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Walden University
2017

Abstract

The Perceptions and Experiences of African American Parents in the

Management and Care of Obese Children

by

Priscilla Ann Huggins

MSA, Central Michigan University, 2005

BSN, North Carolina Central University, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

June 2017

Abstract

Childhood obesity is a global concern among all ethnic groups. Childhood obesity is a problem that continues into adulthood, exacerbating the incidence of diseases such as diabetes or heart disease. The purpose of this phenomenological study was to explore, understand, and describe the perceptions and experiences of African American parents in the management and care of their obese or overweight children. This study used the health-belief model (HBM) as its theoretical foundation, focusing on the constructs of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. This research study used an interview tool and an 8-item demographic questionnaire to explore and describe how African American parents managed the care of obese children between the ages of 6 and 11. Interviews were transcribed and then inductively analyzed for themes. Parents reported having a difficult time deciding how to implement successful overweight strategies on a daily basis. Parents felt helpless in supporting their child's efforts to lose weight. Parents shared that their child and family members participated in weight-loss activities such as making diet changes and physical activities. The implication for social change from this study is in providing local public health leaders with increased understanding of the personal experiences of African American parents in the management of overweight children. Findings may assist in effective program development for the targeted population.

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Dedication

This dissertation is in the memory of my deceased father, James Grady Simmons. Thanks for your guidance as a parent; teaching your daughter the importance of making personal sacrifices to help others in the delivery of community service.

Acknowledgment

I first want to thank God for keeping my mind sane as I completed this tedious dissertation process, due to multiple obstacles. My husband Anthony has been my support from the beginning to the end of this dissertation journey. I am grateful for my mother, papa, sister, brothers, children, grandchildren, and entire Simmons and Huggins family members for your prayers and understanding when I was absent from many family events. I will be forever grateful to my Walden family for your words of encouragement and always giving advice during this process of dissertation completion; especially Crystal Winn, Andrea Davis, Cynthia Bracey, Nadia Muhammad, and my PhD advisor Bridgette Williams. Thank you to former coworkers, Corine Cook and Mary Dunlap, for your prayers and spiritual guidance. A special Thank you for former coworker, Jeffery Jordan, for always keeping my computer updated. Thanks to my committee members for their time and expertise in the completion of this dissertation process: My Chair, Dr. Precilla Belin, Dr. Lawrence Fulton, and Dr. Joseph Robare.

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Chapter 1: Introduction to the Study

Introduction

Overweight is a medical condition defined as excess body fat. Current literature indicates that the diagnosis of children with health problems related to being overweight or obese has increased in the United States and is a major health concern (Centers for Disease Control [CDC], 2009; U.S. Department of Health and Human Services, 2010). Beginning in the 1990s, childhood obesity was ranked as a major public health problem in the United States (Berkowitz, & Borchard, 2009; Ogden, Carroll, Curtin, Lamb, & Flegal, 2010).

During the years 1980 to 2008 in the United States, the rates of childhood obesity doubled for preschool children between the ages of 2 and 5 (CDC, 2009). Rates doubled for the adolescent age group aged 12-19 and tripled for the age group 6-11 years (CDC, 2009). Researchers linked several diseases to obesity in the younger populations such as cardiovascular disease, hypertension, dyslipidemia, insulin resistance, diabetes, fatty-liver disease, and psychosocial problems (CDC, 2009, 2013, 2014a; Juonala et al., 2011; Skinner, Perrin, & Steiner, 2010). Obesity in school aged children and adolescents aligns with a variety of negative health outcomes such as exacerbated asthma attacks, headaches, and iron deficiency, which increase healthcare usage and cost among the youth population (Biro & Wien, 2010; Skinner et al., 2010). CDC (2009) and Healthy People (2010) reported that overweight children are likely to become overweight adults. Of the participants in this research study, 75% believed an overweight child would likely

become an overweight adult. Three parents shared their personal struggles of being overweight children and becoming overweight adults.

Parents are agents of change in addressing childhood obesity problems (Magarey et al., 2011). Parents are key players in addressing the childhood-obesity epidemic in their role as primary caregivers in the home. Parents control the home environment and provide positive role models in eating habits, physical activities, and enforcement of day-to-day routines, or fail to do so, providing ineffective role models. Magarey et al. (2011) averred that parents could work with their 5- to 9-year-old children and help them maintain a weight loss of greater than 10% of preweight after 6 months of interventions by cooking healthy meals and engaging in physical activities with them. Parents can be effective change agents when completing interventions that provide benefits to their children. Overall, parents want their children to be healthy and are pleased with efforts that promote positive results such as weight loss and improved physical health (Magarey et al., 2011).

Background of the Problem

As children transition from youth to adulthood, they make lifestyle choices and establish behaviors that will affect their current and future health status (CDC, 2011). Family members (mother, father, grandparents, aunts, and uncles), teachers, and community members (pastors, deacons, and boy/girl-scout leaders) can influence how children adopt healthy behaviors. Family and community members provide a major influence in effecting change in a family member (Gruber & Haldeman, 2009). The 2011 National Youth Risk Behavior Survey reported that 13% of children in Grades 9–12 in

the United States are overweight and have a body-mass index (BMI) greater than 95% based on age and height, showing an increase of 11.8% from 2009 (CDC, 2011). The BMI (formula: weight (KG) / [height (m)]^2 is calculated by dividing a child's weight in kilograms by the square of height in meters (CDC, 2015). This research study addressed disparities in obesity rates in the African American children while comparing trends with Hispanic and European American children.

Results from the 2011 National Youth Risk Behavior Survey indicated 15% of African American students were obese in 2009 compared to 18.2% in 2011 (CDC, 2011). Obesity trends for Hispanic students in 2009 were 14.1% compared to 14.9% in 2011; trends in the prevalence of obesity for European American students in 2009 was 10.2% and 11.5% in 2011 (CDC, 2011). Additional factors may contribute to higher childhood-obesity rates among African American students in the southeast. For example, African American families living below the federal poverty level with an annual income of $21,834 for a family of four in 2008 had 21.3% obesity compared to 6.7% for European American families (State Center for Health Statistics and Office of Office of Minority Health and Health Disparities, 2010).

Current literature showed a link among parental feeding practices, family mealtime behaviors, and higher obesity rates among children. Many African American and Hispanic mothers feed their 4-month-old infants formula and cereal, although the recommended age to feed infants formula with cereal is 6 months (Gruber & Haldeman, 2009). Low educational levels, low incomes, and higher unemployment rates have been associated with a greater occurrence of health problems in younger children. Maternal

obesity rates are higher among African American and Hispanic mothers than for European American mothers (Han, Lawlor, & Kimm, 2010).

Han et al. (2010) reported that causes of obesity are cultural factors, high calorie consumption, too little physical activity, genetics, decreased metabolism, behavior, and environment. Modifiable risk factors that contribute to obesity that require change are sedentary behaviors and poor diet. Parents play a fundamental role in shaping their child's health behavior and the development of healthy eating habits in childhood. Parents can promote behavioral changes that promote healthy diet and exercise by modeling appropriate behaviors (Bossink-Tuna, L'Hoir, Beltman, & Boere-Boonekamp, 2009; Faith et al., 2012; Gruber & Haldeman, 2009). Parental awareness of childhood obesity is a motivational factor in reducing childhood obesity. Current research of parental perceptions of childhood obesity support that parents are concerned about high obesity rates among children, but parents may not always know how to help their children engage in management and prevention strategies in combating childhood obesity.

Parental recognition that their child is overweight and at risk for developing major medical problems are important factors that could inspire parents to participate in prevention initiatives (CDC, 2009, 2013). In contrast; parents often do not recognize that their child is obese and at a risk for developing a health problem (Doolen, Alpert, & Miller, 2009; Harnack et al., 2009; Lemelin, Gallagher, & Haggerty, 2012; Polfuss & Frenn, 2012; Tschamler, Conn, Cook, & Halterman, 2010). However, the present research study showed that parents were aware that their child was obese or overweight.

Overall, parents reported feeling helpless in managing healthy weights for their obese or overweight child.

Problem Statement

The childhood obesity epidemic continues to be a concern in the United States and specifically in African American families because obesity rates are higher among African American youth than among youth of any other ethnic group (CDC, 2011, CDC, 2015). Current research studies linked obesity in school-aged children and adolescents with negative health outcomes and increased risk for various diseases in adulthood such as diabetes and heart disease, if left uncorrected (Biro & Wein, 2010; Skinner et al., 2010). In the American Heart Association report by Weinraub et al., (2011) overweight children are likely to become overweight adults. Current research trends agree that childhood obesity leads to overweight adults.

Although researchers have revealed that African American parental participation in weight-management interventions results in the reduction of childhood-obesity rates, a gap exists in the research on the management of childhood obesity from the perspectives of African American parents with overweight or obese children (Berkowitz & Borchard, 2009; Faith et al., 2012, Gruber & Haldeman, 2009). Parents can be motivated to model healthy behaviors that will reduce health risks for their children rather than focusing on their own health problems (Nsiah-Kumi, Kang, & Parker, 2012). As caretakers, when parents neglect personal healthcare and routines, they can contribute to their own health problems. Parents do not intentionally neglect their personal health problems, but they may lose focus in long-term management of their overweight child (2012). In the Nsiah-

Kumi et al. (2012) study, African American parents reported a desire for their entire family unit to be healthy; however, they often reported feeling helpless in long-term efforts to manage their overweight or obese child. Although researchers revealed that African American parental participation in weight-management interventions resulted in the reduction of childhood obesity rates, a gap exists in the research on the management of childhood obesity from the perspectives of African American parents with overweight or obese children (Berkowitz & Borchard, 2009; Faith et al., 2012, Gruber & Haldeman, 2009).

Purpose Statement

The purpose of this qualitative phenomenological study was to explore, understand, and describe the perceptions and experiences of African American parents in the management and care of their obese or overweight children. The concern about high obesity rates in the African American community validates the urgency to address the childhood-obesity epidemic. In this research study, I used a qualitative data-collection and -analysis method to explore the perceptions and experiences of African American parents and their views about the management and care of obese children.

Research Questions

The following questions guided the focus and final data results for this research study:

RQ1: How do African American parents of obese or overweight children perceive the health risks of their children as associated with childhood obesity?

RQ2: What family-related factors do African American parents believe contribute to the obesity or overweight of their children?

RQ3: What interventions do African American parents implement to control or reduce the obesity of their children?

RQ4: What are the educational needs of African American parents in the weight management of their children?

Theoretical Framework

The health-belief model (HBM) was used for this research because of its application in public health studies that have explored the attitudes of health-related illnesses in the population. The HBM was used to explain the experiences and perceptions of African American parents in the management of an overweight child in the home. Based on the concept that a person's willingness to change their health behavior rests on their health beliefs, the HBM uses the following constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Glanz, Rimer, & Lewis, 2002). I used the constructs of the HBM to guide the exploration of parents' abilities to identify health problems that can occur from childhood obesity such as hypertension or diabetes.

Additionally, the HBM helped in identifying barriers in the family unit environment that can contribute to childhood obesity in the African American youth population. Individuals are likely to change a behavior when they understand that the benefits of changing that behavior outweigh the costs (Conner & Norman, 2005).

Overall, the HBM can support the concept that the family unit plays a significant role in shaping younger children's beliefs and value systems.

In a qualitative study conducted by Boutelle, Feldman, and Neumark-Sztainer (2012), 27 parents shared the challenges of having an overweight child. The emerging themes included parental concern about adolescent weight, parents feeling guilty, concern related to effective communication with their adolescent, and an inability to control the activities of eating and healthy behaviors during the adolescent years. However, a gap exists in the literature in explaining the perspectives of African American parents about the issues of the management and care of overweight children. In conclusion, the HBM guided this research study in exploring the perceptions of African American parents in the management and care of obese children.

