interview process by reading and rereading the participants' responses; this helps to minimize the frustration that can come when data becomes overwhelming (Miles, 2014). I bracketed my personal beliefs about childhood obesity as much as possible in order to understand the participants' experiences.

### **Themes**

#### **Theme 1**

One theme was time constraints for preparing healthy meals: This theme emerged from responses to IQ5 and IQ9. In response to IQ5, seven out of eight (87.5%) parents said yes, a parent's work schedule affects preschoolers' eating behavior. FA-0219 stated that his wife is home with the children. In response to IQ9: All participants (100%) agreed that it was important to have their child on a set schedule for eating and bedtime. However, their work schedule impedes their ability to prepare healthy meals. Participant

FA-0415 stated, “Let’s just say a parent that gets off later doesn’t have time to cook a good meal. By the time they get the child, they need quick food. So they grab chips, popcorn or fast food”. Participant FA-0321 stated, “Parents work, tired when they get off stop at McDonald’s & Wendy’s. Parents don’t have the time to cook a decent meal”.

## **Theme 2**

The limited activities–playtime theme emerged from IQ6. Two participants answered no, their work schedule did not interfere with the time they spent with their child and FA-0321 was not currently working. Six participants stated that their child did not participate in any activities; one parent stated that his children were involved in outside activities, and one parent stated his son plays in the park daily. Participant MA-0130 stated, “My children don’t attend sports. Although I can make time to attend, I think the scheduling of practice and game days interfere with study”. Participant FA-0219 stated, “I work the grave yard shift. I tried to teach my daughter to ride a bike but she was too heavy to hold her up”.

## **Theme 3**

The inappropriate diet theme emerged from IQ2 and IQ4. According to the results, 37.5% of participants stated the main cause of overweight or obesity was the foods parents buy, foods parents allow children to eat, and parents lack of knowledge regarding serving size. FA-0204 stated, “It isn’t in all children, hereditary and eating and sleeping a lot”. Other answers included lack of exercise and gluten laced foods. FA-0114 claimed, “Of course, I would think foods possibly high in sugar like corn syrup,

things like that can cause children to become overweight and these candy treats and excessive snacking in my opinion can cause children to become overweight”. Two other participants agreed that anything in excess can cause overweight. Fifty percent of participants also agreed that fast foods, junk food, and fried foods are causes of overweight in children.

#### **Theme 4**

The mealtime routine theme emerged from IQ7, IQ8, IQ9 and IQ11. In response to IQ7, Seven (87.5%) participants answered yes, preschoolers would benefit from having one parent home at all times. FA-0419 commented:

I don't think so. Because there would need to be balance and there would need to be both parents in the household if anything. See there are men and women.

Everybody has a role whether its disciplinarian or nurturer. If there was only one parent there – she would still be lacking what the other parent brings to the table.

And, I'm not talking about two of the same as in homosexuals. I'm talking about a man and a woman.

In response to IQ8, Two participants, (FA-0321 and FA-0415) asserted that they cook every meal. Time and money determined if one father would cook. One participant stated she cooks mostly every day, and FA-0219 stated, “I don't cook, I'm old fashion”.

In response to IQ9, all participants (100%) stated it was important to have their child on a set schedule for eating and bedtime. In response to IQ11, three participants had a regular routine for meals and bedtime. One participant had a regular routine for mealtime,

playtime, and bedtime. One parent had an after school routine, but no routine for bedtime; and another parent stated that the children eat with the mother because he does not like African cuisine, which is the mother's culture; therefore, he does not eat with the family. One father stated that the dinner meal was together, and one father stated there is no routine.

### **Theme 5**

The lack of knowledge theme emerged from IQ1 and IQ3. In response to IQ1, the answers varied among the participants. MO-0130 responded, "children who are not fed properly and depending on their height and weight they are setting their self up for a long list of health problems". Three participants (37.5%) replied that America has a lot of childhood obesity. FA-0204 stated, "It ain't good". Other answers were children eating anything, and children above normal height and weight were considered overweight (FA-0321 and FA-0114). Another father stated, "childhood obesity is out of control and children are consuming more processed food and junk food". In response to IQ3, six participants answered yes their child was overweight. One father did not believe his son was overweight because he played football with him in the park, and FA0321 stated his daughter is not overweight any more she was "chubby".

### **Theme 6**

The family time theme developed from IQ10. In response to IQ10. Four participants (50%) had the dinner meal together with their family all the time. Occasionally FA-0114 had breakfast with the family depending on how early they left



home. MO-0130 allowed the children to watch their favorite shows while eating on the weekend. FA-0219 did not share meals with his family. His wife's culture was African, and he did not like African cuisine. FA-0419 ate with his family 3-4 times a week; his work schedule may interfere with mealtime occurring. FA-0415 ate with his family at least twice a week; however, he normally did not eat with anyone because he preferred eating later in the evening.

### **Theme 7**

The America's childhood obesity theme emerged from IQ1: Three (37.5%) participants asserted America is the number one country with childhood obesity. FA-0219 stated, "Childhood obesity is rampant and out of control; children are eating more junk food and processed food. It's not good for them". Another response: "Children will consume anything given to them" (FA-0321). FA-0204 also felt that childhood obesity was not good for children. FA-0114 stated that when a child's height and weight is above normal, a child is overweight. In addition, a mother also responded, "depending on height and weight and a poor diet, children can have a number of health problems".

## **Research Questions**

### **Research Question 1**

Interview Questions (IQ1, IQ2, IQ3 and IQ4) answered Research Question 1: How does the perception of low-income African American parents, in regards to childhood obesity influence obesity in preschool age children? Overall, the participants in the study demonstrated having some perception of childhood obesity as well as what

causes overweight and obesity in preschool age children. The responses to IQ1 were relevant and indicated that each participant knew something about childhood obesity. Three participants knew about inappropriate diet/poor nutrition and 37.5% of the participants' knowledge was related to America as being the number one country with childhood obesity. Two participants knew childhood obesity was not good for children, and one participant was knowledgeable about children who were above normal weight for their height and weight were considered as overweight.

IQ2: Seventy five percent of the participants associated inappropriate diet as the main cause of overweight and obesity in preschoolers. FA-0114 stated, "for myself, I think it is parents' lack of knowledge concerning obesity and the reason why". Parents were considered as the cause of childhood obesity because of the foods they purchase, foods they prepare and "what parents allow children to eat" (FA-0419).

IQ3: Only 12.5% of participants responded yes, their child was overweight. Three participants stated their child was a little overweight. One participant's response was no and another response was "I don't think my son is overweight" (FA-0415). FA0321 stated, "Not any more, my daughter is chubby, not overweight". All participants (100%) stated their child was healthy.

IQ4: Three (37.5%) participants stated, fast foods, junk foods, and fried foods cause children to be overweight. FA-0219 stated, "Anything in excess causes overweight; my children didn't eat junk it wasn't allowed". FA-0321 responded, "kool-aid, chips any food with starch". FA-0419 stated, "cakes, candies basically your normal

sweets; too much indulgence in sweets”. Other answers included, “starchy foods, macaroni and cheese, and bread” (MO-0130). FA-0114 stated, “I would think foods possibly high in sugar like corn syrup, things like that can cause children to become overweight and these candy treats and excessive snacking in my opinion can cause children to become overweight”. Six (75%) participants stated their pediatrician had recommended healthy food choices.

