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Perceptions of Obese African American Women Regarding Altering Traditional Soul Food Preparation

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Walden University
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Abstract

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by

Patricia Ann Young

MA, Chicago State University, 1999

BA, Alcorn State University, 1982

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Health Psychology

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Abstract

The obesity epidemic continues to be a major concern in the United States. The World Health Organization reported that 1.4 billion adults were either obese or overweight. African American (AA) women have the highest incidence of obesity worldwide. The obesity rate among AAs has continued to rise over the past 2 decades. The problem is that AA women prepare and consume high caloric foods that contribute to obesity. This qualitative descriptive study explored the perceptions that obese AA women have about altering how they prepare soul food to make it a healthier soul food. The empowerment model and the health belief model were used to frame this study. Data were collected using a non-probability purposeful sampling strategy. The sample for this study consisted of 4 focus groups with 6-7 obese AA women ($n = 25$) who prepare and consume high caloric soul foods and have a body mass index of 30 and above. Focus group transcripts were analyzed using a constant comparative analysis and NVivo 11 computer software. It was found that obese AA women were willing to alter their traditional soul food preparation only if it tastes good. It was also found that participants would maintain new healthier eating behaviors depending on the taste, availability of recipes to use, low cost of healthy ingredients, accessibility of the ingredients, learning how to substitute various herbs and spices, and amount of food waste. Barriers that could limit participation in an intervention designed to develop healthier eating habits were identified as ignorance and laziness, transportation issues, lack of motivation, lack of education, lack of time, no incentives, and bad reviews.

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Acknowledgments

Writing a dissertation is a long and horrendous endeavor, and it takes a lot of people to see the dissertation process through. First, I would like to thank God. He is the head of my life as well as my Father, friend, and comforter. Second, I would like to thank my dear sweet sister, Dr. Myralynn Catchings, who kept me grounded, alert, and on task daily throughout this process. She prayed with me, sang with me, and provided me with unlimited access to her for advice.

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To my son, Tyrik, please know that with men, things are impossible; but with God, all things are possible. Trust in the Lord with all your heart; and lean not unto your own understanding. A wise man will hear and will increase his learning, and a man of

understanding shall attain wise counsels. You are now a man; therefore, put away childish things and walk boldly into your future with love and kindness. I love you always.

Dedication

This research is dedicated to professional healthcare workers and other researchers who work diligently to find a solution which address the global obesity epidemic. This research will be used as a guide to develop interventions and programs that will help African Americans to understand the value of eating the foods they love in a healthy manner. I would be remiss to not recognize the contributions that the first Lady, Michelle Obama made towards combating childhood obesity. Today, school children are able to eat nutritious meals and hopefully help them to develop an active and healthy lifestyle. Finally, I dedicate this dissertation to my son, Tyrik and I encourage him to continue the legacy of excellence in education, health, and empowering others to enhance their quality of life. As you pursue your doctorate in physical therapy, remain focused and pray.

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Chapter 1: Introduction to the Study

Introduction

The obesity epidemic is a major concern in the United States. The World Health Organization (World Health Organization [WHO], 2014b) reported that 1.4 billion adults were either obese or overweight. Some individuals eat when they are stressed, which contributes to obesity (Bello, Yeh, Verpeut, & Walters, 2014; Sominsky, Spencer, Frank, & Schweiger, 2014). African American (AA) women were found to have the highest incidence of obesity worldwide; therefore, they have a greater risk for developing chronic illnesses and diseases associated with type 2 diabetes, liver and gallbladder disease, cardiovascular diseases, and various cancers (American Medical Association, AMA, 2013). Despite the many studies that have been conducted on obesity over the last 20 years, the obesity rate continues to rise among AAs (Callahan, 2013). The aforementioned chronic illnesses are attributed to higher rates of morbidity and mortality among AAs (Callahan, 2013; Dingfelder, 2013).

Since the early 1600s, when AA slaves were fed discarded foods from their slave owners, AA women began preparing those discarded foods in an appealing manner (Thompson, 2015). These foods were high in calories, fat, salt, and sugar (Callahan, 2013; Dingfelder, 2013). Today, AA women prepare high caloric foods, referred to as soul food (Callahan, 2013; Dingfelder, 2013). Soul food is defined as foods that are prepared with animal fat (specifically pork) and large amounts of salt and sugar (Callahan, 2013). For example, cornbread, vegetables cooked with fatback (e.g., collard greens, turnips, beans, and peas), foods that are fried (e.g., potatoes, chicken, pork chops,

fish, okra, and corn), pork (e.g., chitterlings, ham hocks, ham, pigtails, pig feet, and bologna), and sweetened drinks (e.g., Kool-Aid, tea, coffee, and hot chocolate). Eating traditional soul food increases body weight, which leads to obesity (Callahan, 2013). According to Lopez et al. (2014), AA women continue to prepare traditional soul food because it is a part of their heritage that they do not want to give up. There is very little research on the perceptions that AA women have about altering traditional soul food preparation. Gaining a better understanding of the perceptions that obese AA women have about altering soul food to prepare healthier soul food will provide the necessary information that could be used to develop interventions that would offer AA women alternatives to preparing healthier soul food to reduce obesity. This study may promote positive social change by reducing the mortality and morbidity rates among the AA population due to obesity. Additionally, the results of this qualitative study may fill the gap in the literature regarding obese AA women altering the way they prepare and consume traditional soul food.

In this chapter, I will provide a problem statement and a description of the purpose of the study. I will state the research questions and discuss the theoretical framework that I used for the study. I will also discuss the focus groups that I used to collect data and assess the perceptions of participants to develop interventions based on ideas from participants. In this chapter, I will also discuss the nature of the study, including the research design, quality of the research (e.g., creditability, reliability, transferability, and validity of the findings), handling of my biases, and confidentiality of focus group participants. The definitions of terms that I used in this study are also

included in this chapter. I will present the assumptions, the scope and delimitations, the limitations, and the significance of this study. I will conclude Chapter 1 with a summary.

Background of the Study

I selected articles related to eating behaviors and obesity to address the research problem. Health risks have been found to be associated with obesity among the AA population (Magrone et al., 2013; Scott & Rushing, 2014). Cho, Jae, Choo, and Choo (2014) suggested interventions and strategies that would help AA women to reduce their consumption of unhealthy soul food. Bray and Popkin (2013); Jensen Wallach (2014); Manickavasagan, Mathew, Al-Attabi, and Al-Zakwani (2013); and Talbot, Maguen, Epel, Metzler, and Neylan (2013) discussed the harmful effects of the consumption of sugary foods and beverages that are associated with chronic illnesses and diseases. Talbot et al. (2013) posited that there was a relationship between emotional eating and stress. Rudenga et al. (2013); Stevens-Watkins, Perry, Pullen, Jewell, and Oser (2014); Talbot et al. (2013); Wang et al. (2013a); Watson and Hunter (2015); Wilson and Sato (2014); and the WHO (2012) provided information on obesity among the AA population.

Past studies have focused on developing and implementing interventions, programs, and workshops that include components of obesity, weight loss, and weight maintenance (Amirrood, Taghdisi, Shidfar, & Gohari, 2014; Flegal, Carroll, Kit, & Ogden, 2012; Kumanyika et al., 2005b). Research included studies on nutrition, healthy eating, healthy lifestyles, and nutrition education including cooking lessons (Geller, Dube, Cruz, Stevens, & Bench, 2015; Jurkowski, Lawson, Green Mills, Wilner, & Davison, 2014; Kumanyika et al., 2005a; Lavelle et al., 2016; Resnicow et al., 2004;

Svetkey et al., 2005). There were also studies on physical activity and health behaviors,

spiritual/scripture support, and improving dietary intake to impact body composition and

bodily functions (Davison, Jurkowski, Li, Kranz, & Lawson, 2013; Djuric et al., 2009;

Flegal et al., 2012; Svetkey et al., 2005). Other studies included obesity and diabetes care,

obesity and breast health, general health and safety education, and osteoporosis education

(Djuric et al., 2009; Griffith et al., 2012; Sumlin & Garcia, 2012). Additionally, I found

studies that were conducted on local restaurant and fitness guide, fitness diaries, and

relapse prevention (Boh et al., 2016; Fukawa, 2016; Lavelle et al., 2016; Polsky,

Moineddin, Dunn, Glazier, & Booth, 2016; Rodgers et al., 2016; Yates et al., 2015).

Specifically, Wilcox et al. (2010), as well as Rahmati-Najarkolaei, Tavafian, Fesharaki,

and Jafari (2015), conducted a community-based participatory (CBP) study which

included an intervention that prepared church members to eat more fruits and vegetables,

exercise at least 30 minutes a day, and to try new recipes to ensure healthier meals for

their families.

Talbot et al. (2013) have documented that AA women generally prepare and

consume high caloric soul foods as comfort food. Eating high caloric comfort foods have

been directly related to obesity among this population (Cho et al., 2014; Sominsky &

Spencer, 2013; Talbot et al, 2013; Wang et al, 2013). James, Pobee, Oxjdine, Brown, and

Joshi (2012) stated that AA women could reduce obesity if they would consistently

prepare and consume soul foods that were cooked using healthy ingredients.

The results of this study would shed light on the perceptions and barriers that

obese AA women have regarding altering the way they prepare and consume high caloric

soul food so that interventions that focus on these perceptions and barriers can be developed. My intent is to develop an intervention (informed by the potential participants) that would help obese AA women to reduce obesity.

Problem Statement

The obesity epidemic has affected the entire world, with 1.4 billion adults considered obese or overweight (AMA, 2013). African American women have been hit the hardest by this epidemic (Callahan, 2013). Despite the many studies that have been conducted on obesity over the past two decades, the obesity rate continues to rise among AAs (Callahan, 2013). The rate of obesity in AA women is higher than all other racial, ethnic, and gender groups (Ogden, Carroll, Kit, & Flegal, 2014). Obesity contributes to the risk of hypertension, coronary heart disease, diabetes, depression, and cancer (AMA, 2013).

The problem is that AA women generally prepare and consume high caloric foods that contribute to obesity (Broady & Meeks, 2015; Jensen Wallach, 2014; Manickavasagan, Mathew, Al-Attabi, & Al-Zakwani, 2013; Sominsky & Spencer, 2013; Talbot et al., 2013; Wang, Sereika, Styn, & Burke, 2013b; Wilson & Sato, 2014). The obesity rate is steadily increasing in the United States despite the medical problems that can result from eating high caloric foods (Callahan, 2013). African American women are not willing to give up their cooking tradition because they fear that they would be giving up their heritage (Lopez et al., 2014). In the early 1600s, AA slaves brought their style of cooking to America which became a part of the AA culture and heritage (Petrick, 2011). The AA culture has changed over the years, and today AAs prepare foods that are high in

calories, salt, sugars, and fats. These foods are referred to as soul food (Bratanova,

Loughnan, Klein, Claassen, & Wood, 2016; Hall, 2016; Wang et al., 2013a).

It became a tradition for AA families to come together on special occasions to

prepare and consume soul food (Belle, 2009). Today, some AAs have changed the way

they prepare the traditional soul food in a healthier manner by substituting smoked turkey

instead of animal fats; baking, grilling, and broiling meats instead of frying; consuming

more fresh fruits and vegetables; and using herbs and spices to season their food (Belle,

2009; James, Pobee, Oxjdine, Brown, & Joshi, 2012; Reed et al., 2016).

In this study, I explored the perceptions that obese AA women have about altering

soul food to a healthier soul food. I addressed the gap in the literature regarding

alternatives for preparing the traditional soul food. African Americans may achieve more

health benefits if they prepare the same high caloric foods in a healthy manner.

Purpose of Study

The purpose of this qualitative descriptive study is to gain a better understanding

of the perceptions that obese AA women have about altering the way they prepare

traditional soul food to a healthier soul food. The information collected from participants

is going to be used to develop future interventions that would offer obese AA women

alternatives to preparing healthier soul to reduce obesity. For this study, I used a

descriptive design to explore the perceptions of obese AA women who prepare and

consume high caloric soul food to reduce obesity. The purpose of this qualitative

descriptive study was to gain a better understanding of the perceptions that obese AA

women have about altering the way they prepare traditional soul food. Information was gathered from focus groups using CBP research orientation (Minkler, 2010).

Research Questions

To gain an understanding of obese AA women's perceptions about altering traditional soul food, in this study I addressed three main research questions. The research questions are: Research Question 1: What are the perceptions of obese AA women regarding altering traditional soul food preparation?

Research Question 2: What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?

Research Question 3: What barriers could limit participation in an intervention designed to develop healthier eating habits for obese AA women?

Conceptual Framework

The conceptual framework for this study was taken from the research that has been conducted by other researchers in the field of social sciences and psychology. I used the empowerment model and the health belief model (HBM) to frame this study, and the decision to use these theoretical models was based on evidence from the research that interventions were needed to address the preparation and consumption of traditional soul food. I based this study on Belle (2009) and Beagan and Chapman's (2012) studies which concluded that AA women would not stop preparing and consuming traditional soul food due to the fear of losing their heritage. Beagan and Chapman (2012) noted that AA women felt that their heritage would be lost if they gave up traditional soul food. Belle

(2009) stated that AA women will always prepare and consume traditional soul food because it tastes good, it is inexpensive, and it is a part of AA culture.

I aimed to develop interventions that would help obese AA women alter the way they prepare and consume traditional soul food. I have gathered information and insights from obese AA women on their perceptions and beliefs regarding traditional soul food. This study has filled the gap in the literature regarding how AA women can prepare and consume healthy soul food to reduce obesity. This qualitative descriptive study helped me to gain a better understanding of the perceptions that obese AA women have about altering traditional soul food preparation.

I collected data from focus groups using CBP research orientation. Community-based participatory research orientation involves community members and researchers working together to resolve a health issue which affects a specific community (Frerichs, Lich, Dave, & Corbie-Smith, 2016). Benefits of using CBP research orientation included: (a) participants and researchers sharing equitable interest in the event (Frerichs et al., 2016), (b) participants will be honest and open when offering suggestions and opinions (Minkler, 2010), (c) participants will provide first-hand knowledge on the issue in question which will improve research quality (Xia, Stone, Hoffman, & Klappa, 2016), and (d) strategies and interventions may be developed for implementation which will enhance the community such as increasing education, promoting empowerment, and creating social change Leung, Yen, & Minkler, 2004).

The focus groups consisted of obese AA women who provided data on what interventions would work best to alter the preparation of traditional soul food and to help

obese AA women to adopt and maintain healthier eating behaviors. Participants were encouraged to express their thoughts and their voices were heard. The future interventions that I plan to develop from the results of this study will demonstrate active participation in the development of the interventions. Additionally, using the empowerment model and HBM to frame this study allowed me to empower participants on having an active voice within the community to create positive changes and to educate participants regarding the choices that are available to them to change negative beliefs associated with their health.

Theoretical Foundation

I used the empowerment model and the HBM to frame this study regarding participants' perceptions and barriers to participating in an intervention program designed to alter how obese AA women consume and prepare traditional soul food. The empowerment model (a social process) was developed by Gutierrez, Parsons, and Cox (1998) to bring community members together to create a needed social change (Brodsky & Cattaneo, 2013; Dooris & Heritage, 2013; Gutierrez et al., 1998; Peterson, 2014). The empowerment model remains the same as the original version by Gutierrez et al. (1998). The empowerment model is used in psychology and social work services to enhance self-efficacy, knowledge, and action to impact change with marginalized groups in society (Peterson, 2014). The empowerment model involves (a) recognizing the issues in the community, (b) formulating goals that will help solve the issues within the community, (c) empowering individuals within the community to publicly support recommendations for change, and (d) working collaboratively with community organizations and city and

state officials to promote change (Peterson, 2014). The empowerment model has been

used to develop interventions to address obesity (Geller et al., 2015; Jurkowski et al.,

2014), diabetes (Schulz, 2014), healthy lifestyles (Melnyk et al., 2013), and other chronic

diseases (Ebrahimi, Sadeghi, Amanpour, & Vahedi, 2016). The empowerment model is

appropriate for the communities in this study because community members lacked the

knowledge and the resources to create change without community support to change the

way obese AA women prepare and consume soul food dishes to reduce obesity.