Nature of the Study

The research design used for this study was the qualitative phenomenological design, employed to generate knowledge about the lived experience of individuals engaged in the phenomenon of parenting obese or overweight children (Liamputtong, 2009). For this qualitative research study, I interviewed parents of overweight children living in the eastern geographical region of the United States. Participants included 15 English-speaking parents (single, married, or divorced) who had a child living in the household who was over the 85th percentile range of overweight. Each parent provided the child's actual weight and height; this information was used to determine the child's 85th percentile range of overweight. Through interviews, I collected data for this

population to shed light on their individual life experiences and thereby aid in the development of obesity-prevention programs in the affected communities.

Healthy People 2010 goals identified overweight and obesity as one of the 10 leading indicators of child and adolescent health (Healthy People, 2010). The social implications for this research study are the ability of healthcare professionals, local community leaders, health educators, and researchers to embrace new knowledge in responding to childhood obesity in the African American community. New emerging information shared in African American communities and increased participation of African American parents could lead to the development of new programs. The goal was to lower high obesity rates in the African American youth population.

Definitions

Body mass index (BMI): A number calculated from a child's weight and height, based on the child's age and gender (CDC, 2011). The BMI (formula: weight (KG) / $[\text{height (m)}]^2$ is calculated by dividing a child's weight in kilograms by the square of height in meters (CDC, 2015).

Change agent: Parents as the drivers of adjustments in implementing family-lifestyle modifications (Magarey et al., 2011).

Family: The primary social-learning environment for children and the primary setting for exposure to food choices, eating habits, and involvement in opportunities for play and other physical activity (Gruber & Haldeman, 2009).

Healthy weight: The weight of a child that is between the 5th percentile and less than the 85th percentile on the BMI growth chart (CDC, 2011).

Obese: The weight of a child that is at the 95th percentile or greater on the BMI growth chart (CDC, 2011).

Overweight: The weight of a child that is at the 85th percentile and less than the 95th percentile on the BMI growth chart (CDC, 2015).

Parental opinion: Parental self-description of a problem (Lemelin et al., 2012).

Parental perception: Parental ability to recognize where their child's weight falls on the BMI growth chart (Garrett-Wright, 2011).

Assumptions, Limitations, Scope, Delimitation

The assumptions of this research study included that participants would provide honest responses to the interview questions. Additionally, because each participant had a child who was between the ages of 6 and 11 who the participating parent considered to be overweight based on the BMI growth chart (CDC, 2011); I assumed that the child healthcare provider provided details to the parents about where their child's weight fell on the chart. The BMI standards for overweight and obese children as observed by the CDC (2011) were used as a guideline in this study.

A key limitation of this research study was that interview responses represented the perspectives of participants and the results do not necessarily represent the community at large. A small sample size may further limit the conclusions, preventing generalization to other African American parents from other households or with different experiences. The scope of this research study is limited to the perceptions and experiences of African American parents with obese or overweight children.

The delimitations of the study were as follow:

1. Each participant had to speak the English language and be at least 18 years old.
2. Each participant had to be the biological parent of a female or male child between the ages of 6 and 11.
3. Each participant had to be a male or female African American parent.
4. One parent and one child per household was represented in the research study; other members of the same household were excluded from the study data analysis.
5. The participant and child had to reside in the same household consecutively for at least 1 year.

Significance

Children who are overweight or obese are at increased risk for physical and socioemotional problems and of becoming overweight adults. This study is significant in bringing awareness of the youth obesity epidemic in the United States of young children and the role parents can play as advocates in the prevention of childhood obesity. For this study, I used a parent-focused approach to identify what possible interventions may be implemented in eliminating childhood obesity. Social change can be realized when parents receive support from community leaders in the management and care for their obese or overweight child.

Researchers reported that parents play a fundamental role in shaping the development of their child’s health-behavior decisions and engagement in physical activities. However, a gap exists in the literature in using family-centered interventions

for obesity-prevention research (Davison, Lawson, & Coatsworth, 2012). Obesity-prevention programs in the past focused only on the child; Davison (2012) recommended the focus be on all family members. Family members support each other in efforts to make behavior changes, resulting in greater impact in the family unit.

In conclusion, this research study focused on understanding and exploring the personal challenges African American parents face in the management and care of their obese child. I was an obese child and now am an obese adult. My mother has shared the struggles of trying to help me as a young child with my weight problem, without success. I am not sure if my mother knew how to manage the overweight problem of childhood obesity. Because of childhood obesity, adult health problems have surfaced such as diabetes, high blood pressure, arthritis, and sleep apnea.

A public health threat exists in the population of North Carolina, one of the southeastern states of the United States. In North Carolina, three of every 10 young low-income children ages 2 to 4 are overweight or obese (State Center for Health Statistics and Office of Office of Minority Health and Health Disparities, 2010). In comparison, one of eight children is overweight or obese nationally (2010). The childhood obesity rate for 2- to 4-year-old children in low-income households is 15.4% in North Carolina and for children 10–17 years old in low-income households; the rate is 16.1% (2010). The latest reported obesity rates of children in North Carolina by racial group per Minority Health reports are 27% for Hispanics, 40.4% for African Americans, and 26.6% for European Americans (2010). North Carolina adult obesity ranks 25th of the 50 states with the highest adult-obesity rate, and childhood obesity ranks as 14th of the 50 states (State

Center for Health Statistics and Office of Office of Minority Health and Health Disparities, 2010). As previously stated childhood, obesity can progress into adulthood, influencing health problems and increased medical costs and higher insurance premiums.

The medical cost of obesity in the United States is as high as $147 billion annually (CDC, 2009). Currently, insurance companies are discussing higher premiums for overweight employees. Therefore, this research study was necessary to bring awareness to healthcare providers and community leaders in addressing problems African American parents face in caring for obese children in the home and implementing an action plan to decrease childhood obesity.

Summary and Transition

Chapter 1 provided an introduction and background of the childhood-obesity health problem in the African American youth population. The childhood-obesity health problem targets the development of obesity-prevention efforts that would improve the health of obese children living in the United States. I encourage Congress to take an active role in the prevention of childhood obesity in African American communities. I have used the primary research questions of this study to examine the perceptions and experiences of African American parents of obese or overweight children regarding the health risks of their children associated with childhood obesity.

Chapter 2 examines peer-reviewed journal articles on parental perceptions of childhood obesity in the United States and globally. Chapter 3 details the research project methodology and an interpretation of each research question. Chapter 4 provides a detailed discussion of the data analysis and findings. Chapter 5 concludes the study with

a detailed discussion of results and implications for practice, program development, and future research.

Chapter 2: Literature Review

Introduction

This literature review focuses on research studies of childhood obesity with specific attention to African American populations. Current research studies help practitioners understand reasons parents do not recognize that their child is overweight or at risk for developing adult health problems. This research study focused on parents' personal perceptions in the management and care of their obese child.

The literature search took place using the following databases: Academic Search Premier, Business Search, and ProQuest Dissertation and Theses full-text databases to explore the research topic history and current studies that address this social problem. I used the following search terms in the literature search: *childhood obesity and African American parents, childhood obesity and parental strategies,* and *childhood obesity and parental perceptions.* Key search terms included *parental perceptions, childhood obesity, African American, Black, caregivers, perception,* and *attitudes.* The literature review contains the following sections: parents' and children's perceptions, consequences of childhood obesity, the role of community members, and the future directions of childhood obesity interventions. The childhood obesity epidemic continues to be a concern in the United States and specifically in African American families. Obesity rates are higher among African American youth than among youth of any other ethnic group (CDC, 2011).

Childhood obesity is a health problem that is drawing attention from local, national, and global leaders in efforts to control the childhood-obesity epidemic. Healthy

People 2010 (2010) reiterated the need to create a healthy home environment for children. The value of creating a safe home haven provides an option to decrease the childhood obesity rates in a community. The modeling behavior of making healthy food choices in the home is vital in the prevention of childhood obesity (Doolen et al., 2009; Payas, Budd, & Polansky, 2010; Healthy People, 2014a). This research study focused on the family unit to identify childhood obesity intervention and prevention strategies.

The family unit provides the primary avenue for the development of social learning, exposure to food choices and eating habits, and opportunities for play and physical activity (Davison et al., 2012; Gruber & Haldeman, 2009). The family is a unit that shares values, rules, support, encouragement, and the opportunity to adopt health promoting behaviors for a lifetime. During the preschool years, the family has an opportunity to reinforce healthy eating habits and physical activity in the family because habits in childhood and adolescent years are difficult to change (Garrett-Wright, 2011; Gruber & Haldeman 2009; Lemelin et al., 2012). Additional research would help practitioners understand specific educational needs of parents with overweight or obese children. This research study focused on parents' personal perceptions in the management and care of their obese child.

Parental Perceptions

The purpose of this section is to examine how parental modeling and parental perceptions affect the childhood obesity epidemic in a local, national, and global environment. Parents often do not recognize that their child is overweight (Garrett-Wright, 2011; Lemelin et al., 2012; Payas et al., 2010; Polfuss & Frenn, 2012). Of the 11

studies reviewed on parental perceptions of their child's weight status, only six listed the African American parent as a research study participant. Payas et al. (2010) conducted a cross sectional analysis of 47 mothers of school-aged children, examining the relationship between family living location, family function, mothers' BMI, and the mother's attitudes and behavior concerning their child's eating practices.

The findings from the Payas et al. (2010) study showed that urban African American mothers who had a higher BMI were more concerned about their child's weight status than rural mothers. The study sample size consisted of 23 European American parents, 20 African American parents, two Hispanic parents, one Native American parent and one listed as other. Study results concluded that a barrier existed in the rural family due to larger sized families, which limited resources in buying healthy food. The study indicated the need for future studies that address knowledge about family factors and parents' beliefs and perceptions. Payas et al. advocated for additional childhood obesity educational communication strategies among healthcare professionals, parents and children.

Parents of preschool students often have inaccurate perceptions of their child's body weight, and identifiable factors associated with perceptions of a child's weight did not emerge in the literature (Garrett-Wright, 2011). The Garrett-Wright (2011) study examined the relationships between parental perceptions of a preschool child's weight and parents' psychosocial factors. Study participants consisted of 96 European American parents, four Hispanic parents, 15 African American parents, five listed as other, and 120 preschool children. This quantitative study concluded that over one-third of the children

in the sample size were at risk for becoming overweight or were already overweight and that only 6% of the parents reported their child was overweight.

Qualitative studies completed by Boutelle et al. (2012) and Shrewsbury et al. (2010) aspired to explore communication between adolescents and parents regarding body weight and weight management. The purpose of the Boutelle et al. study was to address the challenges parents of overweight adolescents encounter and what advice these parents were willing to share about their experiences in the management of caring for an overweight child. The aim of the Shrewsbury et al. study was to support discussions in the home environment and family doctor visits related to adolescent weight problems. The authors of both studies identified a gap in the literature on the topic of adolescent and parent communication interactions about body weight and weight management in the home. In the Shrewsbury et al. study, researchers discerned that adolescents prefer to discuss weight management in the home rather than during a doctor visit. The Boutelle et al. and Shrewsbury et al. research studies indicated a need for future research that focus on the development of parental support through communication in the family unit. Both research studies advocated using the family unit as a method to decrease childhood obesity.