### **Research Question 2**

Interview Questions (IQ5, IQ6, and IQ7) answered Research Question 2: How does a parent’s work schedule or lack of work influence childhood obesity? Participants’ responses to IQ5, IQ6 and IQ7 demonstrated how the work schedule impact parents’ ability to prepare healthy meals, influence preschoolers eating behavior and interfere with outside activities for preschoolers. IQ5 had an 87.5% positive response that a parent’s work schedule affected preschoolers’ eating behavior. FA-0219 stated, “Mom is home with the child and she can control what the child eats”. GMO-0123 stated, “Yes, it does. When parents are not home, children eat whatever. Work schedule affects eating behavior in the morning and evening”. MO-0130 stated, “Yes because most women work long hours they do not cook complete healthy meals, it is easier to eat out”.

In response to IQ6: Five (62.5%) participants stated that their work schedule interferes with the time they spend with their child and 87.5% of the participations stated their child do not participate in any special activities such as little league sports or dance. Two parents stated their work schedule does not interfere with the time they spend with

their child and FA-0321 stated, “I’m not working”. FA-0415 stated, he is available to spend time with his son; and his son rides his bike at the park, and play football but “he is not involved in any special activities like little league”.

In response to IQ7: Do preschoolers benefit from having one parent at home at all times? Seven (87.5%) participants stated yes, because someone would be home to monitor what the preschooler is doing and prepare healthy meals. GMO-0123 also replied, “Some households have one parent home and still don’t do anything with the child”. MO-0130 also responded “the child could be taught, receive home cooked meals every day and not to mention the bonding time where working parents aren’t able to do”.

One father commented:

I don’t think so. Because there would need to be balance and there would need to be both parents in the household if anything. See there are men and women. Everybody has a role whether it’s disciplinarian or nurturer. If there was only one parent there, she would still be lacking what the other parent brings to the table and I’m not talking about two of the same as in homosexuals. I’m talking about a man and a woman, (FA-0419).

### **Research Question 3**

Interview Questions (IQ8, IQ9, IQ10 and IQ11) answered Research Question 3: How does the mealtime routine of low-income African American parents influence childhood obesity? The overall responses to the interview questions indicated the mealtime routine and the parent’s work schedule were intertwined. In response to IQ8

37.5% of the participants stated their work schedule determined if they would prepare a meal at home. FA-0219 stated, “I don’t prepare meals, I’m old fashion”. FA-0321 and FA-0415 stated they prepared all three meals. MO-0130 stated, “I do cook mostly every day only Fridays we eat out”. FA-0204 commended, “time and money” were the determining factors for him preparing a meal. Fifty percent of the participants stated they were more likely to prepare the dinner meal.

IQ9 indicated 75% of the participants agreed it was important to have their child on a set schedule for eating and bedtime. However, no participant stated a specific time for meals or bedtime. FA-0415 agrees it is important to have his child on a set schedule for eating but not particularly for bedtime. FA-0204 agrees children should be on a set schedule however, his daughter live with her mother. She is with him after school and weekend so the mother sets the schedule.

In response to IQ10: four (50%) participants share the dinner meal with their family. FA-0219 does not eat with the family because of his dislike for the cultural cuisine prepared by his African wife. FA-0321 has breakfast and dinner with the family and nothing prevents mealtime from occurring. FA-0419 eats with his family 3-4 times per week and his work schedule may prevent family mealtime from occurring. FA-0415 eats with the family at least twice a week; he prefers to eat later and normally he eats alone.

IQ11 answers indicated no participant had a regular routine for mealtime, playtime, and bedtime for his/her child. Each participant had a routine that worked for

him/her. Two parents had a regular routine for mealtime and bedtime. MO-0130 and FA-0321 specified the dinner mealtime and bedtime. FA-0419 specified the bedtime. One father stated the dinner meal is together and because of homework, the opportunity for playtime is limited (FA-0114). FA-0219 responded his children eat with their mother and “they have a set bedtime”. FA-0415 stated, “my family has no set routine”. FA-0204 stated, his children go to sleep when they come home from school and if he wakes them up they will cry. ”They be up at night, no routine for bedtime”.

### **Evidence of Trustworthiness**

#### **Credibility**

The trustworthiness of this phenomenological qualitative inquiry began with developing a respectful, trusting and honest relationship between participant and researcher. It is the responsibility of the researcher to protect the research participant from harm. I treated participants humanely and showed respect at all times. All questions were answered prior to starting the interview and during data collection as needed. Participants provided thick, context-rich responses to the interview questions. To increase credibility, member checks was performed throughout the interview process. Following completion of the interview process, data was read back to participant to confirm accuracy of information. In addition, triangulation of data collection methods, interviews, reflexivity, and observations established credibility.

**Transferability**

To establish transferability, this study provided a table with the demographic characteristics of the participants and details of the settings and processes used to carry out this study. The findings provided thick rich descriptions that allow other researchers to assess the potential of transferability to setting of their own (Miles et al., 2014).

**Dependability**

Dependability was achieved by employing consistency in this research inquiry. I developed eleven-interview questions; which were assessed and approved by subject matter experts in the field, to answer three research questions. An interview protocol guide was used during the interview to assure the interview questions would be asked in the same order. In addition, the role of the researcher was described explicitly (Miles et.al.).

**Confirmability**

Confirmability was achieved by checking and rechecking data during the interview process (Trochim, 2005). Upon completion of the interview process, participant's responses were read back to confirm accuracy of information written and to give participants the opportunity to provide additional information if warranted.

**Summary**

The purpose of this phenomenological research study was to explore how the perception of low-income African American parents' influence childhood obesity. Eight participants recruited from counties surrounding the Metropolitan Atlanta Region in

Georgia took part in this study. Interview questions were designed to elicit responses to better understand how parent's work schedule, perception, and mealtime routine influence obesity in preschool age children.

Responses to the interview questions demonstrated participants' perception of childhood obesity possibly contribute to obesity in preschoolers. In addition, participants were aware of how their work schedule prevents him/her from spending quality time with their child and preparing a healthy meal. As the interviews points out, the work schedule influences the eating behavior of preschoolers, as well as hinders household routines.

This chapter described the pilot study, research setting, demographics, how participants were protected, data collection, data analysis, and evidence of trustworthiness. Chapter 5 summarizes the findings. I discuss the limitations of the study, recommendations for future research, implications for social change and conclusion.



## **Chapter 5: Summary, Recommendation, and Conclusion**

A number of researchers have focused on the causes of childhood obesity. The health consequences associated with overweight/obese children have placed a financial burden on some parents and the population. Even with health care insurance, some parents do not have the resources to seek medical care for their child. Without understanding what role parents play in the prevalence of childhood obesity, it may be difficult to empower parents to become proactive in alleviating obesity and developing an environment that will foster a healthy lifestyle. The intent of this study was to understand how African American parents perceive childhood obesity and if their perception contributed to the high prevalence among low-income African American children.

It has been noted by researchers that African Americans do not participate in research and therefore, finding from quantitative studies do not generalize to the African American population (Corbie-Smith et al., 1999). Without African Americans, participation in research studies, preventive measures put in place may not be effective or accepted. For those reasons, I chose a phenomenological approach in order to necessitate dialogue with participants to hear of their experiences with childhood obesity. A phenomenological approach allowed me to become close to the phenomenon through interviewing the participants in a natural setting and gaining an understanding of their daily experiences.