The HBM was developed by Hochbaum, Rosenstock, and Kegels in the 1950s to

explain and predict individuals' health behaviors (James et al., 2012). The original model

consisted of four constructs (perceived severity, perceived susceptibility, perceived

benefits, and perceived barriers) to gain knowledge on how to successfully contain

tuberculosis and other communicable diseases (Baranowski, Cullen, Nicklas, Thompson,

& Baranowski, 2003). As evidence emerged in the field of psychology, cues to action and

self-efficacy were added to the original four constructs to motivate individual to change

undesirable behaviors (Glanz et. al., 2008). Roden (2004) modified the HBM to include

perceived behavioral control and behavioral intention, and perceived notion of health was

used to replace the perceived threat of disease. Roden's (2004) study was designed to

promote health rather than disease control.

The HBM was appropriate for this study because this study will empower

members of the community to take ownership of their health. The HBM may influence

obese AA women to change the way they prepare soul foods for themselves and their

families to reduce obesity (Glanz et al., 2008). The basis of the HBM is that individuals

must believe that there is a threat for developing a disease or an illness related to obesity before they act to change undesirable behaviors (Becker, Maiman, Kirscht, Haefner, & Drachman, 1977; Boston University School of Public Health, 2016; Sapp & Weng, 2007). To change these undesirable behaviors, individuals must perceive that eating unhealthy soul food contributes to their mortality and decreases their quality of life (Glanz et al., 2008). The constructs of the HBM include (a) eliminating faulty beliefs and barriers, (b) encouraging achievement toward desired goals, (c) promoting health education, and (d) enhancing self-efficacy (Becker et al., 1977; Glanz et al., 2008; Sapp & Weng, 2007; Wood & Neal, 2007). I used the HBM to frame this study because it explains how obesity is perceived by individuals, promotes health education regarding the advantages and obstacles to healthy eating, and enhances self-efficacy which focuses on individuals' engagement in healthy behaviors.

The empowerment model and the HBM can be used to conduct healthy cooking classes focusing on altering the way obese AA women prepare traditional soul foods to reduce obesity by uniting obese AA women in the communities and empowering them to promote a positive change in their lives (Brodsky & Cattaneo, 2013; Dooris & Heritage, 2013). The results of this study will be used to address the efforts of a community of obese AA women who will either be successful or unsuccessful in taking charge of their lives, meeting their needs, and creating positive social change. More detailed information on these two theories is in Chapter 2.

Nature of the Study

I selected a qualitative descriptive design for this research study to gain a better understanding of the perceptions and beliefs of obese AA women regarding altering the way they prepare traditional soul food using focus groups. A qualitative descriptive approach is appropriate when researchers want to summarize information in everyday language to understand a specific phenomenon using a variety of samplings (Sandelowski, 2000, 2010). According to Creswell (2013) and Sandolowski (2000), a quantitative or mixed methods research design would be inappropriate because there is no pre-selection of variables in this study, no manipulation of variables, no testing hypotheses, no experiments, and no testing of relationships among variables. There were other research designs that I considered for this study such as case study, grounded theory, phenomenological, and narrative research. A case study design was not appropriate because I did not study a case that involved an event, a program, or an activity. Because I did not develop a theory, the grounded theory approach would not be a good fit for this study. I did not seek to understand the fundamental nature of an individual's experiences; thus, a phenomenological approach would be inappropriate (Creswell, 2013). Additionally, I did not write the life story of individuals; therefore, a narrative approach would not be appropriate (Creswell, 2013).

I conducted the focus group interviews using guidelines as suggested by Creswell (2013) that were: (a) participants met in a secure and safe environment, (b) all participants were treated with respect by a group leader (moderator), (c) participants signed a consent form to participate in focus groups, (d) there were no incorrect answers,

(e) participates were respectful of one another at all time, (f) participants spoke one at a time, and (g) the moderator guided the group interviews.

I began the focus group session by establishing a rapport with the participants so that participants felt comfortable. I respected the rights and privacy of all participants by providing confidentiality and equal treatment to all. Confidentiality included collecting and reporting unidentified data as well as securing a signed informed consent form. Participants were advised that all focus group interviews would be confidential, and comments made by participants would be restricted to focus group setting only as indicated in the informed consent form. All participants were allowed freedom to express their perceptions and beliefs regarding traditional soul food, and the findings were reported to give voice to the participants as to what elements could be included in interventions that would help obese AA women to alter the way they prepare and consume traditional soul food.

I analyzed the focus data using a constant comparative analysis by identifying themes and patterns which emerged from the raw data to capture the participants' true perceptions. I checked the themes that emerged from the raw data and assigned codes to the raw data to ensure the quality of this research. I further validated the findings, using member checking to verify that the findings were what the participants truly meant. Additionally, I kept a journal on the entire research process to keep me aware of my feelings and beliefs of the research issues as suggested by Lincoln (1995). Keeping track of my thoughts helped me to eliminate researcher's bias in the study.

Definitions

Body Mass Index (BMI): The BMI is a measurement used by researchers to assess the relationship of body fat to lean body mass (Fletcher, 2014). The BMI is the ratio of weight-to-height measurements and is calculated weight (in kilograms) divided by height (in meters) squared (Guthman, 2013).

Comfort Food: Comfort foods are high caloric foods that are consumed to relieve stress and soothe negative feelings (Talbot et al., 2013).

Healthy Eating: Healthy eating is defined as consuming foods that provide the human body with nutrients such as water, proteins, vitamins, carbohydrates, minerals, and fats (Centers for Disease Control and Prevention, CDC, 2016b).

Obesity: Obesity is the accumulation of body fat; a BMI of 30+ (WHO, 2014b).

Soul Food: Soul foods are foods that are high in calories that are prepared with animal fat (specifically pork), salt, and sugars such as chitterlings, cornbread, collard greens, fried foods, pork, and red kool-aid (Bratanova et al., 2016; Hall, 2016).

Assumptions

There were assumptions made in this study. I assumed that this study would be interesting and valuable to the participants and participants would feel free to openly voice their opinions regarding the preparation and consumption of soul food. This assumption was based on the fact that the participants lived on the Southside of Chicago, Illinois and shared similar eating behaviors. I assumed that the information collected would be sufficient to develop interventions that would be openly received by obese AA women. I also assumed that obese AA women who prepared traditional soul food for

their families would have experienced overweight and obesity within their families. Additionally, I assumed that the participants were unaware of the seriousness of the health risks associated with consuming high caloric soul food. I further assumed that if participants are comfortable and knew that they have the right to answer questions or leave the focus group at any time; their participation will be rich and open. The assumptions were necessary for the context of this study because it was important that participants were receptive to the issue of altering the preparation of traditional soul food. This allowed me to collect rich data that would be used to develop interventions to address obesity among this population as a result of eating high caloric soul food.

Scope and Delimitations

Obesity continues to be a health factor among the AA populations (Callahan, 2013; Ogden et al., 2014). Therefore, I selected a qualitative descriptive study to gain a better understanding of the perceptions that obese AA women have about altering the way they prepare traditional soul food to a healthier soul food so that interventions can be developed from this population to help reduce the incidence of obesity over prolong periods of time. This study was limited to obese AA women who prepare and consume high caloric soul food from the Southside of Chicago, Illinois. Other individuals were not included in this study because this study was culturally- and gender-specific to obese AA women.

Instead of using an intervention in this study, I collected information that helped me and other researchers to develop interventions to empower obese AA women to change the way they prepare and consume traditional soul food. Researchers used

qualitative research to gain an in-depth understanding of an issue (Creswell, 2013). In this study, I gathered information regarding ways to alter the preparation of traditional soul food; therefore, the results of this study may not be generalized to other members of the population.

Limitations

There were some limitations that I had to address in conducting this study. One limitation was that all participants may not have the same level of concern for eating healthy as others which could introduce controversy among the participants. Although participants may not agree that a healthy soul food is possible or necessary, I allowed participants the freedom to express their thoughts openly so that barriers to altering the way obese AA women prepare and consume high caloric soul food can be identified.

Another limitation was the location of the research site. According to Krueger (2002), the research site should be comfortable enough for participants to express their thoughts regarding the research problem; therefore, I ensured that the site was clean and comfortable for participants to openly express their views and perceptions. I conducted focus groups at San Justin's Kitchen located in the heart of Chicago's Southside. I chose this site because it allowed participants greater access to and from the site and eliminated transportation issues that participants may have encountered if other sites were used.

I used focus groups to answer the research questions for this study. Focus groups were first used in marketing research but became an effective data collection method within the field of psychology in the early 1900s (Kitzinger, 1995). According to Kitzinger (1995) and Liamputtong (2011), a focus group design will allow the researcher

to examine how the participants think about an important issue, allow participants to

share new ideas, debate different perspectives, and create new concepts (Kitzinger, 1995;

Liamputtong, 2011). The reason I selected this design was because, according to

Kitzinger (1995), a focus group design would be able to (a) identify obese AA women's

perceptions regarding altering traditional soul food preparation to reduce obesity, (b)

identify factors that obese AA women perceive would be helpful to maintain new

healthier eating behaviors, and (c) identify what barriers could limit obese AA women's

participation in an intervention program designed to help obese AA women develop

healthier eating behaviors.

According to researchers, there are potential biases that exist in focus groups and

researchers must address these biases (Drury, Chiang, Esterhuizen, Freshwater, & Taylor,

2014; Gill, Stewart, Treasure, & Chadwick, 2008; Le Bonniec et al., 2016; Liira et al.,

2015). The types of biases that may alter the results of the study's findings are moderator

bias, sensitivity bias, social acceptability bias, mood bias, and consistency bias (Gill et

al., 2008; Pannucci & Wilkins, 2010). Moderator bias occurs when the moderator makes

the participants uncomfortable which tend to hinder participants from responding openly

and honestly (Drury et al., 2014; Gill et al., 2008). Therefore, moderators must remain

neutral about opinions and responses given by participants by refraining from making

negative gestures or facial expressions during the focus group interview (Drury et al.,

2014; Gill et al., 2008; Nagle & Williams, n.d.; Pannucci & Wilkins, 2010). Moderators

must also dress moderately (in business attire), enunciate words clearly, and speak in a

moderate tone. Sensitivity bias occurs when participants feel unaccepted in the group.

Sensitivity bias can be minimized by the moderator in establishing rapport and acceptance with all participants and building trust with all members of the group (Drury et al., 2014; Gill et al., 2008; Nagle & Williams, n.d.; Pannucci & Wilkins, 2010). Social acceptability bias occurs when participants respond in a way that they feel is accepted by society instead of expressing their true feelings. Because participants want to be accepted by the group, they may not respond truthfully (Drury et al., 2014). To address social acceptability bias, the moderator should challenge participants' answers by probing for a clearer response (Drury et al., 2014). Mood bias occurs when participants' answers replicate how they are feeling at that time (Pannucci & Wilkins, 2010). For example, if a participant is angry, they may respond with hostility; if a participant is tired, they may not respond, or they may give very short responses. In these cases, the moderator should probe the respondent by saying that their opinions are important and valuable (Nagel & Williams, n.d.). Consistency bias occurs when participants tend to answer the way others are answering without offering their true thoughts (Drury et al., 2014). The moderator should use a probe to illicit a true response from the participant (Doody, Slevin, & Taggart, 2013). Finally, one participant may be more verbal than others; thus, dominating the interview. The goal of the moderator is to illicit responses from all members of the focus groups to gather thoughts and feelings from all participants (Doody et al., 2013).

Significance

This study is significant to AA families, clinicians, and policy makers and is important because obesity continues to ravage the entire world, with 1.4 billion adults considered obese or overweight and 42 million children under the age of five considered

overweight globally (AMA, 2013; WHO, 2014a). According to Callahan (2013), AA women have been hit the hardest by this epidemic; therefore, this qualitative study is significant to AAs who are obese as a result of consuming high caloric soul food. Recent studies have shown that unhealthy eating habits contribute to chronic illnesses (Manickavasagan et al., 2013; Reed et al., 2016; Rudenga et al., 2013; Sominsky & Spencer, 2013; Talbot et al., 2013) and the traditional soul food that AA women prepare and consume are contributing factors to obesity (Bray & Popkin, 2013; McLeod, 2012; Radford et al., 2015; Studdert, Flanders, & Mello, 2015). Obese AA women are traditionally underrepresented in social science research (Tussing-Humphreys, Fitzgibbon, Kong, & Odoms-Young, 2013); yet, obesity is an alarming problem among the AA population (AMA, 2013; WHO, 2014a). The results of this study may be used to create positive social change by offering AA women alternative recipes to preparing healthy soul food dishes to reduce obesity among the AA population without sacrificing their heritage.

Preparing healthy meals within a home environment generally becomes the task of parents and adult family members (Ogata & Hayes, 2014). However, within most AA families, women prepare the meals for the family and children consume these meals (Acheampong & Haldeman, 2013; Virudachalam et al., 2016). Factors which may contribute to obesity and overweight among AA children are: (a) introduction of solid foods at an early age (Piernas & Popkin, 2011), (b) acceleration of weight gain during infancy (Traveras, Gillman, Kleinman, Rich-Edwards, & Rifas-Shiman, 2013), and (c)

large intake of sweetened drinks and soul food (Dixon, Pena, & Traveras, 2012; Welsh et al., 2005).

This study is important to clinicians because clinicians and patients generally share a unique relationship and, in most instances, food intake and weight issues are conversations that are likely to come up throughout treatment. The results of this study will give clinicians another angle to address obesity among their patients. Clinicians can offer obese patients alternatives to the way they prepare and consume high caloric soul food.

The results of this study may also answer questions which are relevant to public health policymakers. Obesity is a global concern because it contributes to the high mortality and morbidity rate in the US (CDC, 2016a; Fitzgerald, 2013; WHO, 2014a). This concern will affect how policy makers develop and implement programs in communities across the US to combat obesity. It has been reported in research that obesity has been deemed as a disease (CDC, 2016a). Governors and state agencies (including state schools) should collaborate with community organizations to develop and implement programs to address the health issues as a result of obesity (AMA House of Delegates, 2013).

If AA women are trained to create a new tradition within the AA families that includes preparing healthy soul foods for themselves and their children, children will grow up having healthy food-related behaviors which may decrease the obesity rate among the AA population (Virudachalam et al., 2016). The primary goal of this study was to fill the gap in the literature regarding altering the way that obese AA women

prepare and consume traditional soul food to reduce obesity. Consuming high caloric soul food contributes to unfavorable health conditions among this population (Rudenga et al., 2013; Sominsky & Spencer, 2013). Once obese AA women have had the opportunity to voice their perceptions and barriers regarding healthy soul food preparation, the next step would be to use the findings from this qualitative study to develop a community-based intervention program empowering obese AA women to prepare the traditional soul food in a healthy manner to reduce obesity.

Summary

This qualitative study was designed to address the research problem of obesity among obese AA women as a result of consuming high caloric soul food. I wanted to understand the perceptions of obese AA women regarding altering traditional soul food preparation to reduce obesity, and the factors that obese AA women perceive would be helpful to maintain new healthier eating behaviors. I used the empowerment model and the HBM to frame this study. The focus groups provided information that would help me to develop community-based interventions that would alter soul food preparation and consumption to reduce obesity among the AA population. I explained the assumptions, delimitations, and limitations to justify variations that may be evident in the study. Additionally, I discussed the benefits of the study's results to the AA population as well as other individuals who prepared and consumed high caloric soul food.

In Chapter 2, I will explain the strategies that I used to search for the literature in this study, followed by an in-depth discussion of the theories that framed this study. Then I will discuss the literature that were related to obese AA women and soul food, high

caloric foods and obesity, the empowerment model, the HBM, and obesity. Next, I will

provide a summary of the major themes in the literature and end with a conclusion.

Chapter 2: Literature Review

Obese AA women generally prepare and consume high caloric soul food which, according to researchers, contributes to obesity (Broady & Meeks, 2015; Manickavasagan et al., 2013; Sominsky & Spencer, 2013; Talbot et al., 2013; Wang et al., 2013b; Wilson & Sato, 2014). Some examples of soul food are vegetables cooked in animal fat (collards, black-eye peas, and turnips), fried foods (fish, chicken, potatoes, okra, corn), pork (meat that was discarded from pigs), with added salt and sugars (Bratanova et al., 2016; Hall, 2016; Mead, Gittelsohn, Roache, Corriveau, & Sharma, 2013).