The qualitative study conducted by Wright, Wilson, Griffin, and Evans (2010) provided insight on how parental role modeling and parental support influence the adoption of physical activity in the home environment. Children with two physically active parents were six times more likely to participate in physical activities than those with sedentary parents. A child’s physical activity level results from their parents’ beliefs

about the value of exercise, the parents' expectations and goals, and the child's physical readiness to participate. With a sample size of 52 adolescents and 85% African American parents, the researchers conducted a focus group. The adolescent group reported that because their parents participated in various physical activities such as walking, cycling, and playing basketball, they desired to participate in physical activities.

The study conducted by Wright et al. (2010) noted gender differences in parental support. Girls reported receiving emotional support, such as expressions of empathy, love, trust, and caring, whereas boys reported receiving tangible support such as sporting events. Study findings suggested that parental modeling and social support are important elements in future development of programs to increase physical activity in African American communities. Parents often did not recognize the significant possible health risk of overweight children or the significance of modeling healthy behaviors in the family unit (2010). The present research study focused on what factors African American parents believed contributed to obesity of their children and what measures they took to reduce obesity.

Two studies conducted by Jaballas, Clark-Ott, Clasen, Stolfi, and Urban (2011) and Nsiah-Kumi, Ariza, Mikhail, Feinglass, and Binns (2009) focused on family units to address the childhood obesity health issue. The two studies focused on parents' self efficacy and perceptions in influencing health behaviors and physical activities in the home setting. Results from the Jaballas et al. study showed that 26% of parents perceived their child to be overweight and expressed concern, compared to 40% who believed their child would outgrow the condition of being overweight. Of the 942 surveys sent home to

parents, 355 surveys were returned to the researchers, yielding a 38% response rate. The respondents were 55% African American, 31% European American, and 14% comprised of members of other races. In comparison, the Nsiah-Kumi et al. (2009) study results showed those parents with less college education or who had an African American obese child perceived obesity as an unthreatening illness. Both research studies' participants perceived childhood obesity as a health risk to some degree for their overweight child. Both groups of authors concluded that future strategies should focus on supporting parents in making healthy behavioral changes. As stated previously, people will not change a health behavior unless they perceive it as a threat.

Parents' and Children's' Perceptions

This section addresses the perceptions that parents and overweight children share regarding parental guidance, support, and modeling behaviors in the family unit. Adolescent girls whose parents exercised at least three times per week reported they were 50% more likely to exercise than with sedentary parents (Madsen, McCulloch, & Crawford, 2009). The following groups participated in a longitudinal study: 1,213 African American girls and 1,166 European American girls aged 9 to 10 years and 18 to 19 years. Study results indicated that girls' perceptions of parent activity predicted increased physical activity for girls throughout their adolescence years. Second, study results did not report any racial differences in girls' reported physical activity despite decreasing physical activity with increasing age into adulthood. In conclusion, Madsen et al. (2009) stated that parents' actions are important in addressing appropriate

interventions to increase African American children's physical activity to minimize the growing health disparity in the African American family.

In a qualitative study, adolescents and parents preferred to communicate using indirect messages when discussing adolescent weight management; that is, indirect messages focused on discussions about food choices and physical activity without discussing weight as a topic of discussion (Shrewsbury et al., 2010). The least favorite form of communication was direct messages that focused on open discussion of body-weight management in the home environment. Results also showed that adolescents and parents were supportive of their family doctor's role in monitoring and discussing adolescent-weight status. The authors of this qualitative study recommended approaches to weight management in the family environment, advocating direct efforts that support parents to provide healthy eating, physical activity, and well-being. Second, they suggested avoiding direct discussion of weight management, which can lead to defensiveness by the parental group.

The Madsen et al. (2009) and Shrewsbury et al. (2010) studies addressed how parental support can influence the weight management of adolescents. Overall, adolescents and parents willingly participated in these studies. Parents expressed concern over the discussion of weight in the family unit as a means of lowering a child's self esteem. The authors did not identify racial groups that were affected by weight related discussions in the home environment. However, the Granberg, Simons, and Simons (2009) study reported that African American girls are more likely to be overweight than girls of any other racial group because they feel good about their body size and show

little concern about being overweight. The authors concluded that future studies should address self-perceptions and body size among all racial groups.

Two studies conducted by Jaballas et al. (2011) and Lupi, Haddad, Gazmararian, and Rask (2014) revealed that community members play a part in supporting parental efforts to reduce childhood obesity. Parents expressed that pediatricians have a responsibility to screen their child for weight problems and to communicate that information to the parents in a comprehensive matter. Second, parents expressed that the school system has a role in providing nutritional education and fitness class. The present research study focused on the challenges that face African American parents in the management and care of their overweight child.

Racial/Ethnic Disparities in Childhood Obesity

Past and current healthcare debates focused on the concerns of racial/ethnic healthcare disparities of adults. However, according to Raphael and Beal (2010) and Bethell, C., Simpson, L., Stumbo, S., Carle, A., and Gombojay, N. (2010), more attention should focus on inequities in child healthcare because of the growing epidemic of childhood obesity. Raphael and Beal reported that African American adults increasing usage of public insurance in comparison to European American adults, noting that healthcare outcomes for African American adults results in increased death rates in comparison to European American adults.

Parents are key players in addressing healthcare disparities because children depend on their parents to take them to appointments. Possible risk factors for childhood obesity among African American children include maternal obesity, cultural feeding

practices, having a television in the bedroom after the age of 2, and increasing the intake of sugar-sweetened beverages and fast foods Dixon, Pena, and Taveras (2012). The pediatric literature reports improved access to care of medicated pediatric clients; however, African American children receive substandard care in comparison to European American children (Dixon et al., 2012).

Researchers have conducted a limited number of research studies on obese minority populations that explore their unique experiences in reducing obesity rates (Sealy, 2010). Sealy (2010) conducted three focus groups of African American, Caribbean, and Hispanic parents (n = 34). Focus-group questions centered on factors influenced eating habits, food choices, and food-preparation practices. Two key themes emerged that influenced food choices: cultural practices and time constraints in food preparation (Sealy, 2010).

The 2011 National Youth Risk Behavior Survey indicated 15% of African American students were obese in 2009 compared to 18.2% in 2011 (CDC, 2011). The present research study promoted the role of parents in modeling acceptable behaviors for children to replicate in the family unit. This research study emphasizes that African American parents play a significant role in reducing childhood obesity rates among African American children.

Family-Based Obesity Programs

Researchers identified acceptable culturally family-based interventions in schools and places of worship to promote healthier lifestyle habits in the family unit (Maynard, Baker, Rawlins, Anderson, & Harding, 2009). The study aim was to assess and reduce

risk factors for children in the African American population. The sample population was 77 minority children between the ages of 8 and 13 years from ethnicities such as African, Caribbean, Indian, Pakistani, and Bangladeshi. Recruitment from places of worship presented increased difficulty; therefore, oversampling of some groups compensated for the concern raised. Studies in the United States and United Kingdom continued to show African American girls have higher obesity rates compared to European American girls. The present research study focused on identifying barriers that may exist in the family unit that can lead to increased physical activity of minority children in obesity prevention programs.

In a randomized controlled trial to measure the effectiveness of healthy eating and childhood obesity intervention, researchers distributed the program, Mind Exercise Nutrition Do It (MEND), 200 parents of Australian children between the ages of 2 and 4 years at baseline in 6 to 12 month intervals (Skouteris, McCabe, Swinburn, & Hill, 2010). The methodology was qualitative with a phenomenological research design, using interviews to determine strengths for future program development. The MEND study results indicated the need for family based prevention programs that socially influence the behaviors of young children. The goal of the MEND study was to design a prevention program to use at the national or international level for policy changes in obesity prevention programs.

Wyse et al. (2010) conducted the first randomized controlled trial to evaluate a telephone based parent intervention method used to increase the fruit and vegetable consumption of preschool children. The positive outcomes of the telephone intervention

project included an experimental randomized design and the implementation of procedures to reduce potential threats to internal validity such as blinding of data collection interviewers and computer based randomization of groups (Wyse et al., 2010). The telephone based intervention project conducted in New South Wales, Australia, used a sample size of 200 parents from randomly selected preschools. The telephone-intervention projects were printed resource materials and four weekly 30 minute telephone support calls delivered by trained telephone interviewers. The increased consumption of fruits and vegetables was often an effective strategy to control the childhood obesity epidemic, thereby reducing chronic disease in adulthood (Wyse et al., 2010).

The childhood obesity problem has increased in the United Kingdom (UK) since 1995 (Redsell et al., 2010). Children in the United Kingdom are overweight and the obesity rate among 2–15 year olds is 31% for boys and 30% for girls. Through systemic reviews, Redsell et al. (2010) concluded that rapid weight gain during infancy aligned with higher obesity risk factors in adulthood. Multiple risk factors aligned with the development of childhood obesity such as infant-feeding practices, parental response to the infant temperament, and parental perception of infant growth and appetite.

The Redsell et al. (2010) research study provided an opportunity for UK parents to explain their beliefs about their infant's size, growth, behaviors related to feeding practices, and parents' receptiveness to early intervention to reduce the risk of childhood obesity. Systematic reviews found contradictory findings on the relationship between breastfeeding and obesity risk factors. The authors concluded that breastfeeding has a

small but consistent protective effect against the development of obesity during childhood.

Additionally, Redsell et al. (2010) reported that a qualitative study of 14 low-income mothers with overweight children used food to soothe their fussy infant. Mothers had strong beliefs that heavy infants were the results of successful parenting and better health outcomes. Parents had gaps in their knowledge about feeding practices. According to participants, information from their healthcare providers was inconsistent, and cultural and individual preferences in infant-feeding practices varied. Various barriers exist in early intervention for parents of overweight or obese children, such as the need for improved support to provide improved infant-feeding practices. Additional barriers Redsell et al. identified, parents knowing the difference between infant distress and hunger; how to prepare healthy foods; and how to facilitate physical activity for their overweight child. The present research study identified the educational needs of African American parents in the weight management of their children.

Consequences of Childhood Obesity

The obesity epidemic has affected healthcare costs in the United States. The economic cost of childhood obesity has resulted in additional outpatient/emergency-room visits and prescription-drug expenses (Trasande & Chatterjee, 2009). Documented cases of cardiovascular disease, hypertension, dyslipidemia, insulin resistance or diabetes, fatty-liver disease, and psychosocial problems align with childhood obesity (CDC, 2009, 2013). The report by Weinraub et al. (2011) the development of atherosclerosis may

begin in youth and progress into adulthood, and can contribute to nonfatal or fatal life events such as heart attacks.

The Weinraub et al. (2011) report focused on prevention and making modifiable lifestyle changes. The direst cost of cardiovascular disease was $450 billion a year in 2010 with a projection of over $1 trillion by year 2020 (2011). The projections were based on short- and long-term individual costs and not prevention-care costs. Childhood obesity has affected the healthcare costs and usage of healthcare in the United States (2011; Trasande & Chatterjee, 2009). In studies of the economic costs of childhood, obesity showed greater hospitalization for comorbidities (Trasande & Chatterjee, 2009).