## **Interpretation of Findings**

I conducted a transcendental phenomenological study that allowed participants to express their personal views and lived experiences regarding childhood obesity. The study was in a naturalistic setting with African American participants, whose household income did not exceed \$47,700 for a family of four. I developed 11 interview questions, reviewed and found to be valid and in alignment with the research questions, by experts in the field of nutrition and obesity. RQ1 aligns with IQ1, IQ2, IQ3 and IQ4; RQ2 aligns with IQ5, IQ6, and IQ7; RQ3 aligns with IQ8, IQ9, IQ10, and IQ11. To add credibility to the study, member checking was employed during data collection. Because qualitative researchers focus on clarifying the meanings individuals or groups understand about a phenomenon, the findings from this study might enable health care professionals, stakeholders, and learning center directors to better understand how parents perceive childhood obesity and why parents' actions toward dietary intake and physical activity appears as lackadaisical. In addition, health care providers and parents can collaborate on strategies to improve dietary intake and physical activities/playtime. Full interpretations of the findings are in Chapter 4.

## **Research Questions**

### **Research Question 1**

Interview Questions (IQ1, IQ2, IQ3 and IQ4) answered Research Question 1: Overall, the participants in the study demonstrated having some familiarity with the term childhood obesity, as well as what causes overweight and obesity in preschool age

children. Three participants associated their knowledge of childhood obesity with America being the number one country with obese children. Although 25% of the participants understanding of childhood obesity was related to inappropriate diet, 75% of the participants associate bad eating habits with overweight and obese children. It is difficult to determine what criteria parents are using to identify obesity or overweight in his/her child. The responses to IQ3 imply that participants in the study need additional education on childhood obesity. Several participants were reluctant to say their child was overweight. As for what foods cause a child to be overweight, the responses varied from starchy foods, fried foods and fast foods to foods, and drinks with high sugar content.

### **Research Question 2**

Interview Questions (IQ5, IQ6, and IQ7) were used to answer Research Question 2: Eighty seven percent of the participants' responses were positive in relation to the work schedule affecting preschoolers' eating behavior as well as preschooler's playtime activities. MO-0130 stated, "Mothers work long hours, therefore, they cannot always cook healthy meals, eating out is an easy solution". In addition, preschoolers did not participate in any special activities according to 87.5% of the participants. (GMO-0123). With a positive response from the majority of the participants relating to the work schedule and its effect on eating behavior of preschool age children, it was perceived by 87.5% of the participants that one parent being home would have a positive effect on preschoolers' eating behavior.

### **Research Question 3**

Interview Questions (IQ8, IQ9, IQ10 and IQ11) were used to answer Research Question 3: The mealtime routine was affected by the parent's work schedule. Although the majority of participants (87.5%) asserted that it is important to have a mealtime routine, only five participants ate meals with their child daily. Seventy five percent of the participants agreed it was important to have their child on a set schedule for eating and bedtime. Yet, only three (37.5%) of the participants had a routine for meals and bedtime and only two participants specified the time.

### **Limitations**

Within this study, the sample consisted of only low-income African Americans living within one of nine counties surrounding the Atlanta Region. Because qualitative researchers focus on elucidating the meaning of a phenomenon held by an individual or group, the finding from this study are not generalizable to all low-income African Americans. In addition, the majority (75%) of the participants were fathers. Thus, mothers were a minority in this study.

### **Recommendations for Further Research**

Understanding the perceptions of low-income African Americans' relation to childhood obesity is significant; however, it is important to understand the culture of the African American population. No participant referred to his/her child as being obese. In the African American community, children are considered as being thick, healthy, having big bones, and heavy. I suggest using terms that are part of the African American

culture. Based on finding from this study, I recommend that further qualitative studies be conducted with a larger sample size including, parents with higher income and educational levels. Although African Americans show a lack of participation in quantitative studies (Corbie-Smith et al., 1999), I suggest a mixed method approach to compare risk factors identified in previous studies related to parental perception influencing childhood. From the findings in this study, some of the experiences and perceptions of African Americans are parallel to finding in similar qualitative studies.

### **Implications for Positive Social Change**

Gaining a better understanding of the perceptions that African American parents have in relation to childhood obesity is complex. Not only are the day-to-day problems a factor in the decision making process but also the social and economic disparities experienced by other African Americans penetrate the core of the population's existence. Implications for positive social change go beyond understanding the causes of childhood obesity as perceived by African American parents. Positive social change in the lives of African Americans must start with a mutual trust and respect between parents and health care associates (nurses, social workers, dietitians, or physician), researchers who are providing information that can facilitate change and stakeholders who have the power to create and implement policies that can bring about social change.

In this study, I showed a glimpse into the lives of a select population, low-income African Americans. With the understanding gained through this transcendental phenomenological approach, researchers can undertake additional qualitative studies to

expand the body of knowledge pertaining to childhood obesity as perceived by the African American population. In addition, health care providers, in collaboration with parents, can develop corrective/preventive measures to ameliorate overweight and childhood obesity. Learning centers directors can initiate appropriate playtime activities to increase preschooler's physical movement to balance dietary intake. As First Lady Michelle Obama stated, the physical health, security and economic health of the nation is at stake due to childhood obesity (Let's Move, n.d.).

### **Recommendation for Practice**

Childhood obesity is a social issue that requires any means necessary to enlighten parents of their role in alleviating the prevalence of obesity among African American children. It is important that parents understand information provided by health care providers. Akhtar-Danesh et al. (2010) suggested that one method of educating parents is during well health checks for children using nurse practitioners to educate parents on health issues and causes and consequences of childhood obesity. Too often, there is a misunderstanding between what the health care providers tells the patient, and what the patient perceived the information to mean. It is equally important to provide information in a format that all populations can understand.

### **Researcher's Reflection**

When I started this journey, I did not know what to expect. There were always thoughts and comments I had heard as well as my personal beliefs clashing because I knew everyone was not alike and circumstances might be out of one's control. I found it

interesting that children were not looking or acting as children were during my childhood. It was surprising that everywhere I travelled within a 60 miles radius I saw children who were not only overweight but also obese.

I recalled looking at my granddaughter and thinking she is overweight and going to become obese if measures are not taken to improve her eating and activity habits. I also realized what she consumed and when she was active was totally up to her parents. It was that day; I decided not to just talk about the forthcoming problem but to become proactive in contributing to positive social change. The journey was worth the sacrifices. I learned that sometimes just listening and not criticizing could make a difference in how someone will accept suggestions that can improve their health. It is generally true change starts at the top (implementing new policies), but it is just as true change can start anywhere, at the bottom or in the middle (with an individual or group).

### **Conclusions**

Childhood obesity continues to be a quagmire for the country. Identifying how parents perceive childhood obesity can help to promote appropriate strategies to relieve the medical and financial burden associated with childhood obesity. Health related issues due to childhood obesity cost \$14 billion (CDF, 2014). In addition, organizations incur an indirect cost of \$4.3 billion from productivity loss due to job absenteeism (Cawley, 2010; Hammond & Levine, 2010). These facts warrant action by parents, health care providers, policy makers and other stakeholders in order to reduce the economic burden

experienced by the population (specifically parents) and to ensure that children will not be burdened with the aftereffects of childhood obesity.

Understanding the factors associated with obesity is one-step toward alleviating this social issue and preventing an increase in the prevalence of childhood obesity. Two factors identified in several studies were, time restraints and fatigue as barriers for working parents to plan and prepare a meal (Koulouglioti et al., 2011; Sealy, 2010; Storfer-Isser & Musher-Eizenman, 2013). African Americans face some of the same challenges as those identified in similar qualitative studies. The work schedule appears to affect preparing healthy meals, physical activities, and mealtime and bedtime routines. In addition, low-income families are faced with social issues, (e.g., crime and violence, and poverty), and other determinants of health that influence their decisions.