Past studies have focused on developing and implementing interventions, programs, and workshops that include components of obesity, weight loss, and weight maintenance (Amirrood et al., 2014; Flegal et al., 2012; Kumanyika et al., 2005b). Other studies have been conducted on nutrition, healthy eating, and healthy lifestyles (Geller, Dube, Cruz, Stevens, & Bench, 2015; Jurkowski et al., 2014; Kumanyika et al., 2005a; Svetkey et al., 2005). There are studies that were conducted on physical activity and health behaviors (Davison et al., 2013; Svetkey et al., 2005), as well as, spiritual/scripture support (Djuric et al., 2009). Flegal et al. (2012) conducted a study on improving dietary intake to impact body composition and bodily functions. Sumlin and Garcia (2012) conducted several studies regarding obesity and diabetes care, general health and safety education, and osteoporosis education. Other studies from research have addressed relapse prevention (Lavelle et al., 2016; Yates et al., 2015) and obesity and breast health (Djuric et al., 2009; Griffith et al., 2012). Additionally, studies have been conducted on

local restaurants and fitness guides (Fukawa, 2016; Polsky et al., 2016), fitness diaries (Boh et al., 2016; Rodgers et al., 2016), and nutrition education which includes cooking lessons (Lavelle et al., 2016; Resnicow et al., 2004).

The purpose of this qualitative descriptive study was to gain a better understanding of the perceptions that obese AA women have about altering the way they prepare traditional soul food to a healthier soul food and to address the gap in the literature regarding alternatives for preparing the traditional soul food. Additionally, the information gathered from participants will be used to develop community-based interventions (for future research) related to healthy soul food preparation which may help reduce obesity among the AA population.

In this chapter, I will discuss the literature search and the conceptual framework that I used for the study. I will discuss literature that is related to obese AA women, traditional soul food, obesity, healthy eating, the conceptual framework, the empowerment model, and the HBM. Finally, I will summarize the major themes in the literature and provide a conclusion.

Literature Search Strategy

I selected literature for this study based on its relevance to the research topic of interest; to gain a better understanding of the perceptions that obese AA women have regarding altering the way they prepare and consume traditional soul food. I conducted a keyword search to collect relevant information that would inform my research topic from the following data bases: PsycINFO, MEDLINE, Academic Search Complete, CINAHL Plus, and SocINDEX. I used *African American Women* AND *Obesity* AND *Soul Food* as

my first keywords to search for the most recent peer reviewed articles (within the last five years) for my literature review. As other keywords emerged, I further narrowed my search. The other keywords were: S*oul Food*, *High Caloric Foods* AND *Obesity, Healthy Eating*, *Empowerment Model* AND *Obesity,* and *Health Belief Model* AND *Obesity.*

Theoretical Framework

I took the conceptual framework for this study from the research in the field of social sciences and psychology. I used the empowerment model and the HBM to frame this study. My decision to use these theoretical models was based on evidence from the research that interventions were needed to address the preparation and consumption of traditional soul food. This study was built on Belle (2009) and Beagan and Chapman's (2012) studies that concluded that AA women would not stop preparing and consuming traditional soul food due to their heritage. Beagan and Chapman noted that AA women felt that their heritage would be lost if they gave up traditional soul food. Belle stated that AA women will always prepare and consume traditional soul food because it tastes good, it is inexpensive, and it is a part of the AA culture. If AA women are going to continue to prepare and consume traditional soul food, they need to be taught to prepare their soul food in a healthier manner without losing its traditional taste. To develop such an intervention, I need ideas and suggestions from credible sources on how to appeal to obese AA women, so they would be motivated to actively take part in interventions designed to alter the preparation of traditional soul food. Conducting a qualitative study was useful because AA women in the study were a credible source. I conducted this

qualitative study to gather information that would inform later research in which interventions may be developed based on the information gathered from this research.

This study will also fill the gap in the literature regarding how AA women can prepare and consume healthy soul food to reduce obesity. This qualitative descriptive study will help me to gain a better understanding of the perceptions that obese AA women have about altering traditional soul food preparation. Obese AA women who prepare and consume traditional soul food are excellent candidates to provide expert information that will help me to incorporate ideas and strategies into interventions that would motivate obese AA women to change unhealthy eating behaviors by learning how to alter their preparation of traditional soul food to a healthier soul food. The participants in the focus groups in this study provided me with strategies that would motivate them, as well as other obese AA women, to adopt and maintain the practice of preparing and consuming healthy soul food.

I included two models (empowerment model and the HBM) in the theoretical framework that were related to my research topic. Both models are influential in promoting positive social change, education, and self-efficacy (Peterson, 2014; Schulz, 2014). According to Schulz (2014), interventions should integrate both models to enhance the effectiveness of the intervention.

The Empowerment Model

The empowerment theoretical model was developed by Gutierrez, Parsons, and Cox (1998) and is defined as a social process that brings individuals, organizations, and community members together to create a needed social change (Gutierrez et al., 1998;

Peterson, 2014; Swift & Levine, 1987). The empowerment model involves: (a) recognizing the issues in the community, (b) formulating goals that will help solve the issues within the community, (c) empowering individuals within the community to publicly support recommendations for change, and (d) working collaboratively with community organizations and city and state officials to promote change (Peterson, 2014). Several researchers have used the empowerment model to promote change as it relates to the empowerment of individuals working together to create social change (Amirrood et al., 2014; Davison et al., 2013; Geller et al., 2015; Jurkowski et al., 2014; Melnyk et al., 2013; Schulz, 2014).

Amirrood, Taghdisi, Shidfar, and Gohari (2014) posited that eating habits influence obesity, so they conducted a quasi-experimental study (using a pre- and posttest design) to examine the impact of family empowerment training on altering eating habits to reduce obesity using the empowerment model. There were 90 women (who were either overweight or obese) from two health centers in Urmia, Iran who participated in the study. The family empowerment training used in their study consisted of six educational classes to enhance health within the family. Amirrood et al. used the empowerment model to increase knowledge, improve self-efficacy, decrease unhealthy thoughts, and enhance self-esteem about healthy eating habits of the participants. Amirrood et al. found that the empowerment intervention was effective in empowering 89% of the participants to alter their unhealthy eating habits to reduce obesity. The key was to empower women to take an active part in ensuring good health for themselves and their families.

Geller, Dube, Cruz, Stevens, and Bench (2015) conducted a study with 417 children (ages 5-18) who were overweight or obese to evaluate a program called group medical visit (GMV) that was implemented in a federally funded community health center to treat pediatric obesity. Using the empowerment model, Geller et al. noted that there was a significant improvement in stress; physical activities; and the consumption of sweetened soft drinks, beverages, and fast foods. A decrease in stress and consuming sugary beverages were shown to have the highest correlation with weight loss. Geller et al. credited the empowerment model for the significant changes that took place in the lifestyle of the participants that lead to weight loss. More specifically, participants in their study believed that they could make life changes. Participants also felt they were part of a group that wanted to lose weight and they made a conscious decision to become healthier individuals, and participants made a conscious decision to become healthier individuals. The empowerment theory is considered a social theory that helps individuals to make decisions about their health to enhance healthy behaviors, improve health status, and reduce health inequalities in their community (Geller et al., 2015).

Geller et al. (2015) found that the empowerment model was effective in changing unhealthy behaviors to healthier behaviors such as help to: (a) increase the participation in childhood vaccination, (b) improve procedures to provide clean water to communities, and (c) lower the risks associated with obesity. The empowerment model was successful in Geller et al.'s study because it incorporates social supports through social networks. The focus of Geller et al.'s study was to empower participants to try new things and learn how to work together to bring about needed social change.

Davison, Jurkowski, Li, Kranz, and Lawson (2013) conducted a similar study with 423 children (ages 2-5) from low-income families who were enrolled in five different Head Start centers in New York. They found that the key to developing effective interventions to combat obesity in children was to reach out to the parents and engage them. Davison et al. (2013) used a community-based empowerment program to empower parents to take an active part in planning and implementing the intervention. The intervention consisted of the following: (a) letters were mailed out to families reporting their child's BMI; (b) an announcement went out to parents to raise awareness of their child's weight condition; (c) nutrition counseling and education classes were incorporated in the Head Start centers for families to participate in healthy eating activities; and (d) a 6-week program that focused on increasing communication among parents, resolving conflict, empowering parents to adopt a healthier lifestyle, social supports, and media literacy. Davison et al. (2013) concluded that interventions that incorporate empowerment that empowers parents to design and implement the interventions would enhance self-efficacy and promote healthier eating habits for children as well as increase their physical activity. Jurkowski, Lawson, Green Mills, Wilner, and Davison (2014) concurred with Davison et al. (2013) that interventions used to reduce childhood obesity should target the parents because parents are the ones who provide food for their children. Jurkowski et al. (2014) found that empowering parents to advocate for more physical activity and healthier eating habits for their children was beneficial to change unhealthy behaviors and create positive social change.

Melnyk et al. (2013) examined the impact of a Healthy Lifestyles program on healthy lifestyle behaviors and BMI as well as some other factors contributing to healthy living among 779 culturally diverse high school students. The program was named Creating Opportunities for Personal Empowerment (COPE) Healthy Lifestyles Program: Thinking, Emotions, Exercise, Nutrition (TEEN) and incorporated exercise and physical activities into the participants' health class using the empowerment model. The program convened for 15 weeks in which 20 minutes of each health class period were dedicated to exercise and physical activity. Melnyk et al. (2013) concluded that empowering teens to exercise and participate in more physical activities were effective in reducing depression and BMI, as well as increasing social skills among the teens. These findings were consistent with the results of other researchers' studies (Hoying, Melnyk, & Arcoleo, 2016; Lowry Gordon, Roessler, & Caine-Bish, 2013; Smith & Holloman, 2013). Smith and Holloman (2013) and Hoying et al. (2016) studied Appalachian children; however, Smith and Holloman (2013) did not use the COPE Healthy Lifestyles Program: TEEN but used an individual teen mentorship program. Researchers of both studies found that interventions designed to empower youth were effective in improving mental health and promoting healthy lifestyle patterns in children. Lowry Gordon et al.'s (2013) study was similar to Smith and Holloman's (2013) study, in that a dual mentorship program was used to empower students in grades K-college to become advocates for healthy lifestyles. The program included educating the youth on the importance of daily healthy eating and providing community-service projects in which the students actively participated in the projects. They found that the program can be beneficial in raising awareness about

childhood obesity and empowering them to reduce obesity through healthy eating and an active lifestyle.

Schulz (2014) wanted to know if an individual's health literacy was sufficient enough to motivate one to change unhealthy behaviors to healthy ones so that their health status can be improved. Schulz (2014) found that empowerment was vital to interventions and programs that seek to change unhealthy behaviors to enhance a healthier lifestyle; however, empowerment alone would not be sufficient to ensure a successful intervention. Instead, there is a need to integrate both health empowerment and health literacy in the intervention or program because one without the other would prove ineffective (Schulz, 2014). If individuals are empowered to take charge of their lives, they must be educated to increase literacy in the area of the empowerment to be successful (Schulz, 2014).

Likewise, other researchers found that empowerment without literacy prevents individuals from making informed decisions about the best health choices (Schulz & Nakamoto, 2013; Shu-Fang et al., 2016; Sharif & Blake, 2010). Schulz and Nakamoto (2013) stated that obese parents generally have obese children due to the lack of health literacy skills. However, by the time children become teenagers, they adopt their own decisions about health behaviors from their health literacy (Schulz, 2014). All researchers claimed that low empowerment coupled with high literacy is just as harmful as high empowerment with low literacy (Schulz, 2014; Schulz & Nakamoto, 2013; Shu-Fang et al., 2016; Sharif & Blake, 2010). Based on the findings from the literature, it is important to incorporate both factors (health empowerment and health literacy) in any intervention

designed to change health behaviors (Schulz, 2014; Schulz & Nakamoto, 2013; Shu-Fang et al., 2016; Sharif & Blake, 2010).

The empowerment model was appropriate to frame this study because community members lacked the knowledge and the resources to create change without community support to alter the way they prepare traditional soul food dishes to reduce obesity. Furthermore, the empowerment model may help obese AA women to feel a sense of control, to have options to choose, to have the ability to connect with others, and to have a sense of security. It will also provide health education to increase participant's health literacy.

The Health Belief Model (HBM)

The HBM is one of the most common models used to study health-related behaviors (Janz & Becker, 1984). The HBM was developed by social psychologists Hochbaum, Rosenstock, and Kegels in the early 1950s (Bishop, Baker, Boyle, & MacKinnon, 2015; Cao, Chen, & Wang, 2014; Janz & Becker, 1984; Rosenstrock, 1974). Researchers used this model to explain and predict health behaviors by looking at the attitudes and beliefs of individuals (Bishop et al., 2015; Cao et al., 2014; Janz & Becker, 1984; Rosenstrock, 1974). I used the HBM to frame this study regarding altering the way obese AA women prepare and consume traditional soul food for themselves and their families. The basis of the HBM is that individuals must believe that there is a threat for developing a disease or an illness related to obesity before they take action to change undesirable behaviors (Becker, Maiman, Kirscht, Haefner, & Drachman, 1977; Boston University School of Public Health, 2016). For obese AA women to alter the way they

prepare and consume traditional soul food, individuals must perceive that eating

unhealthy soul food contributes to their mortality and decreases their quality of life

(Glanz et al., 2008). The constructs of the HBM include (a) eliminating faulty beliefs and

barriers, (b) encouraging achievement toward desired goals, (c) promoting health

education, and (d) enhancing self-efficacy (Becker et al., 1977; Glanz et al., 2008; Sapp

& Weng, 2007; Wood & Neal, 2007). Many researchers have used this model to explore

interventions and treatments for culturally diverse populations and ethnic groups with

long-term, as well as short-term, health behaviors such as dieting (James et al., 2012),

cervical cancer (Bayu, Berhe, Mulat, & Alemu, 2016), human papillomavirus (HPV)

infection (Ben-Natan & Maor, 2014), addictive behaviors (Sui, Turnbull, & Dodd, 2013),

mental health behaviors (Patel, Wittkowski, Fox, & Wieck, 2013), and chronic illnesses

and diseases (Rahmati-Najarkolaei, Tavafian, Fesharaki, & Jafari, 2015; Truong,

Paradies, & Priest, (2014).

James et al. (2012) conducted a study to investigate how the HBM can be best

used to develop a culturally-specific weight-loss intervention for AA women. The study

consisted of seven focus groups with 50 AA women. James et al. found that although

participants were aware of the health consequences of obesity, they believed that they

were obese because of their culture and genetics. It was also found that participants

realized that if they lost weight, they would have a healthier life, eliminate health-risks,

and enhance their physical appearance (James et al., 2012). James et al. reported that

participants needed motivation, adequate information on dieting, and community support.

James et al. had planned to use surveys to measure perceptions about weight and obesity

but decided to use focus groups to investigate the problem. During the focus group interviews, participants made comments, talked about their experiences, and shared their beliefs and their knowledge on obesity and weight-loss. James et al. used the information collected from the focus groups to design and execute interventions to address the issue. The HBM was used to illuminate the reasons participants decided to lower and maintain weight-loss for better health.

James et al. (2012) concluded that the HBM was appropriate for the information collected from the focus groups which helped them to develop themes from the HBM components to construct a weight-loss intervention. Because focus groups were used, the information was beneficial in evaluating the specific needs of AA women. Other studies examined the perceptions of obese pregnant women, and researchers found that women were willing to change behaviors to reduce obesity during pregnancy as well as postpartum (Phillip, 2014; Sui et al., 2013). James et al. and Sui, Turnbull, and Dodd (2013) recommended that more researchers should use the HBM to develop weight-loss interventions for AA women and pregnant women and should include: (a) plans to change lifestyles such as exercise, healthy eating, and adequate rest; (b) explanation of what normal weight, overweight, and obesity is; (c) stress the benefits achieved with weight-loss; (e) suggest ways to manage obstacles, stressful events, and boost self-efficacy; and (f) the most important component is to stress the significance of obtaining and maintaining a healthy weight. These findings were consistent with Rahmati-Najarkolaei, Tavafian, Fesharaki, and Jafari (2015) in that the HBM is effective in predicting how individuals react to their perceptions.

Bayu, Berhe, Mulat, and Alemu (2016) conducted a community-based cross-sectional study with 1186 women in Mekelle, Ethiopia from February to June in 2015 to examine the relationship between cervical cancer screening and receiving medical treatment. Of the 1186 women, 235 had been tested. Bayu et al. used the HBM to assess participants' beliefs regarding their concerns for cervical cancer. They suggested that if participants perceived that they are at risk for cervical cancer, they would get tested. Additionally, they believed that if participants resided in communities which promoted proactive health care, participants would be more likely to have a cervical cancer screening. Participants who have knowledge and facts on cervical cancer would most likely get a screening each year. These findings were consistent with Kim and Zane (2016) in that women will seek medical help if they perceive that they are at risk of unfavorable health conditions. Bayu et al. concluded that women are not being screened for cervical cancer for several reasons. Some of the reasons that Bayu et al. reported were: (a) participants were not ill and did not have symptoms, (b) fear of examination, (c) past promiscuous behavior, (d) the age of the participant, (e) past diagnosis of a sexually transmitted disease, and (f) lack of understanding about cervical cancer.