Healthy People 2020 (2016) recommended all schools develop policies to implement strategies that restrict sugary drinks for students and increased consumption of five or more serving of fruits or vegetables daily. A comprehensive and coordinated plan in addressing the childhood obesity problem will lead to the greatest impact (Frieden, Dietz, & Collins, 2010). Policy interventions that address healthy dietary and activity choices achieve the greatest outcomes. The authors recommended (a) removing all unhealthy food from all schools and childcare centers, (b) placing zoning restrictions to limit fast-food establishments between schools and communities, (c) increasing the cost of fast foods and decreasing the cost of healthy foods, and (d) providing full service of fresh fruits and vegetables in underserved neighborhoods (Frieden et al., 2010). In 2012, the U.S. Department of Agriculture (2015) provided national standards in the National School Lunch and School Breakfast programs. Each school was to serve at least one to three fresh fruits per day based on a child's age, serve one to three vegetables, one to two

meats, one cup of milk with fat >10, low sodium and a minimum of 350 and maximum of 850 calories (2015). This legislation identified the National School Lunch Act, enacted to protect U.S. children's health and encourage the daily consumption of nutritious food (2015).

According to the U.S. Food and Drug Administration, only one third of the children in the United States consume the recommended number of fruits and vegetables each day (USDA, 2015). Because children consume approximately half of their calories at school and the other half at home, the National School Lunch and School Breakfast program can help in eradicating childhood obesity. In 2013, the USDA implemented the Smart Snacks in Schools, requiring public schools to meet caloric, fat, sugar, whole grain, and sodium limits, or supply fruits/vegetables, dairy, or protein in all vending machines (2015). According to the USDA, no snack sold during school hours can exceed 200 calories. The new rules were put into place in school year 2014–2015, comprising the first snack regulation since 1970 (2015).

In a southern state, approximately 77% of adults do not consume the recommended daily intake of five or more servings of fruits and vegetables per day (Boyington, Schoster, Martin, Shreffler, & Callahan 2009). Scholars suggested putting prevention programs in place, which may be costly; however, the benefits outweigh the cost of short-term and long-term healthcare expenses. According to the American School Health Association (USDA, 2015), school meals can significantly contribute to school-aged children's fruit and vegetable daily consumption.

The Role of Community Leaders

The American Nurses Association (ANA) is an advocacy group that supported and assisted First Lady Obama with critical efforts to address the childhood-obesity problem in the United States (McNamara & Sachs, 2010). In 2010, the ANA used the National Nurses Week theme, Nurses, Caring Today for a Healthy Tomorrow, (2010). President Patton of ANA group stated,

> Obesity can increase the risk of stroke, diabetes, heart disease, hypertension and many other health illnesses. … In addition to the impact on the health of our population, it also threatens the health and safety of nurse and other health care providers who may injure themselves while caring for obese patients. (2010, para 3)

The ANA (2010) is a professional organization that represents 2.9 million healthcare providers. In my role as a registered nurse, I understand the healthcare provider can touch many people's lives from all occupations and educate them on options to make healthier choices.

A family-focused approach is important in influencing dietary habits of very young children, providing prevention activities that start early in childhood, and answering the need for community support and involvement (Berkowitz & Borchard, 2009). The CDC and the ANA support parental involvement in addressing health problems related to childhood obesity through coordinated community efforts and events. As a registered nurse, and in my role as the student researcher, the present research study supported parents as they explored their personal views and opinions about the childhood

obesity health problems in the African American community. Through coordinated efforts in the community, I helped identify small changes through this research study and advocate the implementation of health-promoting activities.

Local and State Programs

According to the USDA, the principle factors behind soaring obesity rates has been the average 300-calorie jump in an individual's diet from 1985 to 2000; 24% came from added fats, 23% from added sugars, and 46% from refined grains (Walilnga, 2010). The United States is the world's largest corn producer, but exports only 20% of the total annual crop and uses a percentage to make high-fructose corn syrup. The United States is the world's largest soybean producer and exports 93% of the crop annually. Foods high in fat and sugar, fast foods, sugared sodas, and cooking oils cost less, whereas healthier food such as fruits and vegetables carry a higher cost (Walilinga, 2010).

Daily fruit and vegetable intake is 3.6 (2.5) servings per day (Robinson-O'Brien, Burgess-Champoux, Haines, Hannan, & Neumark-Sztainer, (2010), and Bethell, C., Simpson, L., Stumbo, S., Carle, A., and Gombojay, N. (2010). Middle-aged children consumed greater amounts of fruits and vegetables while at school than younger children. Coordinated community efforts are needed to address the childhood-obesity health problem through the advocacy of local and state leadership and community members. This research study has provided an urgent need to coordinate community members in addressing the childhood obesity problem within the African-American youth population.

Two studies revealed that parents underestimate their child's weight, denying that their child is overweight or obese (Robinson et al. (2010), and Walilnga, 2010). The

following research studies addressed the ability of parents to serve as effective change agents with assessment/education and policy development at the local and state level through coordinated community activities (Harnack et al., 2009; Harris & William, 2009). The Jaballas et al. (2011), Lupi et al. (2014), and Nsiah-Kumi et al. (2009) studies identified parental lack of knowledge in addressing overweight issues in the management and care of an overweight child. Authors recommended communities work to support parents in the management and care of having an overweight child. Parents rely on the advice of their pediatrician in the management of overweight children (Hernandez, Cheng, & Serwint, 2010; Laurent, 2013). In conclusion, community leaders should coordinate efforts to focus on the needs of parents in eliminating childhood obesity. Although I discussed my research study with community leaders, Pastors and Daycare directors, 6 out of 20 provided feedback. This research study has provided a small impact, however additional research in education of childhood obesity prevention can make a greater impact to community leaders.

Future Directions for Childhood Obesity Interventions

In February 2010, First Lady Obama began the “Let’s Move” campaign against childhood obesity to offer strategies to empower parents and public consumers to focus on the nutritional labels of products (Wojcicki & Heyman, 2010). The First Lady challenged the USDA to improve the National School Lunch Program, increase children’s opportunities for physical activity, and improve access to higher quality foods in all U.S. communities. The First Lady also challenged parents, community local and

state leaders, and healthcare professionals to join in the initiatives to address this public health problem.

The Let's Move campaign focuses on prevention strategies, such as healthcare providers offering parents healthcare counseling related to making healthier nutritional choices, in hopes parents will model that behavior for their children (Wojcicki & Heyman, 2010). Early intervention can prevent the early development of childhood obesity. According to the CDC and the 2007–2008 National Health and Nutrition Examination Survey, approximately one third of U.S. children over 2 years of age are overweight or obese (CDC, 2010). This research study emphasized the integral support needed for parents with obese children. The present research study focused on discerning if educational needs are lacking in the family unit in addressing the childhood-obesity health problem from the parental perspective.

Healthcare Providers' Roles

Prevention programs need to include parents as agents of change in addressing the childhood obesity epidemic because parents act as decision makers for their children (Dorsey et al., 2010; Perryman, 2011). Dorsey et al. and First Lady Obama challenged pediatric clinicians to screen patients for obesity using BMIs to assess obesity-related health factors and counsel families about proposed behavior change. Perryman advocated using the family unit to empower each member in making lifestyle changes that can impede the childhood obesity epidemic. McGee, Maber, Blank (2010) and Lopez, Stuckey and Mallory (2016) advocates that healthcare providers use appropriate educational methods with individual or family unit, such as printed material or video. An

important element in health education is gaining the trust of your patient. The primary care visit with the provider is an excellent opportunity to assess needs and implement an educational plan with the family.

Parents' Role

Barriers challenge family-based interventions in addressing the childhood obesity epidemic; these include accessibility to community resources, family socioeconomic status, and food availability in the community (Perryman, 2011). Perryman, challenged the family unit to adopt and model healthier food choices, reward behaviors without using food, and set consistent meal and snack times. Community leaders can aid as support for parents in addressing their barriers. For example, using land to plant and harvest fresh fruits and vegetables. Recently my Pastor and I discussed a community project of using the church land to plant a garden. The production of fresh fruits and vegetables can address the availability of healthy food options placed within the community.

In addressing the childhood obesity epidemic, it is best practice to understand parents' or caregivers' concerns and beliefs regarding the weight management of their obese children. The present research study explored the perceptions and beliefs African American parents have on taking care of obese or overweight children. The literature review identified that parents are key players in addressing the childhood obesity epidemic. Authors cited in the literature review stated that recruiting and engaging parents to participate in programs that address childhood obesity might be challenging. This research study focused on answering the following research questions:

RQ1: How do African American parents of obese or overweight children perceive the health risks of their children associated with childhood obesity?

RQ2: What family-related factors do African American parents believe contribute to the obesity or overweight of their children?

RQ3: What interventions do African American parents implement to control or reduce the obesity of their children?

RQ4: What are the educational needs of African American parents in the weight management of their children?

Health Belief Model

The HBM proposes that a person's willingness to change their health behavior is due to the following constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Glanz et al., 2002). This research study adopted the following constructs: perceived susceptibility, perceived severity, and perceived barriers. In addressing perceived susceptibility to the childhood obesity problem, this research study identified African American parents' beliefs related to the seriousness of childhood obesity. Once parents recognize the seriousness of obesity as a health problem, the value of parental engagement has become evident in the willingness to adopt new health behaviors.

Parents reported engaging in home activities that aid in reducing childhood obesity in the family unit. Parents willingly begin to engage when perceived benefits outweigh perceived barriers (Randolph, Fincham, & Radey, 2009). In this research study,

parents could identify factors that contributed to obesity but lacked education about how to decrease the childhood-obesity epidemic in the African American family unit.

Summary and Transition

Chapter 2 explained the perceptions that parents place on childhood obesity in the literature review section. The current reviewed studies indicated that parents often do not recognize that their child is overweight or obese. African American parents have not been as widely represented in obesity prevention programs as European American participants have. This research study focused on African American parents' perceptions of childhood obesity, their self-report of any environmental factors, and their self-report of health risks associated with childhood obesity. Chapter 3 will focus on the method of data collection used for this research project.

The childhood-obesity epidemic is currently affecting multiple ethnic populations and needs the immediate attention of coordinated community efforts that involve parents, community leaders, and public health professionals. Healthy People 2010 (Healthy People, 2014) goals identified overweight and obesity as one of the 10 leading indicators of child and adolescent poor health; however, the United States did not meet its target goal of less than 5% obese or overweight children in 2010 (2010). The social implication for this study is to provide new knowledge that informs healthcare professionals, local community leaders, health educators, and researchers, encouraging them to embrace responses to childhood-obesity initiatives in the African American community.

This research study explored the attitudes African American parents about their child's eating habits, physical activity, and concerns about the health problems associated

with childhood obesity. The discovery of how African American parents perceive childhood obesity as a health illness is crucial in addressing the childhood-obesity health issue. The HBM guided this research study in addressing the perceptions of African American parents in the management and care of their overweight child.

It is logical to believe that when people feel they are at risk for developing a disease, they are more likely to make effort to change their behaviors. However, the literature reported contrast that parents is aware of obesity as a health risk, but do not perceive it as a crucial health risk for their child. Through coordinated community efforts, childhood-obesity rates can decrease in communities that join forces with various community partners.

Chapter 3 presents the study design/approach, setting, methodology, researcher's role, validity and reliability of the instrument, recruitment process, participants, data-analysis plan, ethical concerns/issues of trustworthiness, and a summary. Chapter 4 provides the analytical analysis of the research project. I will introduce the results, study setting, participant demographics, data analysis, evidence of trustworthiness, and results. Chapter 5 provides the conclusion and the future direction in eradicating childhood obesity.

Chapter 3: Methodology

The purpose of this qualitative phenomenological study was to explore, understand, and describe the perceptions and experiences of African American parents in the management and care of their obese or overweight children. In a phenomenological study, it is important that participants have experienced the same phenomenon and report their personal expressions of the issue or problem (Patton, 2002). Ultimately, the goal of this research study was to provide parents a voice in talking about the childhood obesity epidemic in African American communities. This chapter presents the study design/approach, setting, methodology, researcher's role, validity and reliability of the instrument, recruitment process, participants, data-analysis plan, ethical concerns, issues of trustworthiness, and a summary.