I also found that the mother may prepare meals but the father may not always eat with the family. According to the results, 87.5% of the participants responded that the work schedule affected preschoolers eating behavior. In addition, the majority of the participants also felt that if one parent was home, the eating behavior of the child would improve. The parent who is home will prepare healthy meals and control what the child is eating. It was expressed by one participant that it takes two incomes for a family. That statement was true for many families regardless of their SES. I suggest that parents become empowered in order to advocate for social change that will have a positive effect on their family.



There is a solution to ameliorating childhood obesity. Lewin posited, “To understand or predict behavior, the person and his environment have to be considered as one constellation of interdependent factors” (as cited in The Tavistock Institute, n.d. para.

4). Understanding the perceptions of parents is one part of the solution.

## References

- Anderson, P. (2012). Parental employment, family routines and childhood obesity. *Economics and Human Biology*, 10(4), 340-351. doi:10.1016/j.ehb.2012.04.006
- Anderson, S., & Whitaker, R. (2010). Household routines and obesity in US preschool-aged children. *Pediatrics*, 125(3), 420-428. doi:10.1054/peds.2009-0417
- Anonymous (2011). Addressing childhood obesity among African Americans. *Journal of Physical Education, Recreation & Dance*, 82(9), 4. Retrieved from <http://search.proquest.com/docview/903536165?accountid=14872>.
- Association of State and Territorial Health Officials, (2013). Georgia: Partnering to strengthen childhood obesity prevention. Retrieved from <http://www.astho.org/Georgia-SHAPE-Initiative-Case-Study/>
- Atlanta Public Schools, (2008). Pre-kindergarten overview: Pre-kindergarten prepares students from the start. Retrieved from <http://www.atlanta.k12.ga.us/Page/982>
- Bell, J. F. & Zimmerman, F. (2010). Shortened nighttime sleep duration in early life and subsequent childhood obesity. *JAMA Pediatrics*, 164(9), 840-845. doi:10.1001/archpediatrics.2010.143
- Bellows, L., Silvernail, S., Caldwell, L., Bryant, A., Kennedy, C., Davies, P., & Anderson, J. (2011). Parental perception on the efficacy of a physical activity program for preschoolers. *Journal of Community Health*, 36(2), 231-7. doi:<http://dx.doi.org/10.1007/s10900-010-9302-1>

- Bezruchka, S. (Producer). (2005, April 15). *From womb to tomb: The influence of early childhood on adult health* [Audio podcast]. Retrieved from <http://www.alternativeradio.org/products/bezs002>
- Bronfenbrenner, U. (1994). Ecological models of human development. In *International Encyclopedia of Education*, vol.3, 2<sup>nd</sup>. Ed. Oxford: Elsevier. Reprinted in: Guvain, M. & Cole, M. (Eds.), *Readings on the development of children*, 2<sup>nd</sup> Ed. (1993, pp. 37-43). NY: Freeman
- Cawley, J. (2010). The economics of childhood obesity. *Health Affairs*, 29(3), 364.371. doi: 10.1377/hlthaff.2009.0721
- Centers for Disease Control and Prevention (2012). Basics about childhood obesity: What are the consequences of childhood obesity. Retrieved from <http://www.cdc.gov/obesity/childhood/basics.html>
- Centers for Disease Control and Prevention (2013). Vital signs: Obesity among low-income, preschool-aged children — United States, 2008–2011. Retrieved from [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6231a4.htm?s\\_cid=mm6231a4\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6231a4.htm?s_cid=mm6231a4_w)
- Centers for Disease Control and Prevention (2014). Healthy weight - it's not a diet, it's a lifestyle! Retrieved from [www.cdc.gov/media/subtopic/matte/pdf/031210-Healthy-Weight.pdf](http://www.cdc.gov/media/subtopic/matte/pdf/031210-Healthy-Weight.pdf)
- Chaput, J.-P., Klingenberg, L., Astrup, A. and Sjödín, A. M. (2011). Modern sedentary activities promote overconsumption of food in our current obesogenic

environment. *Obesity Reviews*, 12(5), e12–e20. doi: 10.1111/j.1467-789X.2010.00772.x

Cherry, K. (n.d.). Kurt Lewin biography (1890-1947). Retrieved from [http://psychology.about.com/od/profilesofmajorthinkers/p/bio\\_lewin.htm](http://psychology.about.com/od/profilesofmajorthinkers/p/bio_lewin.htm)

Children's Defense Fund (2012). Childhood obesity. Retrieved from <http://www.childrensdefense.org/policy-priorities/childrens-health/child-nutrition/childhood-obesity.html>

. Christoffel, K. K., Wang, X. and Binns, H. J. (2012). Early origins of child obesity: Bridging disciplines and phases of development – September 30-October 1, 2010. *International Journal of Environmental Research and Public Health*, 9(4), 1227-1262. doi:10.3390/ijerph9041227

Corbie-Smith, G., Thomas, S. B., Williams, M.V., and Moody-Ayers, S. (1999). Attitudes and beliefs of African Americans toward participation in medical research. *Journal of General Internal Medicine*, 14(9), 537-546. doi: 10.1046/j.1525-1497.1999.07048.x

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage Publications

Datar, A., Nicosia, N., and Shier, V. (2013). Parental perceptions of neighborhood safety and children's physical activity, sedentary behavior, and obesity: Evidence from a

national longitudinal study. *American Journal of Epidemiology*, 177(10), 1065-1073. doi: 10.1093/aje/kws353

Deal, B. (2010). A pilot study of nurses' experience of giving spiritual care. *The Qualitative Report*, 15(4), 852-863 Retrieved from <http://search.proquest.com/docview/757177667?accountid=14872>

Dev, D. A., McBride, B. A., Fiese, B. H., Jones, B. L., & Cho, H. on behalf of the STRONG Kids Research Team (2013). Risk factors for overweight/obesity in preschool children: an ecological approach. *Childhood Obesity*, 9(5), 399-408. doi: 10.1080/00981389.2011.597315

Ebbeling, C. B., Pawlak, D. B. and Ludwig, D. S. (2002). Childhood obesity: Public-health crisis, common sense cure. *The Lancet*, 360(9331), 473-482. doi:10.1016/S0140-6736(02)09678-2

Families USA (2014). Federal poverty guidelines. Retrieved from <http://familiesusa.org/product/federal-poverty-guidelines>

Garrett-Wright, D. (2011). Parental perception of preschool child body weight. *Journal Of Pediatric Nursing*, 26(5), 435-445. doi:10.1016/j.pedn.2010.07.009

George, M., Freedman, T. G., Norfleet, A. L., Feldman, H. I., and Apter, A. J. (2003). Qualitative research-enhanced understanding of patients' beliefs: Results of focus groups with low-income, urban, African American adults with asthma. *Journal of Allergy and Clinical Immunology*, 111, 967-973. <http://dx.doi.org/10.1067/mai.2003.1459>

Georgia Department of Public Health (n.d.). An encouraging trend on childhood obesity.