A cross-sectional study was conducted by Ben-Natan and Maor (2014) with 207 Israeli lesbians to identify the reasons they would receive the HPV vaccination. Ben-Natan and Maor used a questionnaire which included the components of the HBM. The questionnaire included factors related to social demographics, previous sexual partners, previous HPV vaccination, known facts about the HPV vaccination, and history of gynecological examinations. There were no questions related to cues to action or self-

efficacy which are important components of the HBM. Ben-Natan and Maor found that approximately 66 of the participants felt that if they perceived that they might contract cervical cancer, they would receive the HPV vaccination. Additionally, participants believed that if they perceived that they would benefit from the HPV vaccination, they would receive the vaccination. Therefore, Ben-Natan and Maor concluded that the information from their study could provide healthcare workers with strategies that could encourage more lesbians to receive the HPV vaccination.

Patel, Wittkowski, Fox, and Wieck (2013) used the HBM to conduct a qualitative study to examine the perceptions of 11 women with postnatal depression (PND) in Greater Manchester, England. After conducting semi-structured interviews with participants, strategies that used the HBM components were offered to participants. Patel et al. found that the participants did not want to be labeled with PND for fear that others would view them negatively. Therefore, Patel et al. recommended that healthcare providers should offer classes to mothers before and after childbirth about PND and the suggested treatments. The classes should help mothers to gain more knowledge about PND and what actions to take if they experience PND symptoms.

To my knowledge, the HBM has not been used to address obese AA women's perceptions of altering traditional soul food to a healthier soul food to reduce obesity among this population. I selected this model to frame this study because the constructs of the HBM may account for how individuals perceive benefits, barriers, and self-efficacy of preparing and consuming healthy soul food. Perceived benefits may lower negative health concerns, improve health and social support, and enhance the quality of life.

Barriers would include lack of motivation to alter the way traditional soul food is prepared and the accessibility to affordable foods that can be prepared in a healthier manner while maintaining its taste. Finally, self-efficacy will address the lack of engagement in healthy behaviors (Becker et al., 1977; Clemow, 2004; Glanz et al., 2008).

Literature Review Related to Key Concepts

The key concepts for this study were traditional soul food, obesity, and healthy eating. Based on the research of Bratanova et al. (2016) and Hall (2016), traditional soul food was defined as foods which were high in calories and prepared with animal fat (specifically pork), salt, and sugars such as chitterlings, cornbread, collard greens, fried foods, pork, and Kool-Aid. The WHO (2012, 2014b) defined obesity as the accumulation of body fat (a BMI of 30+) that is linked to increased risk of serious health diseases. The CDC (2016b) defined healthy eating as consuming foods that provide the human body with nutrients such as water, proteins, vitamins, carbohydrates, minerals, and fats.

Traditional Soul Food

I selected tradition soul food as a key concept because, according to researchers AA women generally prepare and consume traditional soul food daily (Beagan & Chapman, 2012; Belle, 2009; Manickavasagan et al., 2013; Talbot et al., 2013). Researchers have reported that AA women generally prepare and consume high caloric soul food which contributes to obesity (Broady & Meeks, 2015; Manickavasagan et al., 2013; Sominsky & Spencer, 2013; Talbot et al., 2013; Wang et al., 2013b; Wilson & Sato, 2014). It is important to understand the history of traditional soul food in this study.

Soul food came to America with slaves during the trans-Atlantic slave trade. African slaves introduced America to foods such as okra and rice. During the early 1600s, AA slaves were fed with discarded foods from the slave owners (Thompson, 2015). African American slaves would transform discarded foods into gourmet dishes referred to as food for the soul or soul food. As part of the AA heritage, AA families traditionally come together on special occasions to prepare and consume soul food (Belle, 2009). Even today, AAs continue to prepare foods which are high in calories, salt, sugars, and fats (Bratanova et al., 2016; Hall, 2016; Wang et al., 2013a).

During the civil rights movement, AA women were praised for preparing tasty soul foods and were often depicted in movies and television shows as obese (Chen, Williams, Hendrickson, & Chen, 2012). While most AA females during the 1950s were large, their appearance was viewed as positive, indicating that AA women who were obese cooked good soul food dishes. Today, women from lower socio-economic status tend to be overweight or obese (Dinsa, Goryakin, Fumagalli, & Suhrcke, 2012; Li, Robinson, Carter, & Gupta, 2015; Mastin, Campo, & Askelson, 2012). With the resurgence of fast foods on practically every corner in AA communities, food consumption among the AA population is poor. Additionally, in many AA communities, fresh fruits and vegetables are hard to access or too expensive to purchase (Li et al., 2015).

Obesity

I selected obesity as a key variable because, based on the research from Belle (2009), obesity is an ongoing health issue among the AA population as a result of

consuming high caloric soul food. High caloric soul food contributes to high rates of chronic illness which lead to high rates of mortality and morbidity among the AA population (Manickavasagan et al., 2013; Reed et al., 2016; Rudenga et al., 2013; Sominsky & Spencer, 2013; Talbot et al., 2013). African American women are leaders in preparing high caloric soul food (Callahan, 2013; Dingfelder, 2013). Research has indicated that the consumption of soul food adds pounds to the body that lead to obesity (Callahan, 2013). Despite the many studies that have been conducted on obesity over the past two decades, the obesity rate continues to rise among AAs (Callahan, 2013). The rate of obesity in AA women is higher than all other racial, ethnic, and gender groups (AMA, 2013). Based on research, obesity contributes to the risk of hypertension, cardiovascular diseases, diabetes, depression, and various cancers (AMA, 2013; Johnson & Wesley, 2012; Sheriff, Alshaari, & Manopriya, 2012).

The environment in which AA women live affects the way they prepare and consume soul food (Jurkowski et al., 2014; Lee & Lien, 2015). There are many factors that specifically influence obese AA women to prepare and consume high caloric soul food such as the lifestyle pattern of eating the foods that were feed to them as they were growing up (parental influences). Other factors that influence obese AA women to prepare and consume traditional soul food are generational soul food recipes and the taste of traditional soul food (Jurkowski et al., 2014; Lee & Lien, 2015). I provided an explanation to address the above factors in the next paragraphs.

Parental influences. Childhood obesity is also a prominent health issue in the United States (Li et al., 2015; Nickelson, Lawrence, Parton, Knowlden, & McDermott,

2014). According to Lee and Lien (2015) and Jurkowski et al. (2014), the parents and other adult family members are responsible for childhood obesity because they are the caregivers who provide food for the children. Obese children generally live a sedentary lifestyle, such as extensive sitting while at the computer or video games and watching television, which reduces the amount of time spent engaging in vigorous physical activities (Jurkowski et al., 2014; Lee & Lien, 2015). In addition, several researchers agreed that the intake of sugary beverages and unhealthy foods (e.g., high caloric soul food, fast foods, sugary snacks, and unhealthy chips) especially by children in Hispanic and AA communities has been a contributing factor in childhood obesity (Faber & Dube, 2015; Lanigan, 2012; Nickelson et al., 2014; Reyes, Peirano, Peigneux, Lozoff, & Algarin, 2015). Other factors are that: (a) mothers are breastfeeding their babies less; (b) caregivers are starting solid foods before the age of 1; (c) children start watching television at birth; (d) by the age of 2, children are consuming sugary beverages; (e) on average, by the age of 2, children are not getting 12 hours of sleep each day; and (f) by the age of 3, children are asking for specific fast foods by name (Lanigan, 2012; Nickelson et al., 2014). This is the lifestyle that children are being brought up in, and the parents and adult caregivers influence these unhealthy habits (Jurkowski et al., 2014; Lee & Lien, 2015; Nickelson et al., 2014). Lee and Lien (2015) surveyed 124 parents and adult caregivers in Singapore and found that the best way to reduce childhood obesity was to limit children's consumption of fast foods, encourage more physical activities, provide healthy alternatives such as fresh fruits and vegetables for snacks, prepare

healthier meals using healthy ingredients, ensure that children get enough sleep, and limit the time that children watch television and play video games (Lee & Lien, 2015).

Generational soul food recipes and taste. Another important environmental factor is that AA women pass down soul food recipes from generation to generation in which AA women prepare and consume regardless of socio-economic status (Broady & Meeks, 2015; Thompson, 2015). According to Belle (2009), AAs enjoy the flavor and taste of traditional soul food especially during gathering with friends, family, and members of the community. Because it a tradition for AA women to prepare and consume traditional soul food, then it may be beneficial for AA women to learn how to prepare traditional soul food in a healthy manner to reduce obesity. There were several studies conducted within the last five years in which interventions were developed and implemented regarding reducing obesity.

Existing Interventions to Reduce Obesity

One study that I thought was interesting was conducted by Boh et al. (2016) who wanted to examine the effectiveness of an intervention to help overweight individuals obtain and maintain weight loss throughout their life span. Boh et al. felt that participants could gain more success if the intervention or treatment would extend over a longer period due to environmental factors that may interfere with prolonged weight loss. The intervention provided real-time evaluation while participants were being treated for their obesity utilizing a Smartphone. Participants noted patterns that precede their eating for one week before the intervention. Once the intervention started, the app would send out warnings to the participants to avoid specific behaviors that were previously done before

eating. Boh et al. found that participants increased their consumption of healthy foods and showed long-term weight loss using their intervention.

Rodgers et al. (2016) also implemented a similar intervention using mobile technology (e.g., iPhone or Smartphone) to encourage healthy eating to reduce obesity. Although the results of their study were not favorable, Rodgers et al. acknowledged that using the technology was a creative way to enhance participation in healthy eating intervention, but more work needs to be done to increase adherence. Boh et al.'s (2016) study validated the importance of changing eating habits of obese individuals and is in line with this study in that unhealthy eating habits need to be altered to reduce obesity.

Riley, Mili, Trinh-Shevrin, and Islam (2016) reported results from other studies that seek to gain a better understanding of the factors that affect managing weight loss and promoting physical activity among immigrants in New York City. In line with Riley et al., Shin, Surkan, and Coutinho (2015) conducted a multilevel healthy eating intervention in Maryland to increase participants' choice of healthy foods through advertisement, promotion, and taste testing of healthy foods by store owners. Fukawa (2016) examined the effectiveness of using priming from community marketing to mediate and advocate for marketers to gear promotional efforts toward healthy food products and avoiding advertisement and promotion of unhealthy food products. None of these studies focused on changing the way obese AA women prepare and consume traditional soul food. However, if obese AA women are going to continue to prepare and consume traditional soul food, then it may be advantageous for them to be educated on how to prepare traditional soul food in a healthy manner to reduce obesity.

Healthy Eating

I selected healthy eating as a key concept because it is the type of food consumption that this study will influence. According to researchers, an environmental factor that hinders AA women from eating healthy is the lack of healthy foods within AA communities (availability), as well as the cost of healthy foods (Jurkowski et al., 2014; Lee & Lein, 2015). The middle-class AAs generally reside in segregated AA communities where there are families of low socio-economic status (Cozier et al., 2014; Nederkoorn, 2014). As a result, AA communities are more prone to having fewer grocery stores that provide a wide variety of fresh fruits and vegetables, whole grains, fresh fish and other seafood, and low-fat dairy products; and if healthier alternatives are available, they are considerably higher in cost and lower in quality (Bower et al., 2015; Broady & Meeks, 2015; Cozier et al., 2014; Nederkoorn, 2014). The AA communities are more likely to have fast food restaurants in walking distance of their homes (Laxy, Malecki, Givens, Walsh, & Nieto, 2015; Oexle, Barnes, Blake, Bell, & Liese, 2015).

Interventions Promoting Healthy Eating Habits

A healthy eating intervention study was conducted by Resnicow et al. (2004) referred to as Body and Soul. Although this is an old study, the information is useful in identifying previous studies regarding healthy eating. The aim of this study was two-fold; to increase the availability of fruits and vegetables among community members and to affect change within the church community by developing structured church events, programs, and youth camps to include fresh fruits and vegetables that are served during the activity to encourage and promote healthy eating. Resnicow et al. concluded that the

intervention was successful in increasing the amount of fruits and vegetables that were consumed by the church members.

Another intervention regarding healthy eating included a family-orientated intervention which was geared towards increasing the consumption of fruits, vegetables, and fiber while reducing the intake of fatty foods (Schmied, Parada, Horton, Ibarra, & Ayala, 2015). Yates et al. (2015) implemented an intervention with patients who had undergone cardiac bypass surgery to see if the patient (along with their spouse) would adhere to a healthy eating regime. A study conducted by Lavelle et al. (2016) was closely related to this proposed study. Lavelle et al. conducted 27 semi-structured interviews with male and female participants residing on an Island in Ireland. Twenty-six of the interviews were conducted by telephone, and one interview was conducted face-to-face. The purpose of Lavelle et al.'s qualitative study was to examine how participants defined cooking with raw ingredients and what were the barriers to preparing meals using everyday ingredients. Lavelle et al. reported that participants viewed barriers of cooking using raw ingredients as time constraints, saving money, easy preparation, food choices, and fear of preparing the food inadequately. Based on the information from Lavelle et al.'s study, I understand that obese AA women need to learn how to cook in large quantities and freeze the products for later use. They also need instructions on how to prepare tasty soul food dishes in a healthy manner. There was no research found in which the perceptions of AA women were studied to gather useful information that can be used to develop interventions to help AA women alter the way they prepare and consume traditional soul food.

Summary and Conclusions

In Chapter 2, I provided clarity on the origin of traditional soul food and the literature that supports the need for this study. I presented articles from the research regarding factors that explained why obese AA women prepare traditional soul food. Additionally, I discussed existing interventions that have been developed to reduce obesity and promote healthy eating.

I found in the research that cultural traditions play a pivotal role in hindering obese AA women from changing the way they prepare foods for themselves and their families. Although there were several healthy eating interventions that had been conducted, none of them included soul food recipes that were prepared in a healthy manner. In the field of health psychology, we know that traditional soul food is high in calories and sugars. We also know that consuming traditional soul food contributes to unfavorable health conditions. What we need to know is how to alter the preparation of traditional soul food to help the AA population reduce obesity as a result of eating high caloric soul food and to fill the gap in the literature regarding strategies that can be incorporated into interventions to help reduce obesity among the AA population. No research has been found to teach AA women how to prepare traditional soul food to a healthier soul food. Nor has any research been conducted to gather the perceptions of obese AA women regarding factors or elements that would help researchers to develop effective interventions on altering the preparation and consumption of traditional soul food. The information gathered from existing research, along with the information gathered from this study, will be useful in designing an intervention that would teach

obese AA women to practice healthy soul food preparation to motivate obese AA women to adopt and sustain healthy soul food preparation.

In Chapter 3, I will provide information about the research design and rationale for this study as well as the role that I will play in conducting this study. I will include details about the participants, sampling strategy, criteria for participation, and how participants will be selected in the methodology section. I will describe the instruments that will be used to collect data, the procedures used for collecting the data, and the method of analyzing the data that will be collected for this study. The procedures used to conduct this study will be described in detail which will facilitate duplication of this study by other researchers. I will discuss the procedures that I will use to address discrepant cases, trustworthiness issues (e.g., credibility, transferability, dependability, and confirmability), and ethical concerns. Finally, I will conclude Chapter 3 with a summary and a transition to Chapter 4.

Chapter 3: Research Method

Introduction

The purpose of this qualitative descriptive study was to gain a better understanding of the perceptions that obese AA women have about altering the way they prepare traditional soul food to create a healthier soul food. The information that I gathered will be used to develop interventions using a CBP research orientation related to healthy soul food preparation. I conducted focus groups using a CBP research orientation with obese AA women from different communities on the Southside of Chicago, Illinois to gather data on how to develop interventions that would work best to alter the preparation of traditional soul food for AAs. In this research study, I selected a qualitative descriptive design to explore the perceptions of obese AA women who prepare and consume high caloric soul food regarding the preparation and consumption of that food.

Chapter 3 begins with a description of the research design that I used to conduct this study with a rationale for selecting the research design. I will describe my role as a researcher. In the methodology section, I will describe the participants, sampling strategy, criteria for participation, and how I selected the participants. Then I will describe the instruments that I used to collect data, the procedures that I used for collecting the data, and the method I used to analyze the data that was collected for this study. Finally, I will discuss the procedures that I used to address discrepant cases, trustworthiness issues, and ethical concerns.