Research Design and Rationale

In this research study, a qualitative phenomenological inquiry design, I used 15 participants to answer the research questions of an open- and closed-ended questionnaire. By adopting a qualitative approach, I provided insights into the experiences and responses of African American parents of obese or overweight children. An in-depth interview tool was used as the data-gathering method for this participant group (see Appendix A). Prior to interviews, participants completed a written consent form, and I used their demographic information to determine eligibility for the research study by phone or in person. I offered each participant the opportunity to withdraw from participation in this research study without any coercion before or during the data-collection process.

The phenomenological method is a theoretical perspective that attempts to draw knowledge about how individuals experience events or examine a person or several people in relation to common interests or concepts (Liamputtong, 2009,: Patton, 2002). The interview tool used came from the Stanley Manne Children's Research Institute survey bank on the assessment of perceptions of child appearance and nutritional health-screening tools and Jannetta Publications, a public domain.

Study Sample

I selected participants using the convenience-sampling method from a small rural town in southeast North Carolina. The study sample size was 15 participants. Each participant received a $20.00 gift certificate to Walmart for participation in this research study. All participants of this research study were given alphanumeric codes to protect their identities.

Sampling Strategy/Recruitment/Setting

I posted a flyer in 10 local community churches and 10 local daycare centers (see Appendix B) after receiving approval from the Walden University Institutional Review Board. The local churches represent African American churches of all denominations in a small rural town in the southeast part of the state. I sent the flyer by mail and called each church and day care center 1 week after sending the flyer. I received participation from four local churches and two daycare centers. One daycare director reported that three mothers reported interest, but declined to participate because they thought the study was for them to help with their own weight management problem.

Potential participants contacted me by phone or in-person to indicate interest in participating in this researcher study. I received 10 phone calls from interested participants; seven met the criteria. I received calls from referrals from participants; eight met the criteria. I asked the inclusion questions to confirm if each potential participant was eligible to participate in the research study and then confirmed a time and date to conduct an interview. The data collection took place over 3 months at the local public library.

Permission was not granted to post flyers at local pediatric clinics of a local public hospital due to no direct employee affiliation. I thought it was ideal to post flyers in pediatric offices and local public health clinics, thinking parents had some current information related to their child's height and weight and problem with obesity. I conducted this research study in a small rural town annexed by a large metropolitan city in the southeast region of North Carolina.

I conducted the interviews at the local library after receiving written permission from the librarian (see Appendix C) to use a private room and approval from the Walden University Institutional Review Board to collect data. I selected this setting because it was a convenient public meeting place with no fee charged to the public and provided privacy for all participants. The collected data was placed into a locked file cabinet where it will be kept for 5 years, after which time it will be shredded to ensure confidentiality, a practice aligned with Walden University dissertation guidelines.

I coded the data to draw common codes and similar themes from the interviews using the Dedoose software program (SocioCultural Research Consultants, 2015). The

common codes were developed after reviewing the audio transcriptions. The common codes were entered into the dedoose software program and the audio pdf document transcriptions for the development of similar themes. I organized the collected data by the most common clusters of themes to draw conclusions on the perceptions and attitudes of African American parents' views on the management of overweight children. The following were the research questions for this study:

RQ1: How do African American parents of obese or overweight children perceive the health risks of their children associated with childhood obesity?

RQ2: What family-related factors do African American parents believe contribute to the obesity or overweight of their children?

RQ3: What interventions do African American parents implement to control or reduce the obesity of their children?

RQ4: What are the educational needs of African American parents in the weight management of their children?

An in-depth interview usually means a face-to-face meeting between the researcher and the participant. An advantage of using in depth interviews is that the researcher interacts face to face with the participant, increasing the opportunity to draw interferences from nonverbal communication (Creswell, 2007). A disadvantage to using in depth interviews is the travel cost for participants and time. The gift certificate to Walmart aided the interview process as compensation for the participants' gas and time. I intended to give each participant a gift basket of healthy aids in the management of overweight children (jump rope, walk-in-place-video tape, fruit, and coupons) and a $15

gift card. However, due to my loss of personal items during Hurricane Mathew floodwaters, each participant received a $20.00 gift card. The interview questions included semi structured open-ended questions; in addition, participants provided demographic information. Two questions served as icebreakers before beginning the interview process. I audiotaped the entire interview process in the elected reserved room at the public local library, and used Rev.com services to transcribe the interviews into text documents after the signature of disclosure statement (Appendix D). The Dedoose software (SocioCultural Research Consultants, 2015) assisted in analyzing data to discern emerging clusters. The interviews were audiotaped using a Sony Digital tape recorder, and then saved in a file on the computer for transcription. As a backup plan, I was prepared to use a cassette tape recorder to audiotape the interview process due to potential technological issues when working with equipment. As the primary researcher, I suspended any prejudgments about the reality of what participants said or what I saw or heard in the interviews (Liamputtong, 2009).

The Role of the Researcher

A researcher should be comfortable conducting interviews. My role was to maintain control of the conversation and allow the participant adequate time to answer each question. I obtained approval from the Walden University Institutional Review Board before conducting research (IRB # 612-312-1210). I obtained a written consent from participants as well as approval from sites to post flyers during the recruitment phase. I received permission from the branch librarian to use the conference room to schedule interviews. The interview tool was obtained from a public website for usage.

I immersed myself in the research study and aimed to keep personal bias to a minimum. Reserving personal bias allows participants the opportunity to express their personal feelings without feeling they are being judged. In qualitative research, the researcher is the instrument and must understand the role is that of the outsider and that the participant role is the insider.

Ethical Considerations

The participant received a handwritten copy of interview questions and the study criteria. I gave participants time to ask questions and informed them they could decline to participate in this study. After this process, I guided participants to sign the consent forms if they consented to participate in this study. Once the participant agreed verbally over the phone, I set-up scheduled times in the library conference room to complete interviews.

I continued to offer participants the opportunity to decline to take part in this study project. The African American parents were informed no identifying information on the interview tool and that an alphabetical code would be assigned on each tool. Each participant received written directions related to how the interview process would take place and the processes of data collection and results. I worked to provide participants with current information related to this research study in a timely manner.

Issues of Trustworthiness

According to Creswell (2007), the naturalistic researcher looks for commonality rather than objectivity in explaining the value of data. Creswell (2007) noted four types of validation: triangulation using multiple data sources, methods, and theoretical themes;

construct validation, which recognizes the constructs that exist rather than imposing theory; face validation, a simple yes or no recognition; and catalytic validation, which energizes participants toward knowing reality to transform it. Overall, validation means the researcher should report accurate results. In validation of a research study, the researcher ensures the findings are accurate and supported through documentation of the subject material. For example, validation occurs when the researcher offers no conclusions other than those obtained through the transcription of data (Creswell, 2009).

As previously stated, I obtained signed consent agreements from participants without applying pressure to take part in this research project. I explained to participants that they could withdraw from the research study without any risks or harm. I offered participants a small gift for their time and participation without coercion. I informed participants that they would be given a code number to be used in the research study. They were offered the opportunity to review their audiotaped transcript 2 weeks after the interview. Of the 15 participants, only 6 desired to review their interview. The library conference room was used to review the transcripts; this process took 2 weeks. I offered participants the opportunity to obtain a copy of the final research findings at the end of the research study: 10 requested a copy of the data-analysis summary. In closing, I enhanced reliability by using detailed field notes, using a quality audio recorder, and using the correct tape for transcription. Creswell (2009) stated it is important to assign code names and be consistent in data analysis with code names. Second, the researcher must portray participants' information honestly while using code names to protect their identity.

Summary and Transition

In conclusion, Chapter 3 explained the data-collection process and the methodological process used to draw interferences in completing the data analysis. Chapter 4 provides a description of the data analysis. Chapter 5 describes the findings and provides future recommendations.

Chapter 4: Results

Introduction

In Chapter 4, I reveal the results and data analysis of this phenomenological qualitative study. I accrued the research data using the phenomenological approach. The Stanly Manne Children Research Institute developed the interview tool. The interview tool consisted of 22 open- and closed-ended questions; two icebreaker questions; and eight demographic questions. I gave the interview tool to 15 African American parents who met the criteria to participate in the research study on their perceptions of how they managed to care for their overweight or obese child. Chapter 4 provides the analytical analysis of the research project including the results, study setting, participant demographics, data analysis, and evidence of trustworthiness.

The interviews took place at the local public library face to face in a reserved conference room. After receiving a call from potential interviewees and confirming they met the study criteria, we scheduled an interview time. I reviewed the consent form and provided each participant the ability to decline or continue to participate in this research process. All scheduled participants agreed to the terms and signed the consent form. I tape recorded the interviews after receiving verbal permission from participants.

Rev.com services transcribed the audio tapes into text documents. I obtained a confidentially agreement statement from Rev.com (see Appendix D). I used the Dedoose software program (SocioCultural Research Consultants, 2015) and uploaded all 15 interviews. I developed 15 codes*: (a) daily decision making, (b) emotional issues, (c) family participation, (d) healthy eating, (e) parental awareness of health risks, (f)*

parental enforcement, (g) parental helplessness, (h) parental participation, (i) parental perception, (j) physical activity, (k) physical barriers, (l) physical environment, (m) time constraints, (n) parental participation, and (o) youth participation. Eight themes emerged from the codes using the Dedoose software, and I analyzed the frequency of the occurrence of each code. The identification of 15 themes led to the interpretation of the data by synthesizing the following final themes: *(a) parental attitude in daily decision making*, *(b) parental awareness of the health risk of an overweight or obese child, (c) family participation in obesity prevention efforts, (d) youth participation in obesity prevention efforts, (e) parental participation in obesity prevention efforts, (f) parental enforcement of obesity prevention efforts, (g) parental perceptions of childhood obesity, and (h) parental fears of helplessness.*

Study Setting

I conducted the interviews at a public library where I could maintain control of confidentially, provide a quiet place with few interruptions, and enhance trustworthiness in a comfortable setting. After having attained an approved reservation and agreement from the interviewee, I conducted each interview and served as the principal researcher. Participants each received a $20.00 Walmart gift card for their time and travel to recompense them for completing participation in this researcher study.

Participant Demographics

This transcendental phenomenology study had 15 female participants. Of the 19 parents who showed interest, 18 met criteria. Of the 18 parents who met the criteria, 15 agreed to complete this research study. Participants self-reported their child’s sex: 12

were girls. The median age of their obese or overweight child was 9.33-years-old in the range of 6–11 years old. The median range of the mothers' ages was 31–50 years old. Of the participants, nine had a college degree or advanced degree. Of the 15 participants' self-reports, almost half-made less than $25,000, four made between $25,000 and $50,000 per year, two made between $50,000 and $75,000 per year, and 1 made between $75,000 and $100,000. (See Table 1 for additional demographic information.)

Table 1

Participants of Childhood Obesity Health Interview Tool Demographics

Participant sex	Child sex	Child age	Relationship to child	Age of participant
F	F	11	Mother	31–50
F	F	11	Mother	31–50
F	F	6	Mother	18–30
F	M	10	Mother	31–50
F	F	9	Mother	31–50
F	F	8	Mother	31–50
F	F	11	Mother	31–50
F	F	11	Mother	31–50
F	F	11	Mother	51 plus
F	F	11	Mother	31–50
F	F	11	Mother	31–50
F	F	11	Mother	31–50
F	M	9	Mother	31–50
F	F	9	Mother	18–30
F	M	11	Mother	31–50

Only five rescheduled interviews to address conflicts or life emergencies. I reviewed the interview process at the beginning of the interview, offering each

participant the opportunity to participate or decline participation. Of the 15 participants, all agreed to take part in this research study.