Retrieved from <http://dph.georgia.gov/encouraging-trend-childhood-obesity>

Accessed [24th July 2014]

Georgia SHAPE (n.d.). About Georgia SHAPE. Retrieved 2014 from

<http://www.georgiashape.org/story/about-georgia-shape>

Gillman, M. W., Rifas-Shiman, S. L., Kleinman, K., Oken, E., Rich-Edwards, J. W.

and Taveras, E. M. (2008). Developmental origins of childhood overweight:

Potential Public Health Impact. doi: 10.1038/oby.2008.260

Glanz, K., Rimer, B. K., Viswanath, K. (2008). Health behavior and health education:

Theory, Research and Practice (4<sup>th</sup> ed.). San Francisco, CA: Jossey-Bass

Goodell, L. S., Pierce, MN. B., Bravo, C. M., & Ferris, A. M. (2008). Parental

perceptions of overweight during early childhood. *Qual Health Research*, 18(11),

1548-1555. doi: 10.1177/1049732308325537

Green, H. E. (2014). Use of theoretical and conceptual frameworks in qualitative

research. *Nurse Researcher*, 21(6), 34-38. doi:10.7748/nr.21.6.34.e1252

Haboush, A., Phebus, T., Tanata Ashby, D., Zaikina-montgomery, H., & Kindig, K.

(2011). Still unhealthy 2009: Building community research to identify risk

factors and health outcomes in childhood obesity. *Journal of Community Health*,

36(1), 111-20. doi:<http://dx.doi.org/10.1007/s10900-010-9288-8>

- Hammond, R. A., & Levine, R. (2010). The economic impact of obesity in the United States . *Diabetes, Metabolic Syndrome and Obesity : Targets and Therapy*, 3, 285–295. doi:10.2147/DMSOTT.S7384
- Haugstvedt, K. T. S., Graff-Iversen, S., Bechensteen and Halberg, U. (2011). Parenting an overweight or obese child: A process of ambivalence. *Journal of Child Health Care*, 15(1), 71-80. doi: 10.10.1177/1367493510396262
- Herman, A. N., Malhotra, K., Wright, G., Fisher, J. O., & Whitaker, R. C. (2012). A qualitative study of the aspirations and challenges of low-income mothers in feeding their preschool-aged children. *International Journal of Behavioral Nutrition and Physical Activity*, 9, 132. doi:http://dx.doi.org/10.1186/1479-5868-9-132
- Hernandez, R. G., Thompson, D. A., Cheng, T. L. & Serwint, J. R. (2012). Early-childhood obesity: How do low-income parents of preschoolers rank known risk factors? *Clinical Pediatrics*, 51(7), 663–670. doi: 10.1177/0009922812440841
- Huang, J. S., Barlow, S. E., Quiros-Tejeira, R. E., Scheimann, A., Skelton, J., Suskind, D., ... Xanthakos, S. A. (2013). Childhood obesity for pediatric gastroenterologists. *Journal of pediatric gastroenterology and nutrition*, 56(1), 99.
- Hughes, C. C., Sherman, S. N. & Whitaker (2010). How low-income mothers with overweight preschool children make sense of obesity. *Qualitative Health Research*, 20(4), 465-478 doi: 10.1177/1049732310361246

- Jago, R., Sebire, S. J., Edwards, M. U., & Thompson, J. L. (2013). Parental tv viewing, parental self-efficacy, media equipment and tv viewing among preschool children. *European Journal of Pediatrics, 172*(11), 1543-1545.. doi: 10. 1007/s00431-013-2077-5
- Jimenez-Cruz, A., Bacardi-Gascon, M., Castillo-Ruiz, O, Mandujano-Trujillo, Z., & Pichardo-Osuna, A. (2010). Low income, Mexican mothers' perception of their infants' weight status and beliefs about their foods and physical activity. *Child Psychiatry Human Development, 41*(5), 490-500. doi:10.1007/s10578-010-0183-4
- Jones, A. R., Parkinson, K. N., Drewett, R. F., Hyland, R. M., Pearce, M. S., & Adamson, A. J. (2011). Parental perceptions of weight status in children: The Gateshead Millennium Study. *International Journal of Obesity, 35*(7), 953-62.  
doi:10.1038/ijo.2011.106
- Jones-Smith, J. C., Dieckmann, M., Gottlieb, L., Chow, J., & Fernald, L. H. (2014). Socioeconomic status and trajectory of overweight from birth to mid-childhood: The early childhood longitudinal study-birth cohort. *Plos ONE, 9*(6), 1-10.  
doi:10.1371/journal.pone.0100181
- Kalinowski, A., Krause, K., Berdejo, C., Harrell, K., Rosenblum, K. & Lumeng, J.C. (2012). Beliefs about the role of parenting in feeding and childhood obesity among mothers of lower socioeconomic status. *Journal of Nutrition Education and Behavior, 44*(5), 432-437. doi: 10.1016/j.jneb.2010.09.017



- Kim, Y (2010). The pilot study in qualitative inquiry. *Qualitative Social Work, 10*(2), 190-206. doi: 10.1177/1473325010362001v1
- Kime, N. (2009). How children eat may contribute to rising levels of obesity children's eating behaviors: An intergenerational study of family influences. *International Journal of Health Promotion and Education, 47*(1), 4-11. doi: 10.1080/14635240.2009.10708151
- Koleilat, M., Harrison, G., Whaley, S., McGregor, S., Jenks, E., & Afifi, A. (2012). Preschool enrollment is associated with lower odds of childhood obesity among WIC participants in LA county. *Maternal & Child Health Journal, 16*(3), 706-712. doi:10.1007/s10995-011-0774-0
- Koulouglioti, C., Cole, R., & Moskow, M. (2011). Single mothers' views of young children's everyday routines: A focus group study. *Journal Of Community Health Nursing, 28*(3), 144-155. doi:10.1080/07370016.2011.589236
- Kumanyika, S. K., Whitt-Glover, M. C., Gary, T. L., Prewitt, T. E., Odoms-Young, A. M., Banks-Wallace, J., . . . Samuel-Hodge, C. D. (2007). Expanding the obesity research paradigm to reach African American communities. *Preventing Chronic Disease, 4*(4). Retrieved from [http://www.cdc.gov/pcd/issues/2007/oct/07\\_0067.htm](http://www.cdc.gov/pcd/issues/2007/oct/07_0067.htm).
- Lee, H., Andrew, M., Gebremariam, A., Lumeng, J. C., & Lee, J. M. (2014). Longitudinal associations between poverty and obesity from birth through

adolescence. *American Journal Of Public Health*, 104(5), e70-e76.

doi:10.2105/AJPH.2013.301806

Lee, S., Young, D. R., Pratt, C. A., Jobe, J. B., Chae, S. E., McMurray, R. G., . . .

Stevens, J. (2012). Effects of parents' employment status on changes in body mass index and percent body fat in adolescent girls. *Childhood Obesity*, 8(6), 526-32.

doi:http://dx.doi.org/10.1089/chi.2011.0087

Leff, A. (2002). *Race, poverty and hunger*. (). Washington: Poverty & Race Research Action Council. Retrieved from doi: 10.1038/oby.2008.260

Let's Move (n.d.). America's move to raise a healthier generation of kids. Retrieved [2014] from <http://www.letsmove.gov/about>

Let's Move (n.d.). The facts for African Americans. Retrieved [2014] from [http://www.letsmove.gov/sites/letsmove.gov/files/Let%27s\\_Move\\_Fact\\_Sheet\\_for\\_African%20Americans.pdf](http://www.letsmove.gov/sites/letsmove.gov/files/Let%27s_Move_Fact_Sheet_for_African%20Americans.pdf)

Lumeng, J. C., Ozbeki, T. N., Appugliese, D. P., Kaciroti, N., Corwyn, R. F. & Bradley, R. H. (2012). Observed assertive and intrusive maternal feeding behaviors increase child adiposity. *American Journal of Clinical Nutrition*, 95(3), 640-647. doi:10.3945/ajcn.111.024851