Research Design and Rationale

The research questions for this study were: Research Question 1: What are the perceptions of obese AA women regarding altering traditional soul food preparation?

Research Question 2: What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?

Research Question 3: What barriers could limit participation in an intervention designed to develop healthier eating habits for obese AA women?

The key concepts in this study were traditional soul food, obesity, and healthy eating. In this study, the term soul food referred to foods that were prepared using ingredients that were high in fats and calories. For example, foods that are fried with batter (chicken, pork chops, fish, green tomatoes, french fries, okra); foods that are cooked with pork fat (collard greens, green beans, butter beans); and foods with consist of large quantities of sugar (Kool-Aid, iced tea, candied yams, pies, cakes, and cobblers). African American women generally prepare and consume foods such as pigtails, pig feet, chitterlings, pork neck bones, pork bacon, fatback, and pork sausage (Hall, 2016). It is also important to note that AA women prepare traditional soul foods with table salt, margarine, and whole milk products to add a rich taste to their food (Hall, 2016). Guthman (2013) defined obesity as having excessive body fat in relations to height; individuals are considered obese if their BMI is 30 or above. Healthy eating is defined as consuming foods that provided the human body with nutrients such as water, proteins, vitamins, carbohydrates, minerals, and fats (CDC, 2016b).

I used a qualitative descriptive design for this study because it was an appropriate design to answer the research questions. I considered other research designs, but I found them to be inappropriate to address the research questions. Based on the information from Creswell (2013) and Sandolowski (2000), a quantitative or mixed method approach would not be a good fit for this study because this study does not have any pre-selected variables, no manipulation of variables, no testing hypotheses, no experiments, and no testing of relationships among variables. A case study design would not fit with this study because there was no event, program, or an activity involved. A grounded theory approach would not have been a good fit for this study because I was not developing a theory. A phenomenological approach was not appropriate because I was not seeking to understand the fundamental nature of an individual's experiences; thus, a narrative approach would not have been appropriate because I was not writing a life story of an individual.

Role of the Researcher

The role that I played in this research study was that of a moderator and the researcher which consisted of: (a) setting up the recruitment phase to secure participants, (b) finding venues to host focus groups, (c) moderating the focus groups, (d) collecting data from the focus groups, and (e) analyzing the themes that emerge from focus groups. I had no personal or professional relationship with the participants. I conducted focus groups in communities in which I did not live; this was my first meeting with members of the focus groups. There were no conflicts of interest involved in this study.

There are potential biases that exist in focus groups and researchers must address these biases (Drury et al., 2014; Gill, Stewart, Treasure, & Chadwick, 2008; Le Bonniec et al., 2016; Liira et al., 2015). The types of biases that may alter the results of the study's findings are moderator bias, sensitivity bias, social acceptability bias, mood bias, and consistency bias (Gill et al., 2008; Pannucci & Wilkins, 2010). Moderator bias occurs when the moderator makes the participants uncomfortable, which can hinder participants from responding openly and honestly (Drury et al., 2014; Gill et al., 2008). Therefore, I remained neutral about opinions and responses by participants by refraining from making negative gestures or facial expressions during the focus group interview. I dressed moderately (in business attire), enunciated words clearly, and spoke in a moderate tone. According to Drury et al. (2014), sensitivity bias occurs when participants feel unaccepted in the group. Sensitivity bias can be minimized by the moderator in establishing rapport and acceptance with all participants and building trust with all members of the group (Drury et al., 2014; Gill et al., 2008; Nagle & Williams, n.d.; Pannucci & Wilkins, 2010). Social acceptability bias occurs when participants respond in a way that they feel is accepted by society instead of expressing their true feelings. Because participants want to be accepted by the group, they may not respond truthfully (Drury et al., 2014). To address social acceptability bias, I challenged participants' answers by probing for a clearer response. Mood bias occurs when participants' answers replicate how they are feeling at that time (Pannucci & Wilkins, 2010). For example, if a participant is angry, they may respond with hostility; if a participant is tired, they may not respond, or they may give very short responses. In these cases, I probed the respondent

by saying that their opinions were important and valuable. Consistency bias occurs when participants tend to answer the way others are answering without offering their true thoughts (Drury et al., 2014). I used a probe to illicit a true response from the participant. Finally, according to Doody, Slevin, and Taggart (2013), one participant may be more verbal than others; thus, dominating the interview. My goal was to illicit responses from all members of the focus groups to gather thoughts and feelings from all participants.

Research Methodology

In this section, I will provide a detailed description of the procedures used to conduct this study. I began with the selection of participants and the research site for this study. Then I will describe the sampling strategy that I used, including the type of sample, the manner in which the sample was drawn, and the sample size. Next, I will discuss the focus group protocol and the plans for collecting, analyzing, and interpreting the data.

Population

According to Krueger (2000), there is no need to have many focus group sessions when participants share similar interest. Therefore, there were four focus group sessions with participants who resided on the Southside of Chicago, Illinois. Chicago, Illinois covers three major subdivisions; the Northside, the Westside, and the Southside. The reason participants were selected from the Southside of Chicago was that this area has a high concentration of AA women (Black Demographics, 2014; Hertz, 2014).

Sampling

I used the nonprobability purposeful sampling strategy to select the sample for this study. Purposeful sampling strategy is a technique used in qualitative research to identify and select participants who can meet specific criterion to provide needed information in a research study (Palinkas et al., 2015). For my research study, I needed obese AA women who were knowledgeable and had experience in preparing and consuming traditional soul foods. According to Creswell (2013) and Patton (2002), by selecting these individuals, information secured from the focus group sessions was in-depth and rich in information.

Criteria for Participation

All participants were over the age of 18, had a BMI of 30 or above, and resided on the Southside of Chicago, Illinois. Participants had to reside on the Southside of Chicago, Illinois to eliminate transportation issues that some participants may have encountered. I only invited obese AA women who prepared and consumed high caloric soul food to take part in this study because they were knowledgeable and able to provide rich, in-depth answers to the research questions regarding traditional soul food preparation and consumption. Based on the information from the research, these restrictions did not allow the total population an opportunity to be included in the study; thus, a nonprobability purposeful sampling strategy was appropriate for this study (Creswell, 2009; Frankfort-Nachmias & Nachmias, 2008).

Individuals who are not obese or an AA woman were not included in this study. However, in this study, there were no random selections from the population; therefore, a

true representative sample was not obtained within the sampling frame, which is one of

the weaknesses of the non-probability sampling (Frankfort-Nachmias & Nachmias, 2008;

Trochim, 2006). Other weaknesses of the non-probability sampling are: (a) it would be

difficult for the researcher to determine how well the sample represented the total

population (Doherty, 1994; Suresh, Thomas, & Suresh, 2011), (b) it decreases the

number of possible participants (Trochim, 2006), and (c) it does not allow the researcher

to generalize the results to the total population (Doherty, 1994; Suresh et al., 2011;

Trochim, 2006).

Sample size. The target sample size for each focus group was approximately six

to seven obese AA women. According to Krueger and Casey (2009), effective focus

groups should be small. A sample of six to eight participants should be a large enough

sample to address the research problem and answer the research questions (Krueger &

Casey, 2009).

Recruitment of participants. Once I received approval to conduct this study

from Walden University's Institutional Review Board (IRB), I placed flyers (see

Appendix A) throughout the AA communities on the Southside of Chicago in grocery

stores, store fronts, schools, beauty shops, bulletin boards in housing projects and

apartment buildings, parks, and recreation centers. Flyers informed prospective

participants about the purpose of the study, the need for volunteers, and how to contact

me if they are interested. Additionally, I took announcements (see Appendix B) to AA

churches on the Southside of Chicago to further recruit prospective participants for this

study. All interested individuals met with me in the designated place at the church. I

briefly discussed my study and their role in the study. If individuals wanted to participate, I secured their names and phone numbers and informed them that I would be calling to gather information for the pre-screening.

I contacted interested church members by phone the following week. Volunteers who responded to the flyers contacted me by phone. During the phone conversation with volunteers, I requested the information needed to complete a PEQ (see Appendix C) as a screening process to determine if the volunteer was eligible to participate in the study. If the volunteer met the criteria for participation, I informed the volunteer that she qualified to participate in the focus group and discussed her role in the focus group session. This discussion included the purpose of the study, the consent to participate in the focus group session, and the reason why she was important to the study.

I told each participant that she was important to this study because first-hand knowledge would inform future interventions on preparing healthy soul food. I told her that her expertise and opinions were valuable to this study and contributed to society. I encouraged the prospective participant to ask questions to clarify her involvement in the study, and I answered all her questions. I provided the prospective participant with the times, dates, and the location of the four focus group sessions and asked her to select a date and time that was most convenient for her to participate. I informed her that refreshments would be served and Uber transportation to and from the focus group session would be provided at no cost to her. I obtained the address of the prospective participant and informed her that I would be sending her a confirmation letter (see Appendix D) confirming the focus group session. I recruited participants until I had

secured eight obese AA women to participate in each focus group session. I began

conducting focus group sessions as soon as a session was booked with a minimum of

eight participants. This process continued until the data began to duplicate itself; this was

the point where I achieved saturation.

Instrumentation for Recruitment

The PEQ is a short questionnaire that takes about 5 minutes to complete. I

developed the PEQ to recruit potential participants for this study. I used the PEQ to

record information that potential participants provided me over the phone. To develop the

PEQ, I followed the examples of similar healthy eating instruments to construct the items

on the questionnaire that directly related to the research criteria for participation. The

PEQ consisted of demographic information and three items with *yes* or *no* responses. The

responses informed me if the potential participant prepared and consumed traditional soul

food and how often.

The BMI is an important element in determining if potential participants qualify

for participation in this study; therefore, I calculated the BMI using the height and the

weight that the potential participant reported to me. Calculating the BMI helped me to

identify individuals who had a BMI score of 30 and above. If the responses to all three

items were yes, the individual was an AA woman over the age of 18 and had a BMI of 30

or above; I invited her to participate in this study.

Following the procedures of other researchers who have developed surveys and

questionnaires specifically for their studies (Chesluk et al., 2015; Ironson et al., 2014;

Romine, Sadler, Presley, & Klosterman, 2014; Sheth, Gunasekera, Silwal, & Qureshi,

2015), I tested the PEQ with colleagues to ensure that the items on the questionnaire were feasible and effective in yielding responses that would help me to identify individuals to take part in this study. Additionally, I asked my colleagues to review the items on the PEQ and provide me with feedback on its usefulness in determining if an individual prepares and consumes high caloric soul food. I used their feedback to revise the items that were unclear or deemed irrelevant to my study.

Data Collection

I conducted focus groups at San Justin's Kitchen located in the heart of Chicago's Southside and collected the data once from each focus group session. I received a letter of cooperation was received from the owner of San Justin's Kitchen granting me permission to conduct the focus sessions at their location. Because San Justin's Kitchen is located in the heart of Chicago's Southside, selecting this site for focus groups allowed participants (who desired to provide their transportation) greater access to and from the site. If participants required transportation to and from the focus group site, I offered Uber transportation was provided by me to eliminate transportation issues. I collected data at one point in time during each focus group session (Creswell, 2009). I used a focus group design to answer the research questions for this study. Focus groups were first used in marketing research but became an effective data collection method within the field of psychology in the early 1900s (Kellmereit, 2015; Kitzinger, 1995). The focus group design will allow the researcher to examine how the participants think about an important issue, allow participants to share new ideas, debate different perspectives, and create new concepts, (Kellmereit, 2015; Kitzinger, 1995; Liamputtong, 2011). The reason I selected

this design was that, according to Kitzinger (1995), a focus group design would be able to identify the perceptions of obese AA women regarding altering traditional soul food preparations to reduce obesity, identify factors that AA women perceive would be helpful to maintain new healthier eating behaviors, and identify what barriers could limit AA women's participation in an intervention program designed to help obese AA women develop healthier eating behaviors.

Focus Group Instrumentation and Materials

I issued name tags to focus group members as they entered the focus group session and asked participants to print their first names only for easy identification during the focus group session. I provided informed consent forms and ink pens to each participant. I used two tape recorders to record the focus group interviews along with blank cassette tapes labeled with the focus group session number. I provided poster paper and markers to record the emerging themes from the participants. This way, participants could see what was said and allowed the interview to progress. I used masking tape to secure the poster papers on the wall.

Focus Group Protocol

According to Creswell (2014) and Pedersen, Delmar, Falkmer, and Grønkjær (2015), when several focus group sessions are conducted, a protocol will provide consistency to the moderator for conducting each session. Therefore, I used a focus group protocol (see Appendix E) to guide the procedures as I conducted each focus group. I selected the focus group protocol questions to motivate obese AA women to answer questions regarding their perceptions related to altering traditional soul food preparation,

what they perceive would be helpful to maintain new healthier eating behaviors for themselves and their families, and what barriers could limit their participation in an intervention designed to develop healthier eating habits for obese AA women. I ensured that enough space was provided on the protocol for me to make notations during the focus group sessions. Following the suggestion of Krueger and Casey (2009), I tested the focus group protocol with colleagues to ensure that the questions on the protocol would be feasible and effective in yielding responses that would help me to address the research problem and answer the research question. Additionally, I used this test to verify the time needed to conduct the focus group sessions.

I developed the focus group protocol which consists of nine open-ended questions with probes to elicit in-depth responses from participants. Pedersen et al. (2015) suggested that researchers ask warm-up questions prior to asking interview questions to help make participants comfortable. Therefore, I used the first three questions as warm-up questions to open the interview session. The opening questions were necessary to promote discussions on soul food preparation and to get participants focused on the topic at hand. The first opening question was, "What is the first thing that comes to mind when I say, soul food preparation?" This question helped me to understand participants' thoughts and attitudes about soul food preparation. It was important to know why AA women continue to prepare and consume traditional soul food despite the negative health outcomes. Researchers claimed that some AAs rely on others to prepare the foods that they consume, so they eat whatever is provided to them (Li et al., 2015; Ogata & Hayes, 2014; Phillips, Comeau, Pisa, Stein, & Norris, 2016). Other researchers claimed that AA

women experience a great deal of stress daily, and many of them tend to eat high caloric foods to relieve that stress (Bello et al., 2014; Dingfelder, 2013; Sominsky et al., 2014).

The second opening question was, "How would you describe your preparation of soul food?" The answer to this question helped me to understand how participants prepared their soul food dishes. Finally, the last opening question was, "What is the first thing that comes to mind when I say, healthy soul food preparation?" This question helped me to understand participants' thoughts and attitudes about healthy soul food preparation. African American women may not know that soul food can be prepared in a healthy manner. They may fear that healthy soul food would not taste good nor be satisfying to them. According to researchers, AA women may not know how to prepare soul food in a healthy manner (Jurkowski et al., 2014; Lee & Lien, 2015). I asked seven interview questions to answer the research questions. To access the information that showed which focus group questions answered which research question (see Appendix F).

Procedures for Focus Group Sessions

The target sample size for each focus group was six to eight obese AA women with four focus groups lasting 94 to 113 minutes. According to Krueger and Casey (2009), effective focus groups should be small, participants should share similar interest, the climate should be comfortable and relaxed, the moderator should be skilled to elicit responses from participants using open-ended questions, and group characteristics will help the researcher to understand the topic of interest. According to Sreejesh, Mohapara, and Amisree (2013), when participants are similar in ethnicity, gender, or demographic

background, focus groups should be conducted from 90-120 minutes. Additionally, when participants share similar interest and similar backgrounds, only a few groups are needed to secure relevant information (Krueger, 2000). I made sure that the room for the focus groups had adequate lighting, good ventilation, and a warm environment that invited conversation as suggested by Krueger and Casey.

I arrived at the venue one hour early to set up the focus group session, which included arranging the seating to facilitate communication among participants, setting up a table for refreshments, plugging in the tape recorders, and putting in the tapes that were assigned to that session. Additionally, I set up the materials that were used throughout the focus group session. I began the focus group with a 30-minute meet and greet session in which participants were able to enjoy refreshments and casual conversation. Participants secured their name tags and selected their seats. I closed the doors at the end of the meet and greet.

I introduced myself and reviewed the consent form with participants. The introduction included my role in this research, the participants' role in the research, why I selected the participants, the time frame for the session, the risks and benefits associated with participating in this study, and the process of ensuring confidentiality. I reminded participants that their participation was voluntary, and they could withdraw at any time without consequences. Additionally, I reminded participants that the session would be tape recorded to ensure the accuracy of the information collected. I asked everyone who agreed to participate in this study to sign both copies of the consent form after I signed

both copies. I took up one copy of the signed consent form and let them keep a copy for their record.