As a healthcare provider, I observed the participants: 11 mothers were overweight and said they should not be the role model for their overweight child. I kept my personal attitude separate from the participants self-reports, because I was an overweight child who carried the excess weight into adulthood. As I completed this research study, I reflected on my mother's struggles in raising an overweight child in the home. Some behaviors mothers reported directly reflected my mother's struggle with the management of an overweight child in the home. For example, one mother expressed that her daughter would sneak food into the bedroom or asks for a second serving of food. As a reflection, I demonstrated the same behaviors as a child.

Data Analysis

Transcendental phenomenology was the preferred method of data analysis for this research study, based on the concept from Husserl in the early 20th century (Rosenstock, Strecher, and Becker, 1988) and Creswell's (2007) recent work. According to the phenomenological view, the interest of the researcher is to report the personal experiences of humans from their perspectives rather than using abstract statements (Liamputtong, 2009; Patton, 2002). The objective of this qualitative phenomenological study was to explore, understand, and describe the perceptions and experiences of African American parents in the management and care of their obese or overweight children. This research study outlines how a group of individuals with the same problem shared their human experience in addressing the management of their obese or

overweight child. In this research study, I used a qualitative data-collection and -analysis method to explore the perceptions and experiences of African American parents and their views about the management and care of obese children.

During the process of data collection and analysis, I continued to work to erase any preconceive thoughts about the management of childhood obesity from the perspective of a healthcare provider. During the data collection and -analysis process, it was important for me, as the researcher, to remove the prejudgments arising from my personal and knowledge-based views about childhood obesity. The second step in the transcendental phenomenology data-analysis process entailed reviewing the data obtained from the interviews. I tape recorded the interviews using a Sony ICD-Digital voice recorder, saved the data as a file and exported them to Rev.com services to transcribe the voice-recorded interviews. I then reviewed each transcribed interview document with the participant to obtain their agreement that the statements were correct from our tape-recorded conversation. The Rev.com Company signed a nondisclosure agreement to maintain confidentially of services (see Appendix D). After this process, I listened, read, and reread the tape-recorded documents to identify similar statements. The process of reviewing taped transcriptions took four weeks.

I developed a list of 15 codes from the written interview transcripts. Next, all the interview documents were loaded into the Dedoose software program (SocioCultural Research Consultants, 2015). The computer software program was beneficial in organizing the data into frequencies of occurrence so I could easily recognize meaningful themes in the data analysis of the research results. The data results focused on the

perceptions of the African American parents' self-reports of their personal experiences in managing their obese or overweight child. Table 2 shows the themes that emerged from data analysis to answer the research questions of this transcendental phenomenology study.

Table 2

Themes Frequency of Occurrence

Themes	Frequency of occurrence
Daily decision parental attitude in making	30
Parental awareness of the health risk of an overweight or obese child	25
Family participation of obesity prevention efforts	21
Youth participation of obesity prevention efforts	18
Parental participation of obesity prevention efforts	18
Parental enforcement of obesity prevention efforts	17
Parental perceptions of childhood obesity	16
Parental fears of helplessness	16

Evidence of Trustworthiness

I had developed two icebreaker questions to allow participants time to relax before the interview process began. The questions produced laughter from all participants. I reviewed the consent form before taping the actual interviews, allowing participants the opportunity to decline without any pressure to complete this research study. I restated the interview questions, allowing the interviewee time to process questions and formulate responses. If a participant requested the meaning of a specific question, I restated the question and provided additional information for clarity. I

reviewed with each interviewee that all responses were optional and each participant had the option to stop the interview process at any time.

Results

The themes identified through the Dedoose computer software program (SocioCultural Research Consultants, 2015) were based on participants' responses and relevance to the following research questions:

RQ1: How do African American parents of obese or overweight children perceive the health risks of their children as associated with childhood obesity?

RQ2: What family-related factors do African American parents believe contribute to the obesity or overweight of their children?

RQ3: What interventions do African American parents implement to control or reduce the obesity of their children?

RQ4: What are the educational needs of African American parents in the weight management of their children?

Parent Attitude and Daily Decision Making

The first theme, which addressed the first research question, was parental attitude in daily decision making in the management and care of their obese or overweight child (see Table 3).

Parental Awareness of the Health Risk of an Overweight or Obese Child

The second research question addressed the following theme: Were parents aware of health-risk factors in the management and care of their obese or overweight child? Of the 15 participants, 14 responded to the closed-ended question "yes," their child was

overweight (see Table 4). The data results showed that participants were knowledgeable about physical and mental health risks because of childhood obesity (see Table 4).

Table 3

Parent Attitude in Daily Decision Making

Research question	Response from participant
Do you limit the amount of time your child spends watching TV or using electronic devices daily to less than two hours per day.	"I don't know how much, I am at work. I know that since their home from school, they're eating more at home."
How can parents influence the amount of physical activity their child participates in weekly?	"Just force them to do more." "Make them exercise, or make them run."
Do you spend time with your child participating in any physical activity? If so, how much time weekly?	"No."
What type of snacks do your child receive at home?	"Most of the time it's like juice, chips, sometimes candy. It's mostly candy and chips is mostly what she eats."
	"She eat a snack it would be like potato chips, and maybe honey bun, or apple, or banana, something like that."
Do you limit the amount of daily food intake of your child?	-"No." "Yes, indeed, I do." "My method is replacing what he wants to eat, like, say he wants a cookie, I'll say, "No, let's go ahead and have the apple, or the cherries, or the strawberries."
Do you limit the amount of daily sugary drinks consumed by your child daily?	"She don't drink much sodas. If anything she'll drink water, and more tea, and maybe juice."

Table 4

Parental Awareness of the Health Risk of an Overweight or Obese Child

Research question	Response from participant
Do you think your child is obese or overweight?	14 responded to the closed ended question that “yes” their child was overweight.
	“the participant agreed that her child was overweight, but responded that she felt the obesity cause was directly linked to the side effects of her child’s Asthma medication
What problems do you think an overweight child might have?	“Asthma, lack of energy, and low self-esteem.”
	“I know they have problems at school with bullying and picking, and they have a lot of emotional problems.”
	“Breathing problems, just moving, pretty much just moving around. Just eating too much and not being able to fit and wear clothes.”
	“Being overweight, you have the other underlying health issues, diabetes, high blood pressure, things like that.”
	“Mine gets picked a lot by the other kids at school.”

Family Participation in Obesity Prevention Efforts

Participants’ believed family participation could have positive or negative effects on childhood-obesity-prevention efforts (see Table 5). The results of this study showed that sometimes parents and grandparents had differences in feeding practices.

Youth Participation in Obesity-Prevention Efforts

The following question addressed youth participation: “How much time does your child spend participating in physical activities such as running, biking, basketball, baseball, swimming, and walking, weekly?” Of the 15 participants, 11 responded that their child participated in physical activity at least weekly. Four parents responded their child was uninterested in any physical activity regardless of family participation (see Table 6).

Table 5

Family Participation in Obesity-Prevention Efforts

Research question	Response from participant
What has made it difficult to control your child's weight? Have there been any barriers?	"Difficult to control his weight is, he didn't like exercise, so it makes it very difficult." "Just because we're involved in so much, we're not home most of the afternoon. Either she's got something to participate in or I've got something that I have to go participate in. It's hard to stay focused the way we need to." "She spends her time with me, but when I'm working she is with grandma. Grandma cooks like she's feeding an army." "There's a lot of stuff that my mom cooks that I don't have here at home. Or a lot of stuff that she has there snack wise, because at my house I don't buy candy and Debbie cakes. My mom buys that stuff." "We can go outside. We can throw a ball together. We play volleyball. We've tried to do fun things to make it seem like it's just a game."

Table 6

Youth Participation in Obesity-Prevention Efforts

Research question	Response from participant
How much time does your child spend participant, in physical activities such as running, biking, basketball, baseball, swimming, walking, weekly?	"Weekly, right now, he just finished a swimming program at the YMCA. He was swimming Monday through Thursday. He was doing it for an hour." "They participate. You said how much? They participate every day. They play around and play basketball and stuff outside everyday." "She will go walking. She did that a lot this summer. Probably about ... Maybe an hour and a half, three or four days a week this summer." "Well, he's active with the children in the neighborhood. They play ball in the afternoons after he gets his homework and stuff done, and two, he's in football."
Overweight children would exercise more if their parents exercise regularly. That's a perception, yes or no.	Of the 15 participants, only 5 parents replied yes.

Parental Participation in Obesity-Prevention Efforts

The questions explained in this section are, "What weight reduction programs did your provider offer to help you? Was there any community center that helped"? Of the 15 participants, only three reported some assistance from their healthcare provider. Six mothers believed more support could have been offered from their child's healthcare provider in weight management (see Table 7).

Table 7

Parental Participation in Obesity-Prevention Efforts

Research question	Response from participant
How can parents influence the foods that a child eats?	"I think by leading by example. If your child sees you eating healthy, then 9 out of 10, they'll want to eat healthy too."
What weight reduction programs did your provider offer to help you? Was there any community center that helped?	"No really programs. She just referred us to a dietitian and gave us some suggestions on what to eat and what not to eat as far as my daughter working out more."
What have you tried to do to control your child's weight?	"I've tried getting him to go walking with his sister. She exercises and walk a lot. I also tried getting him to ride his bike."
	"It's not really a problem as far as setting routine. Some stuff she likes to do that I don't like to do, but I will try to do the exercise she likes so she will do them."
	"I think by leading by example. If your child sees you eating healthy, then 9 out of 10, they'll want to eat healthy too."

Of the 15 participants, all were aware of the health risk from having an overweight or obese child. All participants expressed concerns related to the potential of health risks of their individual child (see Tables 8, 9, and 10).

Table 8

Parental Perceptions of Childhood Obesity

Interview question	Response from participant
What problems do you think an overweight child might have?	"Difficulty breathing, difficulty sleeping well, difficulty changing their habits in eating."
How do you feel about your child's weight? This is your perception?	"I already heard you mention that you feel like her overweight is contributing from the medicine that she's taking with asthma."
	Of the 15 participants, only one parent believed her child weight was the result from environmental factors.
	"I would like her to get at least maybe ten pounds off her right now, but I understand that she's on the medicine."
How can parents influence the foods that a child eats?	"I would say every parent hates to do it, take them when you go to the store and give them the healthy options."
	"Let them pick out their favorite fruit, or yogurt, or what it is that they like, and don't buy the high-sugar, yogurts and stuff, and just let them pick what they want but also it gives them a chance to have healthy options."
How do you feel about your child's weight? This is your perception?	"I'm not happy about my child's weight. I feel that he needs to lose weight, and that he could lose weight if we put him on a program."
	"I feel she can do a little bit more to try to control it, with more help from me and other family members."

Table 9

Parental Fears of Helplessness

Interview question	Response from participant
Do you have any concerns with your child's family or friend relationship?	"Sometime the family could just be a little bit more accepting, and may not say hurtful things."
How do you feel about your child's weight?	"I feel he really need to lose weight, because he can't play basketball or play games without getting really tried after 5 minutes of activity."
	"I think she's overweight and I'm just worried about her health-wise. I want her to at least be healthier."
	"I'm concerned because she's not very athletic and active. She is more of a bookworm and sedentary and doing other stuff. It bothers me, because I would rather her be up moving around more."
What has made it difficult to control your child's weight? Have there been any barriers?	"Keeping him from sneaking in the refrigerator."