Malhotra, K., Herman, A. N., Wright, G., Bruton, Y., Fisher, J. O. & Whitaker, R. C. (2013). Perceived benefits and challenges for low-income mothers of having family meals with preschool-aged children: Childhood memories matter. *Journal*

*of the Academy of Nutrition and Dietetics*, 113(11), 1484-1493. doi:

10.1016/j.jand.2013.07.028

- Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum : Qualitative Social Research*, 11(3) Retrieved from <http://search.proquest.com/docview/869912466?accountid=14872>
- Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage Publications
- May, A. L., Freedman, D., Sherry, B., & Blanck, H. M. (2013). Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC. Obesity – United States, 199-2010. *Morbidity and Mortality Weekly Report (MMWR)*, (November 22, 2013), 62(03), 120-128. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a20.htm>
- Miles, B. M., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage Publications
- Moore, K. G., & Bailey, J. H. (2013). Parental perspectives of a childhood obesity intervention in Mississippi: A phenomenological study. *The Qualitative Report*, 18(48), 1-22. Retrieved from <http://search.proquest.com/docview/1505320956?accountid=14872>

- Murashima, M., Hoert, S. L., Hughes, S. O. & Kaplowitz, S. A. (2012). Feeding behaviors of low-income mothers: directive control relates to a lower BMI in children, and a nondirective control relates to a healthier diet in preschoolers. *American Journal of Clinical Nutrition, 95*:1031-1037
- Nahar, V. K., Ford, M. A., Hallam, J. S., Bass, M. A., Hutcheson, A., & Vice, M. A. (2013). "Skin Cancer Knowledge, Beliefs, Self-Efficacy, and Preventative Behaviors among North Mississippi Landscapers". *Dermatology Research and Practice, 1-7*. doi:10.1155/2013/496913
- National Collaborative on Childhood Obesity Research (n.d.). Childhood obesity in the United States. Retrieved [2014] from [http://www.nccor.org/downloads/ChildhoodObesity\\_020509.pdf](http://www.nccor.org/downloads/ChildhoodObesity_020509.pdf)
- Nicklas, T. A., O'Neil, C.,E., Stuff, J. E., Hughes, S. O., & Liu, Y. (2012). Characterizing dinner meals served and consumed by low-income preschool children. *Childhood Obesity, 8*(6), 561-71. doi:<http://dx.doi.org/10.1089/chi.2011.0114>
- Nsiah-Kumi, P., Ariza, A. J., Mikhail, L. M., Feinglass, J. & Binns, H. J. (2009). Family history and parents' beliefs about consequences of childhood overweight and their influence on children's health behaviors. *Academic Pediatrics, 9*(1), 53-9. Retrieved from <http://search.proquest.com/docview/208561969?accountid=14872>
- Obesity Society (2014). Childhood overweight. Retrieved from <http://www.obesity.org/resources-for/childhood-overweight.htm>

- Ogden, C. L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2012). Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010. *Journal of the American Medical Association, 307*(5), 483-490. doi: 10.1001/jama.2012.40
- Onwuegbuzie, A. J., Leech, N. L., & Collins, K. M. T. (2010). Innovative data collection strategies in qualitative research. *The Qualitative Report, 15*(3), 696-726. Retrieved from <http://www.nova.edu/ssss/QR/QR15-3/onwuegbuzie.pdf>
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage Publications
- Peña, M., Dixon, B., & Taveras, E. M. (2012). Are you talking to me? the importance of ethnicity and culture in childhood obesity prevention and management. *Childhood Obesity, 8*(1), 23-7. doi:<http://dx.doi.org/10.1089/chi.2011.0109>
- Perception. (n.d.). Retrieved October 23<sup>rd</sup>, 2014 from <http://www.merriam-webster.com/dictionary/perception>
- Roden, J. (2004). Revisiting the Health Belief Model: nurses applying it to young families and their health promotion needs. *Nursing & Health Sciences, 6*(1), 1-10.
- Rudestam, K. E. & Newton, R. R. (1992). *Surviving your dissertation: A comprehensive guide to content and process*. Newbury Park, CA: Sage Publications
- Sealy, Y. M. & Farmer, G. L. (2011). Parents' stage of change for diet and physical activity: Influence on childhood obesity. *Social Work in Health Care, 50*, 274-291. doi: 10.1080/00981389.2010.529384

- Shape America. Society of Health and Physical Education (n.d.). Active start: A statement of physical activity guidelines for children from birth to age 5, 2<sup>nd</sup> edition. Retrieved on March 20, 2015, from <http://www.shapeamerica.org/standards/guidelines/activestart.cfm>
- Spivack, J. G., Swietlik, M., Alessandrini, E., & Faith, M. (2010). Primary care providers' knowledge, practices, and perceived barriers to the treatment and prevention of childhood obesity. *Obesity Journal, 18*(7), 1341-1347. doi: 10.1038/oby.2009.410
- State of Georgia, (2013). The Governor's office of student achievement. Georgia pre-k: investing in Georgia's four-year-old students. Retrieved from <http://gosa.georgia.gov/georgia-pre-k-investing-georgias-four-year-old-students>
- Strasburger, V. C. (2011). American Academy of Pediatrics Policy Statement. Children, adolescents, obesity, and the media. *Pediatrics, 128*(1): 201 -208. doi: 10.1542/peds.2011-1066
- Storfer-Isser A. & Musher-Eizenman D. (2013). Measuring parent time scarcity and fatigue as barriers to meal planning and preparation: quantitative scale development. *Journal of Nutrition Education and Behavior, 45*(2):176-82. doi: 10.1016/j.jneb.2012.08.007

- Sundaram, S. S. (2012). Pediatric non-alcoholic fatty liver disease. Retrieved from American Liver Foundation website:  
<http://www.liverfoundation.org/chapters/rockymountain/doctorsnotes/pediatricnafld/>
- The Tavistock Institute (n.d.). Kurt Lewin – ‘Field Theory Rule’. Retrieved from <http://www.tavistockinstitute.org/projects/field-theory-rule/>
- The White House (2010). Office of the First Lady. First Lady Michelle Obama launches Let's Move: America's move to raise a healthier generation of kids. Retrieved from <https://www.whitehouse.gov/the-press-office/first-lady-michelle-obama-launches-lets-move-americas-move-raise-a-healthier-genera>
- Thornburg, K. (2011). A very brief description of developmental origins of health and disease.  
Retrieved from [http://www.ohsu.edu/xd/about/news\\_events/news/2011/08-29-dohad/history.cfm](http://www.ohsu.edu/xd/about/news_events/news/2011/08-29-dohad/history.cfm)
- Towns, N. & D'Auria, J. (2009). Parental perceptions of their child overweight: An integrative review of the literature. *Journal of Pediatric Nursing*, 24(2), 115 – 130. doi:10.1016/j.pedn.2008.02.032
- Treviño, R. P., Vasquez, L., Shaw-Ridley, M., Mosley, D., Jechow, K., & Piña, C. (2015). Outcome of a food observational study among low-income preschool children participating in a family-style meal setting. *Health Education & Behavior*, 42(2), 240-248. doi: 10.1177/1090198114550823

Trochim, W.M. (2006). Research Methods Knowledge Base. Sampling terminology.