I lead the focus groups; being careful not to state my thoughts and opinions. I began each focus group session by ensuring that all participants were comfortable. I made sure the interview room had a non-threatening and friendly environment. Then I explained the rules that would be followed while participating in the session. The rules were as follows:

- Once questions were asked, participants should talk among themselves, and I wrote down the themes that emerged from the interview.

- There are no right and wrong answers, just different viewpoints.

- Participants were instructed to listen to one another and respect the opinions of others, even if they did not agree with their point of view.

- The participants had to be respectful to one another, and only one person spoke at a time.

I informed participants that I may quote statements that were made during the focus group session, but it will be done anonymously. I followed focus group guidelines (see Appendix G) to conduct each focus group. I had to interrupt and redirect the interview to ensure that all participants remained focused on the questions that were being asked. As the researcher, I documented all interactions among the participants (verbal and non-verbal). At the end of each focus group session, I debriefed the participants. During the debriefing, I ensured that the group understood what would happen with the information that I had collected during the focus group sessions. I collected audio recordings and all

the data after debriefing the participants of focus group sessions. I kept all research materials confidential. I assigned an identification number to each focus group and placed all research materials in a file folder and locked it in a file cabinet throughout the research study. I was the only individual who had access to the raw data; however, all data will be available to Walden University's staff upon request. I will store all data for a minimum of 5 years, after which, I will shred all data.

Data Analysis

I audiotaped each focus group session. I compared the perspectives of the participants. I used NVivo to examine the data. I analyzed the focus group data using a constant comparison analysis as recommended by Hewitt-Taylor (2001) by identifying themes and patterns that emerged from the raw data to capture the participants' true perceptions. As suggested by Lincoln (1995), I kept a journal on the entire research process to keep me aware of my feelings and beliefs of the research issues. Keeping track of my thoughts helped me to eliminate researcher's bias in the study.

I analyzed the data and wrote up a final report of the findings based on my analysis of the data from the focus group sessions. The final report is my interpretation; reflecting the ideas, concepts, and suggestions made by the participants only (Creswell, 2013). I interpreted the data and used the exact words of the participants to support each theme in the analysis as recommended by Gläser and Laudel (2013). The data presented useful strategies and suggestions that would help me to develop an intervention program that would be effective in changing the way obese AA women prepare and consume high caloric soul food to reduce obesity.

Transcribing and Coding the Data

Immediately after each focus group, I transcribed the audio tapes verbatim in a Word document on my laptop computer. Researchers must extensively review audio tapes to include everything that was recorded on the audio tapes (Taylor & Gibbs, 2010). Therefore, after the transcriptions, I listened to the audio tapes again to ensure that all words, phrases, and utterances were recorded accurately in the Word document. According to Gläser and Laudel (2013) and Miles et al. (2014), qualitative data analysis is defined as the process of gathering data, reading through the data, identifying emerging themes, assigning codes to the themes, arranging the data for analysis, and writing up the findings in a final report.

As recommended by researchers, themes or patterns were identified by combing through the data; applying constant comparison when coding the data (Patton, 2015; Taylor & Gibbs, 2010). Other ways that themes or patterns can be identified are using word frequency or repetition, Aboriginal terms, key-words-in context, information that is missing, inquiries from social science, metaphors and analogies, different colors to code the raw data, and by examining the text that has not been coded, by comparing and contrasting the text, and by cutting and classifying the text with codes (D'Andrade, 1995; Guba, 1978; Lakoff & Johnson, 2003; Patton, 2015; Ryan & Bernard, 2003; Taylor & Bogdan, 1998; Taylor & Gibbs, 2010). I coded the data based on the themes or patterns that were identified from the raw data. Researchers can hand code the raw data or use a computer-assisted qualitative data analysis software (CAQDAS) program such as NVivo (Bazeley, 2007; Taylor & Gibbs, 2010).

Hand coding. Taylor and Gibbs (2010) defined hand coding as the process of identifying themes or patterns within the raw data so that information in the different categories can be easily recognized during data analysis. For this study, I used NVivo to help me identify information under the different themes that emerged from the raw data. I coded the text by placing corresponding codes at the end of the text, enclosing the codes in brackets, and coloring similar text that related to the research topic and research questions. I read and re-read the data as well as added new codes as the data presented new ideas and patterns or as new themes emerged. Additionally, patterns that emerged that needed further investigation were coded as such.

Researchers have suggested that "constant comparison" is an ideal method to address issues of quality (Patton, 2015; Taylor & Gibbs, 2010). In other words, constant comparison is the process of comparing the text for similarities and differences (Patton, 2015; Taylor & Gibbs, 2010). Codes and sub-codes may have to be modified to specifically identify a similar theme with more clarity (Ryan & Bernard, 2003; Taylor & Gibbs, 2010). One of the most important steps used in constant comparison to ensure that the coding is consistent and easily understood, is for researchers to look for internal homogeneity and external heterogeneity of the data while analyzing for convergence and divergence (Patton, 2015; Taylor & Gibbs, 2010). Once coding is completed, researchers must reread the data that was not coded to make sure that this information did not need to be coded or included in the final analysis (Ryan & Bernard, 2003).

Coding using a computer-assisted software program. There are various CAQDAS programs that may be used to help researchers identify themes or patterns in

the raw data (Bazeley, 2007; Gläser & Laudel, 2013). Although CAQDAS programs do not analyze the data for the researcher, they help the researcher to organize, store, and code the data more effectively (Bazeley, 2007). Additionally, Gläser and Laudel (2013) stated that CAQDAS programs would help researchers to understand the data better.

For this study, I used qualitative content analysis (QCA) to organize and analyze the raw data. Friese (2011) and Legewie (2013) stated that the raw data that produced too many codes can be handled more efficiently by using QCA. Therefore, I used the QCA to help me reduce the amount of data that needed to be analyzed. I coded the relevant information from the raw data, italicized the information that was not relevant, and analyzed only the information that was coded. By using the NVivo software program, I will able to easily identify themes or patterns and organize them into categories that provided more clarity.

NVivo software. I used an inductive approach to make sense of the raw data that was being analyzed as recommended by researchers (Blackstone, 2016; Creswell, 2013; Gabriel, 2013; Thomas, 2006). Furthermore, I used NVivo to help organize and analyze the raw data from the interview transcripts. I created a folder for this project study and labeled it "Dissertation" to analyze the data using the NVivo program. Next, I created four subfolders to represent each focus group session. Then I imported the data into the appropriate sub-folder. I created nodes using the codes that were developed for each theme or pattern. I assigned a color to each node based on the research questions. As new themes or patterns emerged, I added new nodes as suggested by the Pell Institute and

Pathways to College Network (2015). Finally, I created a backup copy to secure all tasks

that had been completed (Bazeley, 2007).

I analyzed the data using a constant comparison approach. I compared the raw

data from each theme and made connections between them. I rearranged and created my

codes by using axial and selective coding. This meant that I examined each portion of

coded data and ensured that sub-codes were under the proper theme or pattern so that I

could write up a summary that addressed the research questions. Graphics from the

NVivo program were used to display the data. Direct quotes of participants were included

in the final report of the findings.

Writing up the final report. The final report consisted of the analysis of the data

for the focus group sessions. As recommended by Creswell (2013), I ensured that the

final report included my interpretation of the data (reflecting the ideas, concepts, and

suggestions made by the participants); being careful not to inject my ideas and thoughts.

As I interpreted the data, I included the words of the participants to support each theme in

the analysis as advised by Gläser and Laudel (2013). My expectations were met in that

the data provided useful strategies and suggestions that would help me to develop an

intervention program that can be used in a later study that would be effective in changing

the way obese AA women prepare and consume high caloric soul foods to reduce

obesity.

Discrepant Cases

Researchers defined discrepant cases as that information in the data which

deviates from the research questions or contradict the patterns that are emerging from the

data during data analysis (Creswell, 2009; Lincoln & Guba, 1985; Patton, 2015). To address discrepant cases in this study, I looked for divergent information, italicized it, and explained why this information did not support the research. In qualitative research, it can be difficult for researchers to eliminate all biases (Creswell, 2009; Patton, 2015). Creswell (2009) stated that if biases cannot be eliminated, researchers must account for them with an explanation. Therefore, I worked hard to account for any discrepant cases which appeared in the data.

Issues of Trustworthiness

While the issues of trustworthiness, quality, and credibility are of great importance, Sousa (2014) proposed techniques used to establish validation which was similar to those proposed by Creswell (2013) and Patton (2015). Each of these criteria would require different techniques, for example, credibility would require the qualitative researcher to use triangulation or peer debriefing (Lincoln & Guba, 1985). I have learned from the research that an efficient qualitative researcher should ensure that research designs are consistent with the research focus (Agostinho, 2005; Creswell, 2013; Devers & Frankel, 2000). In other words, are interviews and observations conducted in a natural setting and does the research study allow for flexibility?

Researchers should use rigor to maintain trustworthiness and authenticity (Agostinho, 2005; Creswell, 2013; Patton, 2015). Trustworthiness refers to credibility, transferability, dependability, and confirmability; whereas, authenticity refers to open dialogue which occurs between the researcher and the participants (Agostinho, 2005; Creswell, 2013; Patton, 2015). Researchers should review the data, identify themes that

emerge from the data, code the themes, organize the coded data for analysis, and write up

a final report of the findings (Gläser & Laudel 2013; Miles et al., 2014; Patton, 2015).

Finally, researchers should clearly state the need for the study (Agostinho, 2005;

Creswell, 2013). Was the study informative and did the study have an impact on society?

Credibility

Credibility in qualitative research refers to ascertaining that findings from the

research study are ingenuous, realistic, and of high quality (Lincoln & Guba, 1985; Smith

& Noble, 2014). To establish the credibility of this study's results, I used a variety of

techniques such as triangulation, peer debriefing, and member checking. According to

researchers, participants and other researchers are the only individuals who can determine

the credibility of the study's results (Lincoln & Guba, 1985; Patton, 2015; Smith &

Noble, 2014).

Triangulation

Triangulation is the process of using data from multiple sources to provide

consistency and in-depth understanding of the research problem (Lincoln & Guba, 1985).

Lincoln and Guba (1985) stated that researchers should not use triangulation to validate

the findings but to make sure that the data is rich and inclusive which provide deep

understanding. Patton (1999) identified types of triangulation as (a) "methods

triangulation, (b) triangulation of sources, (c) analyst triangulation, and (d)

theory/perspective triangulation" to ensure consistency of the research findings (p. 1193).

Methods triangulation is done by examining data from different research methods such as

a mixed methods research design (qualitative and quantitative), triangulation of sources is

done by examining data from different data collection methods within the same research design (e.g., qualitative only), analyst triangulation is done by having different researchers to analyze the data, and theory/perspective triangulation is done by using different theoretical viewpoints to interpret and analyze the data (Patton, 1999). For this study, I used the theory/perspective triangulation since the viewpoints from the empowerment model and the HBM were used to interpret and analyze the data.

Peer debriefing. Lincoln and Guba (1985) defined peer debriefing as the "process of exposing oneself to a disinterested peer in a manner paralleling an analytical session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (p. 308). Researchers use peer debriefing to help illuminate researcher's ideas, thoughts, opinions, and biases that may have been included in the research findings (Lincoln & Guba, 1985). Because I was very passionate about this study, peer debriefing helped me to identify emotional ties that I had injected in the research findings. According to Lincoln and Guba (1985) peer debriefing is in examining whether the findings were reasonable and were of true quality (Lincoln & Guba, 1985).

Member checking. Member checking is the process of the researcher checking with participants to see if their interpretations of the data were the true thoughts of the participants and represented the true information that the participants intended (Lincoln & Guba, 1985). For this study, I conducted member checks by asking participants if I may call them as a follow-up to give them my interpretation of what they stated in the focus group session. I called the participants who agreed for me to contact them over the

phone and read my interpretation to those focus group members. I asked the participants if my interpretation was correct. I gave the participant the opportunity to correct any misinterpretations at that time. Once the information was confirmed, I thanked the participant for their cooperation.

Transferability

Transferability occurs when the results of a qualitative research study can be transferred or generalized to other time periods, locations, circumstances, and populations (Bitsch, 2005; Lincoln & Guba, 1985). However, for a qualitative research study to be transferable, the researcher must ensure that participants are purposively selected in order to provide information that is rich in description, is the direct testimony of the participants, and that the results of the study are written in a manner in which others can identify with the data (Tracy, 2010). Following the suggestions of Trochim (2006), to improve transferability in this study, I thoroughly described the research population and identified any assumptions in this study so that other researchers could make informed decisions regarding the degree to which this study could be transferred to the context of their study.

Dependability

Researchers defined dependability as presenting findings that are consistent and can be duplicated in the other studies (Creswell, 2009; Lincoln & Guba, 1985; Miles et al., 2014; Trochim, 2006). In other words, if this study was conducted again, the results should be the same. My dissertation committee at Walden University reviewed this study to assess the accuracy of the findings. The committee determined that the data in this

study supported my explanations, findings, and conclusions that were reported in this study.

Confirmability

Confirmability is defined by researchers as the process that researchers go through to ensure that the study's findings are confirmed by others to be free of researcher's bias, influence, or passion for the research problem (Lincoln & Guba, 1985; Trochim, 2006). For this study, I constantly checked and rechecked the data for accuracy and kept a journal documenting the entire research process. Additionally, I used an external data audit to ensure that the data collection and analytical procedures used in this study did not include any biases that I had injected into the findings. The external data audit was an expert in the field of psychology who has a doctoral degree and was actively conducting research at an accredited university.

Ethical Procedures

Ethical Concerns

According to researchers, each participant was treated with respect, dignity, and compassion during the research process (Altheide & Johnson, 1994; Angen, 2000; Spradley, 1979); therefore, I was respectful to all the participants throughout the research process. Once I received approval from Walden University's IRB, I began collecting my data. My IRB approval number is 11-06-17-0069640. I secured permission from each participant to participate in this study by their signature on an informed consent form that was provided by me before the start of the focus group sessions. I assigned each focus group with an identification number based on the date of the focus group sessions to

ensure confidentiality as suggested by Creswell (2013). I reminded each participant that her participation could be discontinued at any time without any repercussions.

I protected the privacy of participants in an ethical and professional manner. I stored all data that was recorded from the focus groups sessions in a Word document on my personal computer. I secured all research files in a password-protected electronic file on my computer. Additionally, I stored all data on a Universal Serial Bus (USB) flash drive to provide safety of data in the event of a computer crash. I kept the original audio tape recordings and USB flash drives in a locked filing cabinet in my home office. I did not use anything that would identify participants in the write up of the research findings. he raw data will only be accessible to me but is available to Walden University's IRB if requested. I will destroy all data after 5 years from the completion of this study.

Summary

In this chapter, I described the qualitative descriptive research design that I used to conduct this study and provided a rationale for using this research design. I described my role as a researcher/moderator; indicating that there was no conflict of interest involved in this study. I presented the methodology section in which I described the participants, sampling strategy, criteria for participation, and how the participants were selected. I described the instruments that I used to collect data, the procedures I used for collecting the data, and the method of analyzing the data that I collected for this study. I concluded this chapter with procedures that I used to address discrepant cases, trustworthiness issues, and ethical concerns.

In Chapter 4, I will examine and analyze the data that will be collected from the focus groups and report the findings. I will describe the setting in which the focus groups will be conducted, the demographics of the participants in this study, how the data will be collected (noting any adjustments that were made from the original plan), and how the data will be analyzed (including the themes that emerged from the raw data as well as the codes that will be assigned to each theme). I will also discuss how discrepant cases and trustworthiness issues were handled in the analysis process. In reporting the results of this study, I will address each research question using the data to support each question; including tables to illustrate the findings. I will conclude Chapter 4 with a summary of the research questions that were answered and a transition to Chapter 5.

I will begin Chapter 5 by restating the purpose of this study, the rationale for conducting this study, and a summary of the key findings. I will include my interpretations of the findings; including how the findings will add to the knowledge base in the field of social sciences and psychology. I will present the limitations of this study, and recommendations that will be made for further research studies. I will describe the implications for positive social change and conclude with a summary which highlights the fundamental nature of this study.