Table 10

Parental Enforcement of Obesity-Prevention Efforts

Research question	Response from participant
Do you limit the amount of daily food intake of your child?	"Yes, indeed, I do."
What have you tried to do to control your child's weight? I think you've already mentioned that, you just limit her intake?	"Yes ma'am."
Do you limit the amount of daily food intake of your child? That's either a yes or a no?	"No and I say no because I don't really have that issue with her. She'll eat breakfast and then she'll do dinner, kind of. I don't have too much of that eating in between unless it's the fruit or stuff like that but not just going in and eating two or three meals in between."

Of the 15 participants, few reported limiting their child's daily intake of food or liquids. Two parents reported implementing a physical fitness routine and enforced rules for child's participation. Those parents who enforced rules reported the plan was ineffective.

Summary

Chapter 4 provided written data analysis of the raw data obtained from the lived experiences described using the transcendental phenomenological approach collected from the 15 participants. I first described the demographics of participants then outlined the data-collection and data-analysis processes. I reported the development of the themes that guided answers to the study research questions. I extracted verbatim excerpts from the interviews, coded to the appropriate theme based on the four research questions listed below:

RQ1: How do African American parents of obese or overweight children perceive the health risks of their children as associated with childhood obesity?

RQ2: What family-related factors do African American parents believe contribute to the obesity or overweight of their children?

RQ3: What interventions do African American parents implement to control or reduce the obesity of their children?

RQ4: What are the educational needs of African American parents in the weight management of their children?

Participants' responses reflected that all parents agreed their child was obese or overweight and some accepted responsibility that their child needs their guidance in

setting the tone for weight management in the home. Few parents received guidance from their child's primary care doctor and few community programs helped them in the home. The overall theme response was parents' concerns of feeling powerless and helpless despite their weight-management interventions in the home. In Edmunds's (2005) and (Tucker, 2015) study, parents reported not receiving much assistance from healthcare providers on the subject of childhood obesity. This research study supported the notion that healthcare providers continue to fail to engage in guidance in the management of childhood obesity during routine pediatric visit.

According to Lopez (2016), Wright (2010) and Alexander, Alfonso, & Cao (2016) healthcare providers often miss the opportunity to engage in conversation promoting making healthy choices during primary care visits. An additional need for program development may be the need for education programs to address how healthcare providers can provide meaningful conversation on weight management of children and adults. During the early stage of selecting a place to conduct my research study, I contacted several Pediatric offices via the phone, none agreed to be a community support partner.

In the final chapter, Chapter 5, I discuss my conclusions, including the final themes, social-change implications, and recommendations based on this study's results. Subica, Grills, Douglas, and Villanueva (2016) proposed that an organized community effort is necessary to promote healthier behaviors in communities of color through a grassroots approach. These researchers suggested using views from parents to move

forward with community leaders and healthcare providers in the promotion of eradicating childhood obesity.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this chapter, I present an interpretation of the results shared in Chapter 4. This phenomenological study's purpose was to identify how African American parents self-report how they manage caring for an obese or overweight child in southeastern North Carolina. The focus of a phenomenological study is to explore or understand the essence of an individual or group about their lived experiences (Willing, 2008; p. 344,). The data obtained allowed parents to self-evaluate their views and concerns on the health status of their child. Parents had the opportunity to share the real-life experiences they face daily in the home or community environment. When the viewpoints of African American parents are shared with community leaders to aid in development of prevention strategies childhood obesity can be reduced.

Of the 15 participants, 14 readily agreed that their child was obese or overweight, and one parent agreed with hesitancy, due to the belief that child obesity was caused only by a child's disease process. One participant believed that the child's overweight problem contributed to the child's need for asthma medication. Parents identified that making decisions to be healthier requires family involvement, time commitment, and motivation. Of the 15 parents, three identified conflicting perceptions between family members about negative food choices and healthy food choices. Of the 15 participants, only four reported receiving obesity prevention information or community support from their child's primary care provider. Parents expressed lack of concern from their child's primary care

provider related to their concerns of their child's weight and health risk. One participant reported that her child participated in an obesity research protocol; the single mother reported that the time of the program conflicted with her work schedule. The mother expressed that for the 3 weeks her child attended, results were positive.

Interpretation of the Findings

The current research data continues to conclude that childhood obesity rates are higher among African American children. Childhood obesity has been a prevalent problem in the United States and globally over the last 20 years (CDC, 2009, 2014b). This research study was imperative to reflect the role African American parents play in caring for an overweight child. As previously stated in 2011, obesity rates among African American students was 18.2%, compared to 14.9% in Hispanic students, and 11.5% in European American students (CDC, 2011).

The digital audio transcripts were uploaded to Rev.Com services for transcription into a word document. Participants had the opportunity to review the word document for agreement with the taped interview. I listened to the taped interviews and reviewed the written word documents of the interviews, seeking similarities for the devolvement of codes. I uploaded the codes into the Dedoose computer software program (SocioCultural Research Consultants, 2015). The themes discussed in detail in Chapter 4 accrued from the data report of the occurrence of frequencies and clustering.

When conducting interviews, I followed Walden's privacy policy in protecting participants. I obtained a written nondisclosure agreement from Rev.Com to maintain confidentially of all raw data from the digital interviews. I placed transcripts on a secure

password-protected network in the Dedoose software program (SocioCultural Research Consultants, 2015). The results based on the research questions follow.

Research Question 1 was: How do African American parents of obese or overweight children perceive the health risks of their children as associated with childhood obesity? All 15 participants expressed agreement that their child was at risk to develop diseases such as high blood pressure, diabetes, arthritis, respiratory illness, high cholesterol, low self-esteem, eating too much, and lack of energy. Three parents reported their child had asthma and one parent perceived the asthma contributed to the child being overweight. Of the 15 participants, six reported a concern related to school bullying and that school classmates have called their child “fat.” One parent has Type 1 diabetes and reported feeling concerned the child could develop diabetes due to genetics. Another parent explained that the genetics of overweight and obesity are prevalent in the child’s family, feeling concerned that her child is at risk for high blood pressure and diabetes. Parents’ perceptions were not consistent with previous research studies that reported caregivers do not recognize the that their child is at risk for the development of chronic health problems (Alexander et al., 2016; Garrett-Wright, 2011; Lemelin et al., 2012; Payas et al., 2010; Polfuss & Frenn 2012).

Research Question 2 was: What family related factors do African American parents believe contribute to the obesity or overweight of their children? Of the 15 participants, eight reported a family history of health concerns such as weight problems, high blood pressure, and high cholesterol, living a sedentary life style, smoking, and lack of motivation. Participant 6FF said the child is more motivated when eating a healthier

diet and exercising daily. Some parents shared that some family members have different views from their own about feeding their child healthy food versus unhealthy food. For example, Participant 1AA said her grandmother often cooked cakes for her children. Participant 8HH shared that her mother and sister give her children candy and fast food when babysitting, despite her recommendations. One parent reported that her views on her son's eating plan of healthier food are sometimes different from that of her husband. This mother further explained that her husband believes it is acceptable for her son to have cookies, chips, and soda despite the concern of obesity. Aligned with findings from Eli, Howell, Fisher, and Nowicka study (2016), grandparents who disagreed with parental feeding practices criticized the parent for not preparing balanced nutritional meals.

Parents perceived that when their child overeats, it contributes to being overweight. Of the 15 participants, on average, parents make home-cooked meals at least 75% of the time. Of the 15 participants, only five reported limiting their child's intake of food. Some parents reported their child would get food without permission, hide food in their room, eat food while the family is asleep, and ask for second helpings during meal times.

Aligned with a study conducted by Danford, Schultz, Rosenblum, Miller, and Lumeng (2015), parents identified factors that contributed to their child becoming overweight. Contributing factors were types and quantities of food, parenting behaviors, lack of activity, amount of screen time, genetics, stress or emotion, and limited access to resources. Conclusions from this study show that parents were able to identify strategies for childhood obesity but lacked knowledge about implementation. Parents expressed

fears about how to help their child successfully manage weight. Few parents reported having time constraints as a barrier to weight management of their obese or overweight children. Parents' recognized the importance of daily physical activity and the involvement of the complete family unit in combating childhood obesity; however only four parents reported having a physical workout plan.

Research Question 3 asked: What interventions do African American parents implement to control or reduce the obesity of their children? A few parents reported placing restrictions on portion sizes, whereas many of the parents reported not placing restrictions on portion sizes. One parent reported serving her son no sugary snacks, only fruit for snacks. A few parents participated in a community program for weight management. One parent reported the community program was successful; however, she had to stop taking her son due to a conflict with her work schedule. Of the 15 parents, only four reported they participated in a community weight program for their child.

Three parents reported placing their children on a schedule for physical activity; the parents were able to report the positive effects of physical activity. The parents did report most of their meals were home prepared; however, I did not request sample menus. Most parents did not place limits on snacks and reported their child received high sugary snacks. A few parents mentioned offering fruit to their child. Of the 15 participants, two reported allowing their child the opportunity to shop or provide input when buying healthy foods. One mother reported it was beneficial to allow her daughter to participate in shopping because she would be willing to eat the food.

Research Question 4 was: What are the educational needs of African American parents in the weight management of their children? Many parents reported feeling helpless in the overall success of their child losing weight and sustaining the lower weight. Parents could recognize that their child was obese or overweight and were knowledgeable of health risks related to being overweight. Parents reported giving their children sugary snacks; only a few parents expressed following any healthy food-choice guidelines for snacks. I asked parents about how they prepared the dinner meal and about fast food versus home-prepared meals. All parents responded that at least 75% of meals were prepared at home. However; I did not ask parents for their meal plan and thus am unsure if the parents needed education in this area. Overall, parents requested help with long-term planning to address their child's weight problem and many agreed that their family participates in weight-reduction activities. The age range of the parents were 31–50. The parents in this study had been addressing the needs of an overweight child for a few years with little success in long-term management.

Limitations of the Study

The parents who volunteered for this study self-reported their personal views of how they managed the health status of their obese or overweight child. The convenience sample accrued on a voluntary basis so only individuals who chose to be part of this data-collection process were available for this research study. Because the sample size was small, this study supports generalization on to a small geographic location and does not represent a larger population of people. This limitation prevents representation from all 100 counties in North Carolina. The obesity problem is prevalent in all ethnic groups.

This research study focused only on African American parents' personal beliefs related to the management of childhood obesity. The findings are important enough to be applied to everyday experiences that can aid in the development of a new program to address the needs of African American parents' in long-term management of childhood obesity.

Recommendations

A longitudinal study that explores' different cultures' perceptions in the management of childhood obesity, such as the Hispanic, European American, and Asian populations would provide useful insight. As stated previously, different ethnic groups have reported positive results in childhood-obesity weight-management prevention interventions. Such a study could be valuable in sharing positive strategies to combat childhood obesity from the perspectives of all cultural groups. Sealy (2010) conducted a focused study group with Caribbean, Hispanic, and African American parents on cultural feeding practices. Sealy reported that a limited number of studies addressed the perceptions of African American parents' views of how they managed care of an overweight child.

A comparative study in a similar rural region versus an urban region would provide insight into perceptions of parents facing the same problem with children 6 years or younger. Olstad and McCargar (2009) reviewed childhood obesity and offered prevention strategies for children younger than 6 years old. The researchers addressed the importance of early intervention with parents using behavior modification and prevention. Parents in the Olstad and McCargar study had older children reporting they did not know how to implement successful weight-reducing strategies over time. A study

conducted by Danford et al. (2015) concluded from their study that mothers could identify strategies for childhood obesity, but lacked knowledge to implement those strategies.