Retrieved from <http://www.socialresearchmethods.net/kb/sampterm.php>

Trust for America's Health and Robert Wood Johnson Foundation (2014). The state of obesity. Special report: Racial and ethnic disparities in obesity. Retrieved from

<http://stateofobesity.org/disparities/blacks/>

Trust for America's Health and Robert Wood Johnson Foundation (2014). The state of obesity. Obesity Among 2- to 4-Year-Olds from Low-Income Families, 1989-

2011. Retrieved from <http://stateofobesity.org/rates/>

U.S. Department of Health and Human Services (2014). Office of the Assistant Secretary for Planning and Evaluation. 2014 Poverty guidelines. Retrieved from

<http://aspe.hhs.gov/poverty/14poverty.cfm>

United States Department of Agriculture (2004). Food and Nutrition Service, Testimony of Eric M. Bost Under Secretary, Food, Nutrition and Consumer Services before the House Committee on Government Reform Subcommittee on Human Rights and Wellness. Retrieved from

<http://www.fns.usda.gov/cga/speeches/ct091504.html#top>



U.S. Department of Health and Human Services (2014). Office of The Assistant

Secretary for Planning and Evaluation. Retrieved from

<http://aspe.hhs.gov/poverty/14poverty.cfm>

University of Twente (2014). Theory clusters: Health Belief Model. Retrieved from

[http://www.utwente.nl/cw/theorieenoverzicht/theory%20clusters/health%20communication/health\\_belief\\_model/](http://www.utwente.nl/cw/theorieenoverzicht/theory%20clusters/health%20communication/health_belief_model/)

van Manen, M. (2011). Phenomenology online: A resource for phenomenological

inquiry. Retrieved from <http://www.phenomenologyonline.com/scholars/husserl-edmund/>

World Health Organization (2014). Global strategy on diet, physical activity and health:

commission on ending childhood obesity. Retrieved from

[http://www.who.int/dietphysicalactivity/childhood\\_why/en/](http://www.who.int/dietphysicalactivity/childhood_why/en/) Accessed on [30<sup>th</sup> July 2014]

World Health Organization (2012). Obesity and overweight. Retrieved from

<http://www.who.int/mediacentre/factsheets/fs311/en/index.html>

**Appendix A: Research Question 1 and Interview Questions**

Alignment of research questions with interview questions.

**Research Question 1**

How does the perception of low-income African American parents, in regards to childhood, influence obesity in preschool age children?

**Interview Questions**

1. Tell me what you know about childhood obesity.
2. What is the main cause of overweight or obesity in preschool age children?
3. Do you think your child is overweight? Is your child healthy? Explain.
4. What foods cause children to become overweight? Has your pediatrician recommended healthy food choices for your child?

**Appendix B: Research Question 2 and Interview Questions**

## Research Question 2

How does a parent's work schedule or lack of work influence childhood obesity?

**Interview Questions**

5. Do you think a parent's work schedule affects preschoolers' eating behaviors? Explain
6. Does your work schedule interfere with the time you spend with your child? Does your child participate in any special activities such as little league sports or dance? Do you have time to attend these events/activities?
7. Do preschoolers benefit from having one parent at home at all times?

## **Appendix C: Research Question 3 and Interview Questions**

### **Research Question 3**

How does the mealtime routine of low-income African American parents influence childhood obesity?

### **Interview Questions**

8. What determines if you will prepare meals at home? Which meals are you most likely to prepare at home?
9. Is it important for you to have your child on a set schedule for eating and bedtime? Explain.
10. How often does your family eat meals together? Is there anything that prevents family mealtime from occurring? Explain.
11. Describe your daily routine for mealtime, playtime, and bedtime for your child. Does this routine work for you?

**Appendix D: Interview Protocol**

Interview# \_\_\_\_\_

Date \_\_\_\_\_

## Interview Protocol

Welcome and thank you for your participation today. My name is Vickie Sims-Johnson; I am a PhD student in Health Services at Walden University conducting a qualitative phenomenology study in partial fulfillment of the requirements for my degree. The purpose of this study is to understand better the perception of low-income African American parents as it relates to their experience with an obese/ overweight preschooler 4-5 years of age. Thank you for completing the demographic survey. Before we begin the (face-to-face) interview, you will need to sign the informed consent. The interview will take 45-60 minutes and will include 11 questions regarding your (parent's) perception and influence on childhood obesity. I would like your permission to tape record this interview, that way I will be able to document your responses verbatim.

All of your responses are confidential. There will be no personal identifying information on the interview form. Data collected from this interview is to develop a better understanding of low-income African American parents' perception of and influence on childhood obesity in preschool age children. Participation in this study is voluntary and if you feel uncomfortable with the process or content at any time during the interview process you make withdraw. As well, if you need to stop and take a break please let me know. I am the sole investigator. You and I both have signed and dated each copy of the informed consent, certifying that we agree to continue with the interview. You will receive a copy and I will keep a copy

under lock and key. Do you have any concerns or questions? With your permission, we will begin the interview.

Interview Protocol: Parents' Perception of and influence on CHO

Time of Interview:

Date:

Place:

Interviewee:

Position of interviewee:

Interview Questions

1. Tell me what you know about childhood obesity.
2. What is the main cause of overweight or obesity in preschool age children?
3. Do you think your child is overweight? Is your child healthy? Explain.
4. What foods cause children to become overweight? Has your pediatrician recommended healthy food choices for your child?
5. Do you think a parent's work schedule affects preschoolers' eating behaviors? Explain
6. Does your work schedule interfere with the time you spend with your child?  
Does your child participate in any special activities such as little league sports or dance? Do you have time to attend these events/activities?
7. Do preschoolers benefit from having one parent at home at all times?

8. What determines if you will prepare meals at home? Which meals are you most likely to prepare at home?
9. Is it important for you to have your child on a set schedule for eating and bedtime? Explain.
10. How often does your family eat meals together? Is there anything that prevents family mealtime from occurring? Explain.
11. Describe your daily routine for mealtime, playtime, and bedtime for your child. Does this routine work for you?

Conclusion: Thank participants for their time as a research participant. Inform participants when they will receive a copy of the transcribed data to check for accuracy of information.



**Appendix E: Information Flyer****FLYER****Information Poster**

Dear Prospective Research Participant,

I am Vickie Sims-Johnson, a PhD candidate in Health Services at Walden University conducting a research study related to African American parents' perception and influence on childhood obesity.

I am seeking parents or (guardian) as participants to interview (face to face) who speak English fluently, live in one of the counties surrounding the Atlanta Region. Participants should be African American, have at least one child 4-5 years old who attend a Pre-K program, and income does not exceed \$47,700 for a family of four. Participants must be 21 years of age or older. Participation in the interview is voluntary. The interview may last between 45-60 minutes. At any time during the interview process, you may withdraw if you feel uncomfortable with the process or content.

You must sign an informed consent if you wish to participate in this research study. There will be no personal identifying information on the interview form and your responses will be kept confidential.

If you are interested and agree that you meet the criteria for this research study, please contact me via the information provided below.

Thank you for your consideration

Vickie Sims-Johnson, MSA, BSN, RN, CNOR (E)

PhD Health Services Candidate

Vickie.Sims-Johnson@waldenu.edu

678.428.7181-Mobile

## Appendix F: Demographic Profile

Participant #: \_\_\_\_\_

Date: \_\_\_\_\_

Please read each question and place an X next to your answer.