Chapter 4: Results

Introduction

The purpose of this qualitative descriptive study was to gain a better understanding of the perceptions that obese AA women have about altering the way they prepare traditional soul food. I collected the data from the focus group interviews to identify obese AA women's perceptions towards eating and preparing foods which are high in fat, sugar, and calories; to identify the positive and negative aspects of preparing soul food in a healthy manner; and to identify what would prevent AA women from learning how to prepare soul food which is healthy. Also, I collected data to identify the barriers that may prevent AA women from participating in an intervention that may help them to alter their preparation of traditional soul food and what would be needed to sustain or adopt a healthier way to prepare traditional soul food.

I used the following research questions to collect data from the focus group interviews: Research Question 1: What are the perceptions of obese AA women regarding altering traditional soul food preparation?

Research Question 2: What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?

Research Question 3: What barriers could limit participation in an intervention designed to develop healthier eating habits for obese AA women?

I will begin this chapter with a description of the setting describing any conditions that influenced participants during the study. I will present demographics of the participants that were relevant to this study. Next, I will explain the procedures that I used to collect the data for this study which included the research site, how often data were collected, how long it took to collect the data, and other pertinent information. Then I will describe the data analysis process, followed by evidence of trustworthiness which will include credibility, transferability, dependability, and confirmability. Then I will present the results of the focus group sessions. I will discuss the discrepant cases and conclude with a summary of chapter 4 and a transition to chapter 5.

Recruitment and Research Sites

Once approval from the Walden University IRB was granted, I began the recruitment process by contacting prospective participants for the study. I recruited obese AA women from six locations on the Southside of Chicago. The first two locations of recruitment were two beauty salons; both salons provide services to AA women, specializing in weaves and hair braiding. The third recruitment location was the Women's Veterans Clinic at the Veteran's Administration Hospital; this location provides medical services to female veterans only. The forth recruitment location was the Women's Health Clinic; this government and state agency provides health services to low-income women, infants, and children (WIC) under a special supplemental program addressing individuals' nutritional needs. The last two recruitment locations were two AA churches.

I conducted all focus group sessions at San Justin's Kitchen on the Southside of Chicago, Illinois. I secured prior consent to use this research site from the owner of San Justin's Kitchen. This research site provided a positive atmosphere for conducting focus group interviews sessions. Participants appeared to be relaxed and interacted freely with others. The environment was clean, warm, and inviting. The chairs were comfortable, and the research site provided adequate security for safety. To the best of my knowledge, there were no personal or organizational conditions that influenced participants or their experience at the time of this study that may have influenced the interpretation of the study results.

Demographics

I recruited a volunteer sample of 25 obese AA women who resided on the Southside of Chicago, Illinois (ranging in age from 18-90 years) was recruited to participate in four focus group interview sessions. Table 1 shows the results of the data that I collected on the PEQ for the participants who attended the focus group sessions.

The mean age of group participants was $M = 55.04$. The majority (56%) of the participants had a BMI between 30 and 35, while the other participants (44%) had a BMI of 36 or above. All the participants reported preparing and consuming high caloric soul food. Many of the participants (40%) prepared the same amounts of high caloric soul food as they consumed; however, 16% of the participants consumed a higher amount of high caloric soul food than they prepared while 44% consumed less high caloric soul food than they prepared.

Table 1

Demographics of Participants

Participants	*n*	%
Ages		
Young Adults (18-35)	3	12
Middle-aged Adults (36-55)	6	24
Older Adults (56-65)	10	40
Senior Citizens (over 65)	6	24
BMI		
Between 30-35	14	56
Over 35	11	44
Prepared Traditional Soul Food		
Daily	4	16
4-5 days a week	2	8
2-3 days a week	4	16
Only on weekends	11	44
Once a month	4	16
Consumed Traditional Soul Food		
Daily	4	16
4-5 days a week	2	8
2-3 days a week	8	32
Only on weekends	7	28
Once a month	4	16

Recruitment Process

Originally my plan for recruitment was to place flyers at grocery stores, store fronts, schools, beauty shops, bulletin boards in housing projects and apartment buildings, parks, and recreation centers on the Southside of Chicago. However, I changed the location and the process of recruitment. Researchers stated that participants who are recruited using a gender-specific, age-specific, or situation-specific criteria should be recruited in a private manner (Chang et al., 2017; Sharp, Fitzgibbon, & Schiffer, 2008). Therefore, I recruited from a location that provided services to predominately AA women in which I could recruit participants in a private and sensitive manner. I arrived at each

location and spent 45 to 60 minutes at each site handing out flyers to prospective

participants and explained the purpose of my research study in a sensitive manner,

including the confidentiality of the study. I made eye contact with the prospective

participant and established a rapport with her. I handed out flyers, a consent form, and a

self-addressed, stamped envelope to interested individuals who appeared to meet the

inclusion criteria (AA woman, overweight, and over the age of 18) as they were leaving

the recruitment site. After approximately one hour, I posted a flyer at each location.

These locations included the VA Women's Clinic, Women's Health Clubs, WIC

locations, and beauty salons which service predominately AA women on the Southside of

Chicago, Illinois.

I attended two AA churches on the Southside of Chicago and made an

announcement to recruit participants. All interested individuals met with me in a

designated area at the church. Once I discussed my study and their role in the study,

prospective participants were given a consent form to read over and a self-addressed,

stamped envelope to return the consent form to me (whether signed or not). I also

informed them that if they have any questions or concerns regarding their participation,

please feel free to contact me by phone, text, or email and I will be happy to answer any

of their questions. I thanked each prospective participant for their interest in my study.

Data Collection

I used focus group interviews to collect data for this study. I selected focus

group interviews (using a non-probability purposeful sampling strategy) because this

allowed me to collect data from participants who shared similar interest. The interactions

among the participants allowed participants to share new ideas, debate different perspectives, and create new concepts.

Focus Groups

Eligibility criteria included participants being at least 18 years old, having a BMI of 30 or above, residing on the Southside of Chicago, Illinois, and being an obese AA woman who prepares and consumes high caloric soul food. Twelve to 14 women were recruited for each focus group session, but only six to seven women participated in each focus group interview. After my third focus group interview, similar accounts in the data collection process appeared among the participants. Although the data appeared to be similar, I conducted a fourth focus group to see if the data would provide any new perspectives or insights. Each focus group interview session was audio taped and lasted 72-110 minutes. Study participants received refreshments before each focus group interview session. Although Uber transportation was offered to participants, no one requested transportation to or from the focus group research site.

Once I received the signed consent form from prospective participants, I telephoned them and requested the information needed to complete a PEQ as a screening process to determine if the volunteer was eligible to participate in the study. I thanked the prospective participants who did not meet the criteria to participate in the study for their time and informed them that they did not meet the criteria for participation. All prospective participants who met all the criteria to participate in the study were informed that they qualified to participate in the study.

I used the "Follow-Up Call for Recruitment" protocol during the phone conversation (see Appendix H). I encouraged the participant to ask questions. Again, I informed the participant that her participation was strictly voluntary and at any time she could leave the group interview or simply just quit, no explanations would be needed. I expounded on my role as the researcher and the risks and benefits to her participating in the focus group interview.

I then provided the participants with the times, dates, and the location of the four focus group sessions and asked participants to select a date and time that was convenient for them to participate in. I informed the participants that refreshments would be served, and that Uber transportation would be provided to and from the focus group session at no cost to them if needed. Once I confirmed the participant's time and date for the focus group, I informed her that I would be sending her a confirmation letter confirming the focus group interview.

I recruited 12-14 participants for each focus group to ensure that I would have at least 6 to 8 participants to interview. I scheduled 12 participants to participate in the first focus group interview. Each focus group session was conducted at San Justin's Kitchen located at 157 West 75th Street in Chicago, Illinois. This location was selected because of its centralized location on the Southside of Chicago.

After the time slot for the first focus group was filled, I conducted the first focus group. To ensure confidentiality, each participant was assigned an identification number. For example, the first participant was documented as Participant 1, the second participant

was documented as Participant 2, and so on. All focus group interview sessions were recorded using a tape recorder and an iPad.

Focus Group 1. I conducted the first focus group on November 12, 2017, at 3:00 p.m. I sent out confirmation letters to 12 participants who were scheduled to attend the first focus group session, but only seven participants attended. The ages of the seven participants ranged from 22 to 74 years old. The environment at the research site was peaceful, relaxed, and comfortable which may have contributed to participants freely sharing their ideas and perceptions. This focus group session lasted for 94 minutes.

Focus Group 2. I conducted the second focus group on December 1, 2017, at 6:00 p.m. I sent out confirmation letters to 14 participants who were scheduled to attend the second focus group session, but only six participants attended. The ages of the six participants ranged from 56 to 68 years old. The environment at the research site was cheerful; participants were relaxed and seemed to enjoy themselves. This focus group session lasted for 113 minutes.

Focus Group 3. I conducted the third focus group on December 3, 2017, at 2:00 p.m. Fourteen participants were scheduled to attend the third focus group session. After I sent out the confirmation letters, three participants sent me a text to cancel. Out of the remaining 11 participants, only six participants attended. The ages of the six participants ranged from 29 to 59 years old. This focus group session lasted for 97 minutes.

Focus Group 4. The fourth focus group was first scheduled for December 10, 2017; however, due to inclement weather, it was rescheduled for December 17, 2017, at 2:00 p.m. I called each participant to reschedule a date and time. Four of the participants

confirmed that they would attend on the 17th of December. I contacted participants who

had canceled previous focus group sessions, and two of the participants attended the

session. This gave me a total of six participants for the fourth focus group session. The

ages of the six participants were from 18 to 90 years old. This focus group session lasted

for 106 minutes.

Data Analysis

The recordings of each focus group session were transcribed verbatim in a Word

document within 48 hours following each focus group session. I used an inductive

approach to make sense of the raw data that had to be analyzed. The data analysis process

included reading and re-reading through the data, identifying emerging themes and

patterns, assigning codes to the data, arranging the data for analysis, and writing up the

findings in a final report. I reduced the amount of data that had to be analyzed by using

qualitative content analysis (QCA) to organize and analyze the raw data. I hand coded the

relevant information from the raw data, italicized the information that was not relevant,

and analyzed only the information that was coded. I identified themes which emerged

from the raw data and assigned codes to the themes. A list of the themes and the codes

that were assigned to the raw data are presented in Table 2. I rearranged and created my

codes by using axial and selective coding (Gläser & Laudel, 2013). In other words, I

examined each portion of the coded data to ensure that all sub-codes were under the

proper theme so that I could properly address the research questions.

I used constant comparative analysis to compare the text from the four focus

group sessions for similarities and differences. Then I compared the raw data from each

theme and made connections between them. Although I hand coded the raw data, I also used Nvivo 11 to help me identify themes in the raw data, as well as information under the different themes that emerged from the raw data. Nvivo 11 helped me to organize, store, and code the data more effectively to achieve an in-depth understanding of what AA women think about altering the preparation and consumption of traditional soul food.

Table 2

List of Themes and Codes

Research Question/Themes	Main Codes/SubCodes
RQ1/ Altering Soul Food Preparation	ASFP
Taste	ASFP-T
Family Values	ASFP-FV
Consequences	ASFP-C
Improves Health	ASFP-C-IH
Reduces Chronic Illnesses	ASFP-C-RCI
RQ2/ Factors for Eating Healthy	FEH
Tastes Good	FEH-TG
Recipe Availability	FEH-RA
Low Cost for Healthy Ingredients	FEH-I-LC
Accessibility of the Ingredients	FEH-I-A
Substituting Herbs and Spices	FEH-I-S
Food Waste	FEH-FW
RQ3/ Barriers for Participation in an	
Intervention	BPI
Ignorance and Laziness	BPI-Ig&Lz
Transportation Issues	BPI-TI
Lack of Motivation	BPI-LoM
Lack of Education	BPI-LoE
Lack of Time	BPI-NHT
No Incentives	BPI-NI
Bad Reviews	BPI-BR
Other Relevant Ideas	ORI

I initiated a thorough analysis of the data using the computer software, NVivo 11 for Windows. I imported the transcripts from the focus group interviews into the Nvivo 11 software. NVivo 11 provided me with relevant themes for analysis through common word recognition. The results of the word frequency query are displayed in Appendix I. Therefore, I identified themes and subthemes that were relevant to address the research questions. Additionally, I created a backup copy of the NVivo 11 results to secure the work that had been completed. It was also helpful for me to keep a journal of the entire research process because it kept me aware of my feelings and beliefs about the research issues (Bazeley, 2007; Creswell, 2013; Gläser & Laudel, 2013; Patton, 2015).

Evidence of Trustworthiness

Credibility

Participants and other researchers can determine the credibility of the study's results (Lincoln & Guba, 1985; Patton, 2015; Smith & Noble, 2014). Therefore, to ascertain that the findings from this research study were trusting, realistic, and of high quality; I used techniques such as triangulation, peer debriefing, and member checking to establish the credibility of this study's results. I used triangulation (using data from multiple sources) to provide consistency and an in-depth understanding of the research problem (Lincoln & Guba, 1985). For this study, the theory/perspective triangulation was used since the viewpoints from the empowerment model, and the HBM were used to interpret and analyze the data. Peer debriefing was used to help illuminate my ideas, thoughts, opinions, and biases that may have been injected in the research findings, as well as examining whether the findings were reasonable and were of true quality (Lincoln

& Guba, 1985). Member checking was used to verify with the participants that their interpretations of the data were the true thoughts of the focus group and represented the true information that the participants intended (Lincoln & Guba, 1985). I received permission from the focus group members to call them as a follow-up to give them my interpretation of what was stated in the focus group session. Therefore, I called each focus group member and read my interpretation of their focus group interview session. My interpretation was confirmed by each participant; however, four of the participants made a few corrections. I revised my interpretation based on the corrections made by the focus group members.

Transferability

A research study has transferability when the results can be transferred or generalized to other time periods, locations, circumstances, and populations (Bitsch, 2005; Lincoln & Guba, 1985). Following the suggestions of Trochim (2006), I made sure that participants were purposively selected so that I could provide rich, in-depth information that can be used by other researchers to determine the extent to which the results can be transferred to other time periods, locations, circumstances, and populations. As suggested by Tracy (2010), I wrote the results of the study so that others could identify with the data. Additionally, I thoroughly described the research population and identified any assumptions in this study so that other researchers could make informed decisions regarding the degree to which this study's results could be transferred to the context of their study.

Dependability

Researchers should make sure that their study can be duplicated in future research studies (Creswell, 2009; Lincoln & Guba, 1985; Miles et al., 2014; Trochim, 2006). For this study, I provided findings that were consistent and reliable so that other researchers can duplicate this study in future research. My dissertation committee at Walden University reviewed this study and has determined that the data in this study supported my explanations, findings, and conclusions that I reported in this study. Additionally, I ascertained dependability through (a) examining the interview transcripts several times to eliminate errors during transcription, (b) journal documentation of the entire research process, and (c) validation of my interpretation during member checking.

Confirmability

I checked and rechecked the transcripts for accuracy and kept a journal documenting the entire research process to ensure that the study's findings were free of researcher's bias, influence, or passion for the research problem. Additionally, I secured an external audit who is currently researching at an accredited university to review my data collection section to ensure that this did not include any biases that I had injected into the findings.

<div align="center">

Results

</div>

I presented the findings from the focus group sessions in this results section. I organized and presented the results by research questions. I used the themes that emerged from the data to address each research question. Participants offered an abundance of information that adequately addressed the research problem and answered the three

research questions. I used quotes from the participants to support and validate the findings that were reported. Additionally, I discussed the discrepant cases that were found in the data and explained why this information was irrelevant to this study.

Research Question 1

For the first research question, I wanted to know the perceptions of obese AA women regarding altering traditional soul food preparation. As I combed through the data, several themes emerged. I presented the themes that emerged to answer the research questions. The main theme for RQ1 was altering soul food preparation.

Altering Soul Food Preparation

There were three subthemes that emerged under altering soul food preparation. The first subtheme that I presented was taste. Taste was very important to participants when they considered altering soul food preparation. The second subtheme that was presented was family values. Soul food and family seemed to go together. The last subtheme that was presented was consequences. The outcome of consuming soul food was an important factor for altering soul food preparation.

Taste. All participants loved the way traditional soul food tastes; therefore, it is important to consider the taste of any altered soul food preparation to create willingness for AA women to change the way they prepare traditional soul food. Participant 5 had this to say:

> I'm just saying healthy soul food doesn't taste the same. Now you can accept
> what you get from the final results if you chose to, but it will not taste the same.
> And certainly, I think millenniums have made that transition in a lot of ways.