Implications on Social Change

This phenomenological study revealed that parents desire help with long-term strategies in the weight management of their children. Parents could recognize that their children were obese or overweight but reported feeling helpless in achieving long-term goals. Parents reported that families and the child did participate in weight-management strategies; however, long-term interest to maintain the interventions became lost. Parents expressed lacking motivation for long-term interventions, but expressed knowing the health risks of childhood obesity. Parents expressed they lacked significant direction from their child's primary care provider. The social change of implementing successful long-term childhood-obesity programs could reduce childhood obesity of all ethnic groups with community involvement. Community members include families, healthcare providers, school systems, and state leaders.

Tucker and Lanningham-Foster (2015) led a successful school-based obesity-prevention program with nursing students, nurse faculty, parents, and an obese or overweight child. Their study had partnership with an elementary school, university, public-health department, and academic medical center in the promotion of health awareness of childhood obesity. Nursing students used positive health messages in mentoring their individual student, eating lunch with them, and strengthening their

knowledge base of addressing childhood obesity in the community. Results showed weight loss occurred in the two groups over 3 months.

In conclusion, this research study was significant in highlighting the needs voiced by African American parents in combating childhood obesity. The participant group verbalized their needs; it is now time to address their needs with community leaders and healthcare providers. As a healthcare provider, I can contribute to making social change through the education of community members in partnership with the local health department and church organizations. As an adjunct nursing instructor, I could work with university nursing students in a community project that addresses childhood obesity. According to Lopez et al. (2016), a strong need exists for healthcare providers to work collaboratively with parents and pediatric clients in the promotion of health education. Lopez et al. conducted a study with pediatric patients with high blood-pressure readings. Because of follow-up appointments and coaching to make life-style changes, the high blood-pressure readings decreased along with weight among the pediatric patients. Social change can occur when community members recognize the need to work together to take action and implement healthy behavior changes.

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Appendix A: Perception of Child Appearance and Health Interview Tool

Date: ______ Field Research Student: ______________________

Time: ___________ End:_________________

Demographics

Place a check for your individual response to each question

1. Interviewee Sex: M___________ F _______________ Code Number: _____________

2. Child Sex: M____ F___ Child Age: ________ Wt:_______ Ht: ____________

3. Your Relationship with child: Mother___________, Father__________, Other_______

4 . Interviewee Age: 18-30 _____________ 31-50 ____________ 51 plus___________

5. Interviewee Race: ____________________

6. Educational Level:

High School Diploma or less: _________________ College Degree or less: ___________

Post Graduate Degree or Certificate: _______________

7. Income Level:

Below $25,000/ Year_____ Below $50,000/Year_____ Below 75,000/Year_________

Below $100,000/year____________ Above $100,000/Year_______________

8. How long have you lived at your residence? _____________

9. What is your favorite Color: ___________________

10. What is your favorite childhood memory?

We will now begin the audio-taped session of the interview.

1. Do you think your child is overweight? Yes or No

2. What problems do you think an overweight child might have?
3. How do you feel about your child's weight?
4. What have you tried to do to control your child's weight?
5. What has made it difficult to control your child's weight?
6. Did your child's doctor ever tell you that your child is over-weight? If so, what weight-reduction programs were offered by your child's healthcare provider or community center?
7. What medical conditions exist within your child's family member (Mother, Father, Grandmother, Grandfather, Uncle, Aunt, Sister or Brother? If a medical condition exist, do you believe the medical condition was related to: **Smoking, Alcohol use, Diet, low physical activity, obesity or none or all.**
8. Overweight children are likely to become overweight adults. Yes or No. If Yes, explain?
9. Over-weight children are likely to have problems in their social relationship with non-over-weight children? If yes, explain any concerns with child's family/friend relationships?
10. Over-weight children will exercise more if their parents exercise regularly?
11. How can parents influence the foods that a child eats?
12. How can parents influence the amount of physical activity their child participates in weekly?
13. How much time does your child spend participating in physical (running, biking, basketball, baseball, swimming, walking) activities weekly?

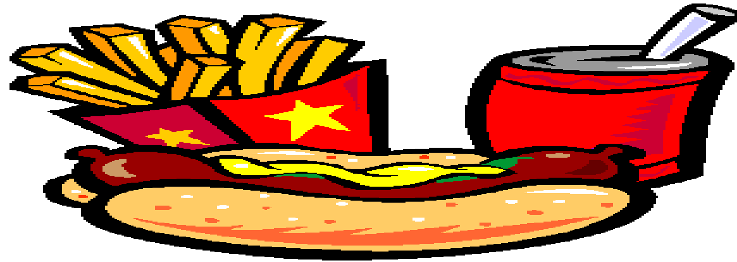
14. Do you spend time with your child participating in any physical activities? If so, how much time weekly?
15. How much time does your child spend watching television or any other electronic device weekly?
16. How much time do you and your child spend in physical exercise daily? What are the benefits of physical exercise daily?
17. If you participate in weekly or daily physical activity with your child, explain any problems with a routine of physical exercises?
18. What type of snacks do your child receive at home? How do you prepare your family meals (Home-cooked, fast food, pre-packaged)?
19. Do you limit the amount of daily food intake of your child? If so explain your methods?
20. Do you limit the amount of daily sugary drinks consumed by your child daily? If yes, explain methods?
21. Do you limit your child television or electronic daily usage to less than 2 hours per day or less?
22. Have you or your child participated in a weight reduction program in the past? If so, what were the results?

- Interview tool developed by the Stanley Manne Children Research Institute in Chicago and Jannetti Publications Inc.
- The 1st Five interview questions- reprinted from "Parental perception of the preschool obese child," by S. Myers & Z. Vargas, (2000). The same interview questions published in "Maternal Perception of their Overweight Children," by Mary Hackie & Cheryl Bowles (2007).

The interview questions 6-22, semistructured from the latest study by (Nsiah-Kumi, P., Ariza, A., Mikhail, L., Feinglass, J., & Binns, H. (2009).

Appendix B: Flyer

IN NEED OF AFRICAN AMERICAN PARENTS TO TAKE PART IN A RESEARCH STUDY IN HOPE MILLS, NC ON YOUR VIEWS ABOUT CHILDHOOD OBESITY



WOULD YOU LIKE TO BE PART OF A RESEARCH STUDY AND PROVIDE YOUR VIEWS ON TAKING CARE OF AN OVERWEIGHT CHILD?
YOU CAN REFER ANY INTERESTED MOTHER OR FATHER WITH AN OVERWEIGHT CHILD TO CONTACT PRISCILLA HUGGINS

Contact : Priscilla Huggins, RN, BSN, MSA, "doctoral student" @ PRISCILLA.HUGGINS@WALDENU.EDU OR
Place: Local DayCares & Churches in Hope Mills, NC
Date: June- August 2016

Appendix C: Letter of Cooperation From a Research Partner

Community Research Partner Name: Hope Mills Public Library

Contact Information: ██████, Circulation Manager

Date: June 30, 2015

Dear Researcher Priscilla Ann Huggins,

Based on our conversation related to your research study, I give permission for you to conduct the study entitled “The Perceptions and Experiences of African American Parents in the Management and Care of Obese Children” at the Hope Mills Library. As part of this study, I authorize you to conduct 15 one on one in person interviews using audiotaping of the conversation. As agreed, this is a public facility, no exchanges of money or gifts will be exchanged during the use of this facility. Individuals’ participation will be voluntary and at their own discretion.

We understand that our organization’s responsibilities include, the coordination and approval of the conference room, use of audiotaping equipment to conduct interviews, and commitment of privacy will be maintained during the interviews. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that, I am authorized to approve research in this setting and that this plan complies with the organization’s policies.

I understand that the data collected, will remain entirely confidential and may not be provided to anyone outside of the student’s supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Circulation Manager

██████

Appendix D: Nondisclosure Statement

CLIENT NON-DISCLOSURE AGREEMENT

This CLIENT NON-DISCLOSURE AGREEMENT, effective as of the date last set forth below (this "Agreement"), between the undersigned actual or potential client ("Client") and **Rev.com, Inc.** ("Rev.com") is made to confirm the understanding and agreement of the parties hereto with respect to certain proprietary information being provided to Rev.com for the purpose of performing translation, transcription, video captions and other document related services (the "Rev.com Services"). In consideration for the mutual agreements contained herein and the other provisions of this Agreement, the parties hereto agree as follows:

1. Scope of Confidential Information

1.1. "Confidential Information" means, subject to the exceptions set forth in Section 1.2 hereof, any documents or other text supplied by Client to Rev.com for the purpose of performing the Rev.com Services.

1.2. Confidential Information does not include information that: (i) was available to Rev.com prior to disclosure of such information by Client and free of any confidentiality obligation in favor of Client known to Rev.com at the time of disclosure; (ii) is made available to Rev.com from a third party not known by Rev.com at the time of such availability to be subject to a confidentiality obligation in favor of Client; (iii) is made available to third parties by Client without restriction on the disclosure of such information; (iv) is or becomes available to the public other than as a result of disclosure by Rev.com prohibited by this Agreement; or (v) is developed independently by Rev.com or Rev.com's directors, officers, members, partners, employees, consultants, contractors, agents, representatives or affiliated entities (collectively, "Associated Persons").

2. Use and Disclosure of Confidential Information

2.1. Rev.com will keep secret and will not disclose to anyone any of the Confidential Information, other than furnishing the Confidential Information to Associated Persons; provided that such Associated Persons are bound by agreements respecting confidential information. Rev.com will not use any of the Confidential Information for any purpose other than performing the Rev.com Services on Client's behalf. Rev.com will use reasonable care and adequate measures to protect the security of the Confidential Information and to attempt to prevent any Confidential Information from being disclosed or otherwise made available to unauthorized persons or used in violation of the foregoing.

2.2. Notwithstanding anything to the contrary herein, Rev.com is free to make, and this Agreement does not restrict, disclosure of any Confidential Information in a judicial, legislative or administrative investigation or proceeding or to a government or other regulatory agency; provided that, if permitted by law, Rev.com provides to Client prior notice of the intended disclosure and permits Client to intervene therein to protect its interests in the Confidential Information, and cooperate and assist Client in seeking to obtain such protection.

3. Certain Rights and Limitations

3.1. All Confidential Information will remain the property of Client.

3.2. This Agreement imposes no obligations on either party to purchase, sell, license, transfer or otherwise transact in any products, services or technology.

4. Termination

4.1. Upon Client's written request, Rev.com agrees to use good faith efforts to return promptly to Client any Confidential Information that is in writing and in the possession of Rev.com and to certify the return or destruction of all Confidential Information; provided that Rev.com may retain a summary description of Confidential Information for archival purposes.

4.2. The rights and obligations of the parties hereto contained in Sections 2 (Use and Disclosure of Confidential Information) (subject to Section 2.1), 3 (Certain Rights and Limitations), 4 (Termination), and 5 (Miscellaneous) will survive the return of any tangible embodiments of Confidential Information and any termination of this Agreement.

5. Miscellaneous

5.1. Client and Rev.com are independent contractors and will so represent themselves in all regards. Nothing in this Agreement will be construed to make either party the agent or legal representative of the other or to make the parties partners or joint venturers, and neither party may bind the other in any way. This Agreement will be governed by and construed in accordance with the laws of the State of California governing such agreements, without regard to conflicts-of-law principles. The sole and exclusive jurisdiction and venue for any litigation arising out of this Agreement shall be an appropriate federal or state court located in the State of California, and the parties agree not to raise, and waive, any objections or defenses based upon venue or forum non conveniens. This Agreement (together with any