In which county do you live? Fulton \_\_\_\_\_, Gwinnett \_\_\_\_\_, DeKalb, \_\_\_\_\_, Cobb \_\_\_\_\_,  
Clayton \_\_\_\_\_, Rockdale \_\_\_\_\_, Douglas \_\_\_\_\_, Coweta \_\_\_\_\_, Fayette \_\_\_\_\_

What is the total family yearly income in U.S. dollars before taxes? Less than  
\$25,000 \_\_\_\_\_

Less than \$35,000 \_\_\_\_\_, less than \$40,000 \_\_\_\_\_, less than \$47,800 \_\_\_\_\_, above \$48,000 \_\_\_\_\_

How many people live in your home? \_\_\_\_\_

What is your primary language? English \_\_\_\_\_, Spanish \_\_\_\_\_, Other \_\_\_\_\_

What is your child's age? 4 years old \_\_\_\_\_, 5 years old \_\_\_\_\_ Is your child overweight?  
\_\_\_\_Y\_\_\_\_N

What is your relationship to the child attending a pre-k program? Mother \_\_\_\_\_,  
Father \_\_\_\_\_, Legal guardian \_\_\_\_\_

What is your age? 18-20 \_\_\_\_\_, 21 and older \_\_\_\_\_ Are you an African American  
\_\_\_\_Y,\_\_\_\_N

*PhD Candidate: Vickie Sims-Johnson, MSA, BSN, RN, CNOR(E)*

## Appendix G: CONSENT FORM

You are invited to take part in a research study for the purpose of better understanding the perceptions of African American parents regarding childhood obesity. The researcher is inviting parents (mothers/fathers or legal guardians) living in one of the 9 counties surrounding the Atlanta Region with a 4-5 year old overweight/obese preschooler attending a pre-kindergarten class to be in the study. This form is part of a process called “**informed consent**” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named **Vickie Sims-Johnson** who is a **doctoral student** at Walden University.

### **Background Information:**

The purpose of this study is to better understand the perception of African American parents, mothers/fathers or legal guardian, regarding their perception and influence of childhood obesity.

### **Procedures/Criteria:**

If you agree to be in this study, you will be asked to answer 11 questions; instructions will be given to you prior to the research session. This consent form is to inform you about the study in order for you to make an educated decision and represents your understanding/acceptance to perform the study. The criteria for participants are:

- Complete a demographic survey which are the criteria required to participate in the study. The demographic survey includes the following criteria:
- African American 18 years old or older, mothers/fathers or legal guardians
- having at least one obese/overweight child 4-5 years old attending a pre-k program (parent will self-select if the child is overweight/obese on the demographic survey)
- low-income, (\$47,700 or less for a family of 4)
- live in one of 9 counties surrounding the Atlanta Region

The interview will be recorded via audio for the purpose of ensuring accuracy of information. At the end of the interview, responses will be read aloud to give you an opportunity to make any corrections or include additional information. The approximate

time needed for this entire process is 45-60 minutes (depending on your responses). A written report of the interview will be transcribed for your review. This process helps to ensure your responses are understood by the researcher.

**Here is one sample question:** Do you think a parent's work schedule affects preschoolers' eating behaviors? Explain

**Voluntary Nature of the Study:**

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at this learning center will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

**Risks and Benefits of Being in the Study:**

Being in this type of study may have minimal risk such as not being comfortable sitting for a period of time required to complete the interview and other minimal risks. Being in this study would not pose risk to your safety or wellbeing. The benefit of this research is that pediatricians and other professionals can develop appropriate interventions and preventive measures, with input from parents, that can help reduce the occurrence of obesity in children.

**Payment:**

There is a small monetary gift (\$5 gift card) for your participation within this research.

**Privacy:**

All information you provide will be kept confidential. I (the researcher) will not use your personal information for any purposes outside of this research project. Also, I (the researcher) will NOT include your name or anything else that could identify you in the study reports. Data will be kept secure by Vickie Sims-Johnson (researcher). Data will be kept in a password protected computer system and locked safe. Data will be kept for a period of at least 5 years, as required by the University's policies. To ensure privacy, the interview will take place in an assigned room at the learning center.

**Contacts and Questions:**

You may ask any questions you have now. Or if you have questions later, you may

contact the researcher via email ([vickie.sims-johnson@waldenu.edu](mailto:vickie.sims-johnson@waldenu.edu)). If you want to talk

privately about your rights as a research participant, you may call Dr. Leilani Endicott.

She is the Walden University representative who can discuss this with you. Her phone

number is (612) 312-1210. The IRB approval number from Walden University for this study is **01-12-16-0309823 and expires on January 11, 2017**

The researcher will give you a copy of this form to keep

**Statement of Consent:**

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, you (participant) are agreeing to the terms described above.

Date: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_  
(Use of email address for signature is allowed)

Researchers' Signature: Vickie Sims-Johnson \_\_\_\_\_

PhD Candidate: Vickie Sims-Johnson, MSA, BSN, RN, CNOR(E)

Appendix G-2: CONSENT FORM  
Pilot Study

You are invited to take part in a research study for the purpose of better understanding the perceptions of African American parents regarding childhood obesity. The researcher is inviting parents (mothers/fathers or legal guardians) living in one of the 9 counties surrounding the Atlanta Region with a 4-5 year old overweight/obese preschooler attending a pre-kindergarten class to be in the study. This form is part of a process called “**informed consent**” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named **Vickie Sims-Johnson** who is a **doctoral student** at Walden University.

**Background Information:**

The purpose of this study is to better understand the perception of African American parents, mothers/fathers or legal guardian, regarding their perception and influence of childhood obesity.

**Procedures/Criteria:**

The procedure and consent form for the pilot study is identical to the consent form and procedure for the main study. However, the pilot study will be used to help refine the interview questions as needed, and identify any issues, barriers or biased.. Every question that you answer will also be answered by every participant.

If you agree to be in this study, you will be asked to answer 11 questions; instructions will be given to you prior to the research session and this consent is required and represents your understanding/acceptance to perform the study. The criteria for participants are:

- Complete a demographic survey which are the criteria required to participate in the study. The demographic survey includes the following criteria:
- African American 18 years old or older, mothers/fathers or legal guardians
- having at least one obese/overweight child 4-5 years old attending a pre-k program (parent will self-select if the child is overweight/obese on the demographic survey)
- low-income, (\$47,700 or less for a family of 4)
- live in one of 9 counties surrounding the Atlanta Region

The interview will be recorded via audio for the purpose of ensuring accuracy of information. At the end of the interview, responses will be read aloud to give you an opportunity to make any corrections or include additional information. The approximate time needed for this entire process is 45-60 minutes (depending on your responses). A written report will be transcribed for your review. This process helps to ensure your responses are understood by the researcher.

**Here is one sample question:** Do you think a parent's work schedule affects preschoolers' eating behaviors? Explain

**Voluntary Nature of the Study:**

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at this learning center will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

**Risks and Benefits of Being in the Study:**

Being in this type of study may have minimal risk such as not being comfortable sitting for a period of time required to complete the interview and other minimal risks. Being in this study would not pose risk to your safety or wellbeing. The benefit of this research is that pediatricians and other professionals can develop appropriate interventions and preventive measures, with input from parents, that can help reduce the occurrence of obesity in children.

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**Privacy:**

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**Contacts and Questions:**

You may ask any questions you have now. Or if you have questions later, you may

contact the researcher via email ([vickie.sims-johnson@waldenu.edu](mailto:vickie.sims-johnson@waldenu.edu)). If you want to talk privately about your rights as a research participant, you may call Dr. Leilani Endicott.

She is the Walden University representative who can discuss this with you. Her phone number is (612) 312-1210. The IRB approval number from Walden University's for this study is **01-12-16-0309823 and expires on January 11, 2017**

The researcher will give you a copy of this form to keep

**Statement of Consent:**

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, you (participant) are agreeing to the terms described above.

Date: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_  
(Use of email address for signature is allowed)

Researchers' Signature: Vickie Sims-Johnson \_\_\_\_\_