Now, I mean, I love my daughter dearly, but when she cooks for me and she gets

all excited, "Wow mom, I want you to try this; just taste it," and I taste it and Ok,

its a beginning, you know, but it is different; however, she is healthy, she comes

from a very healthy perspective, she's not going to use unhealthy oils, she's not

going to use a bunch of salt. So in that respect, I feel like its also incumbent upon

me to make a change, to try to transition some of my thinking; but, in terms of my

taste buds, no.

Family values. I discovered that the participants felt that high caloric soul food

was a part of their heritage and it placed joy in their hearts. Participant 4 stated, "during

holidays, you want to cook your best dishes and they're [going to] fall back to soul food.

It's something that the people look forward to; it puts a smile on your face." Participant

5said that, "it brings the family together. Its tasty." Participant 2 stated that," it's a love

thing, when you prepare these foods, it's like a love thing; it's a way of giving comfort to

one another." Participant 16 stated:

It's about family; it's about coming together and about people showing how they

love one another and feeding their family. I don't think it was ever meant to be

bad. I think it was meant for families to enjoy each other; everybody has their

traditions.

Consequences. All of the participants expressed that the traditional soul food was

not healthy to eat; however, they felt that the positive aspects and the good taste

outweighed the consequences of eating it. For example, Participant 21 stated, "I don't

think we're supposed to eat [high caloric soul food], but we eat it anyway." Participant 24

added, "Down the road, when you get older, you get sick from eating unhealthy soul food."

Participants in all four focus group sessions agreed that eating high caloric soul food causes unfavorable health conditions such as heart attacks and other problems such as high cholesterol, stroke, clogged arteries, hypertension, obesity, diabetes, and respiratory problems. As a result, the participants felt that if soul food could be prepared in a healthy manner and still tastes good, they would be willing to change the way they prepare it. Participants realized that the traditional soul food negatively affected their health and if it could be prepared in a healthy manner and still tastes good, then it would improve health and reduce chronic illnesses.

Improve health. Participants in all four focus groups agreed that eating healthy soul food would improve their health which would lower the cost of healthcare. Specifically, this is what Participant 16 had to say:

> There're studies about it; that's why I know. And not only that, I mean, like you were saying about your family, look at your family and look at what they eat and why they're leaving here…dying. What illnesses do they end up with that they end up struggling with throughout the time of their living? You can look at that and see that something needs to change. If healthy soul food tastes good, then I would eat it and I would cook it.

Reduce chronic illnesses. All participants agreed that eating healthy soul food would reduce chronic illnesses such as hypertension, diabetes, and heart diseases. Participant 15 stated the following:

I'm looking at, high in fat, high in sugar, and it's a no-no, and the reason why I

say no-no, [because] I know what it has done to people. I'm watching people be

obese, including myself. My doctor even told me, he said, "you're obese" and I'm

sitting there like, I'm not obese, what you talking about. Then he shows me this

chart, to show me that I am obese; compared my height to my weight. I know how

my emotions sometimes are affected with my eating. So as to be more conscious

of all of that and just try to work towards doing better, I would change if the food

was tasty. I feel a little bad sometimes when I eat soul food and know I shouldn't

do it and I do it anyway, and sometimes someone would say, "just don't do it,

how about that," but it's just not easy to say no to good soul food. Y'all know

what I'm talking about. But like she said, if healthy soul food can be made to taste

good, I would change the way I prepare it.

Most of the participants felt that eating soul food was not harmful if you eat it in

moderation. Participant 9 stated:

People who are a little plump don't eat in moderation. And I think that when we

get full, we just overeat because it's good to us, we just eat a little more, and I'd

just have a little more of this and a little more of that, because we enjoy it. But a

little bit, every now and then, won't hurt you. We need to eat soul food in

moderation and not all the times.

Research Question 2

The second research question was "What factors do obese AA women perceive

would be helpful to maintain new healthier eating behaviors for themselves and their

families?" Some of the factors that were mentioned in the focus group sessions were: (a) tastes good, (b) availability of recipes to use, (c) low cost of healthy ingredients, (d) accessibility of the ingredients, (e) learning how to substitute various herbs and spices, and (f) food waste. The main theme that emerged to address RQ2 was factors for eating healthy.

Factors for Eating Healthy

There were six subthemes that emerged under factors for eating healthy. The first subtheme that was presented was tastes good. Taste was found to be the motivational factor for maintaining healthy eating behaviors.

Tastes good. One factor that the participants perceived would help to maintain new healthier eating behaviors for themselves, and their family was that the new soul food tastes good. Participant 19 stated:

And the biggest thing about food is texture and taste. If the texture and the taste [are] there, most times, people will go for it. But if the texture isn't there and the seasoning is bland, no one is going to want it. Unless they were raised eating it.

All participants in the four focus group sessions felt that healthy soul food would not be tasty because of their past experiences trying to consume healthy soul food. Participant 8 shared this experience with the group and said:

I know I was at church a few Sundays back and a lady cooked some collard greens. That was the worst mess I ever had in my life. They had no meat in [them] and no grease in [them]. They were taste-less… They just were not good at all. I mean not at all. I can do, you know, with less fat or a different kind of fat, but

don't just give me some dry collard greens with no meat. They didn't even have

mushrooms; I've seen them prepared with mushrooms, you know it looks like

meat, and they were good; they had some kind of taste in [them], but this had no

taste, and I just can't quite come to accept eating something like that because it's

healthy. I think she forgot the meat, you know, she's supposed to be a good cook.

Participant 11's attempt at preparing healthy chili failed. She shared her experience by

saying:

Sometimes, it [is] so bad that you can't even hook [the food] up, it's only one

good spot for it; the garbage can. I called myself [going to] make me some chili;

some healthy turkey chili. I brought, it must have been, four pounds of ground

turkey; I know I had four pounds of beans. I thought the meat had to be brown, so

I fried the ground turkey and sautéed it until it was good and brown. I must have

killed it 40 times. I followed all of the directions, seasoned my chili with a ton of

seasoning, and I tasted that chili and I thought maybe it will taste better in the

morning after sitting in the refrigerator overnight. The next morning, I tasted that

chili and I threw the whole pot in the garbage can. They said at work, I thought

you were bringing lunch, I told them I threw it in the garbage can, I couldn't eat it

and you couldn't eat it. Nobody could have saved it and I haven't tried to make

any healthy chili since. I just wasted all that food.

The participants were adamant about the taste of soul food; it had to taste good before

they would try consuming or preparing it.

Recipe availability. The second factor (or subtheme) that the participants perceived would help to maintain new healthier eating behaviors for themselves and their family was recipe availability. The only soul food recipes that the participants knew were those that were handed down through the generations. They had not heard of healthy soul food recipes. Participant 5 stated the following:

> [Soul food] represents a lot of love and experience, it represents my family, it represents my mother; it's not just food, it's a much broader experience. And now for me, it's also has come to represent Black people, my culture, the things that we have come to value. I don't know anybody who has healthy recipes for soul food that taste good.

Participant 12 explained it this way:

> We use recipes that have been passed down from family members. You know, the different foods that they ate, we would cook them the same way that they taught us to cook them. Let's say, if my mom cooked, prepared macaroni and cheese with carnation milk, then I'm going to prepare mines that way and then my children will possibly prepare theirs that way. We don't have any other recipes. Where are these tasty soul food recipes?

All the other participants agreed with her.

Low cost of healthy ingredients. The third factor (or subtheme) that the participants perceived would help to maintain new healthier eating behaviors for themselves and their family was the low cost of healthy ingredients. Participant 17 had this to say:

As long as it's not cost prohibitive, I'm cool, I mean there are certain things, like

certain flours, [that] can be more expensive, a good olive oil is actually pretty

pricy. I buy it, but I have the luxury of being like, Ok, we're not getting the cheap

olive oil; we're getting the real olive oil. Balsamic vinegar, that's pricy too. You

know what I mean, it's just like we're getting there, but that stuff cost money.

Participant 18 added to the discussion by saying:

The average person cannot afford any of those things. So when you talk about

changing your diet, your soul food; then now you [got to] change their

pocketbook. And if you can't change a person's pocketbook, then it's kind of hard

to change their perceptions on how to eat. Tell me where I can find low cost

ingredients.

Participant 20 said that "a lot of people can't cook healthy, because it cost so much."

Then Participant 22 added that "they're on a fixed income." Participant 22 agreed by

saying, "Yeah, because they really can't buy the ingredients and stuff." Participant

21explained by saying "the cost to eat healthy is very expensive here, I mean, I was

brought up in the South, we ate off the land where we grew our food. We didn't get sick

until we came here, to Chicago." Participant 6 explained her viewpoint this way:

So it's just a matter of finance for a lot of people in our community; it is not a

matter of ignorance, it like some people may use shortening because it's cheaper

than oil. Unless you're better off and able to afford the best, especially with some

olive oil, which burns quicker; some peanut oil or some canola oil; that stuff is not

cheap and you telling somebody to spend that kind of money. Even if I love

butter, real butter, or a pint of butter; it [is not] cheap. If healthy food items were less expensive, people will be more apt to cook healthy.

Accessibility of the ingredients. The fourth factor (or subtheme) that the participants perceived would help to maintain new healthier eating behaviors for themselves and their family was the accessibility of the ingredients needed to prepare healthy soul food. Participant 6 stated:

But to prepare [healthy soul food], you [going to] know how to get it, and if the store is not there… if you don't have access, again, you need fresh ingredients, you know, it's not going to be the same. If you only got like 'Mom and Pop' store down the street that's selling can goods, where they don't have fresh meat, or if they don't have fresh vegetables, it's not going to be the same… It's not like these people want this, but everyone can't go or have a car or is not on the car line or the bus stop to go and get these things.

Participant 13 had this to say:

And the thing about it is, cooking soul food, they call it comfort food. And I guess it's because it's so heavy…But everybody can't get fresh vegetables; all they can get are canned stuff and that [is not] healthy. Transportation is a problem for some folks. You [have to] have a car or a way to go buy the healthy stuff.

Participant 14's explanation was very similar when she stated:

I would say starting off by drinking plenty of water, and just knowing about making the right choices, the right food combinations, and the healthier way of preparing the food using salt substitutes and more herbs and spices. You know a

lot of us don't have cars. People in the hood can't go buy fresh fruits, vegetables, and herbs from the corner store. Those stores just don't have that healthy stuff cause it too expensive. They have fried chicken, fried fish, French fries, pork sausages sandwiches, hot dogs, and stuff like that; fattening stuff and it tastes good.

Participant 20 expressed her concerns by saying:

Well, I feel like huh learning more about herbs, [because] it's a lot of herbs out there that people don't know about, or what the benefits of certain herbs are. So I would try to educate myself on different herbs and add it to my cooking. Where would people get these herbs?... How available are they to the people in our communities? …I have never seen any herbs at the corner market. Not even fresh vegetables. They have a few apples, bananas, and oranges. But they have   plenty of fried chicken though, and it is cheap.

Participant 6 summed it all up when she stated:

It's about economics, if you're living in a food desert or you do not have access to fresh vegetables, fresh greens, and different things like that, like we eat, it's going to be difficult, because some of that money that you have to pay for transportation, you can't apply to the cost of food, or it takes away from that cost. And it's not like everyone owns a car or has access to a car, and everyone does not have public transportation. I think that New York and Chicago are the only two cities that have 24-hour public transportation. And they do have transportation, but it's limited in certain areas; in Chicago alone, we know that

they have, what they call a lot of food deserts, where somebody [goes] to the store

to get some milk. If you go to the gas station, it's $3.29; if you could go to

grocery store, it may be $2.29. So it's a lot of disparity as far as prices in what

people can afford and if I'm in the suburbs and I'm middle class and of another

persuasion, I can take my car and go to a store.

So, accessibility and availability of fresh vegetables, fruits, and herbs are an issue in the

AA communities, especially if residents do not have transportation.

Substituting herbs and spices. The fifth factor (or subtheme) that the

participants perceived would help to maintain new healthier eating behaviors for

themselves and their family was learning how to substitute various herbs and spices. This

was the case in all four focus group sessions. For example, in focus group 1, Participant 3

stated that, "that's a part of ignorance, because if you learn how to substitute mama's

stuff for healthier stuff, then it can still make the food taste just as good." In focus group

2, Participant 12 stated that:

With the substitute of stuff like herbs and stuff and using different kinds of

healthy herbs versus the salt that you [are] use to, like accent or something like

that. Using things like salt that would be a concern, because it's not the same

flavor that you had growing up, it's like, Oh, this don't taste like mom's, mom's

food didn't taste like that. So taste is an issue.

Participant 11 added:

Taste is an issue if you're thinking about preparing it differently than how you

were used to being raised. Like with the recipes, so the recipes were like hard core

back in the day, so when your mind gets healthy, then you substitute stuff. Instead

of using whole milk, you use that 2% milk; which you don't have the same flavor,

you know that's the concern of learning how to prepare soul food in a healthy

manner by substituting healthy stuff.

In focus group 3, Participant 17 discussed her experience with substitution by saying:

I think that healthy soul food preparation is like substituting; so instead of me

using lard, I'll use grapeseed oil or olive oil or some other type of clean oil, like

peanut oil. I may still boil the smoked turkey wings, but now instead of using that

first patch of water, I'll pour that off and boil it again so as to get all of the sodium

out because of the high blood pressure that I have, so it's really like making the

choices. So instead of using salt, I might go with dragoman acid or the bone meal

or Mrs. Dash, it's still going to give a salt taste, I will use more fresh herbs and

dry herbs now, because it will add a depth of flavor. All of that to me is soul food.

Although the preparation is not like before, where I would just rinse off the ham

hocks and throw them in the pressure cooker with the beans. Now, I may still eat

the ham hocks, but it's very few and far in between. I could benefit from getting

educated on other herbs and spices that I could substitute [because] my list is very

short.

In focus group 4, Participant 22stated:

You could bake your food or broil it or grill it. You don't have to use the Lawry

salt and all that; you can use the herbs and put on there and it will make it taste

good. You just need to know what herds to use and how much to use to get the

desired taste.

Therefore, participants were somewhat knowledgeable about substituting herbs and

spices for their soul food to make it healthier, but they all expressed the need for

information on how to substitute healthy ingredients to enhance the taste.

Food waste. The last factor (or subtheme) that the participants perceived would

help to maintain new healthier eating behaviors for themselves and their family was food

waste. Participants discussed the possibility of having to throw food away because when

they prepared it in a healthy manner, it was not tasty. Therefore, food waste was a major

concern. Participant 5 had this to say:

It is a matter of tradition because I am not changing my mama's recipe. That's

what she used, so that's what I'm [going to] use. Especially if folk are coming

over for a yearly dinner like Christmas, Thanksgiving, or New Years. I would be

reluctant to change her recipes and risk my family not enjoying the dinner

because it tastes nasty and flavorless. Furthermore, I would end up throwing the

food out. I can't afford to waste food like that.

Participant 9 stated:

People might have that fear that if it [doesn't] taste right... It's a lot of reasons

why people do what they do, fear of it not tasting good; fear of not tasting right.

You [invite] a lot of people over and you want to impress them, you know

something like that, a fear of change, fear that I [have] made this big pot of greens

[that] don't taste right, it's taste-less. Either you [going to] learn to hook it up or you [going to] throw it out.

Participant 15 shared similar thoughts. She stated:

It has to taste good. I wouldn't want to have to throw food in the garbage [because] it tastes awful. Food costs too much to throw away. I was taught to never throw away food. So cooking it the way I know, it will be eaten up. But if I change it and nobody can eat it; it will go in the garbage.

Participant 24 stated:

You'll have health issues eating high-fat soul food. If you try and cook it healthy, you may end up throwing it away cause it don't taste good. I have tried eating my soul food healthier, but I couldn't eat it. It was horrible, no matter how I tried to spruce it up. So the garbage can was happy. I rather fix it unhealthy than throwing food away.

Participants discussed the factors that would be helpful to maintain new healthier eating behaviors for themselves and their families. They mentioned taste, having access to healthy soul food recipes, accessing healthy ingredients at affordable prices, learning how to substitute various herbs and spices to make it tasty so food would not be wasted. Participants from all focus group sessions were adamant about the factors above because they felt that there needs to be a change.

Research Question 3

The third and final research question was "What barriers could limit participation in an intervention designed to develop healthier eating habits for obese AA women?" It

was suggested that if AA women do not eat soul food, they would be hesitant about participating in such intervention. Participant 3 stated, "For those who don't eat or cook soul food, I think it would be uninviting to them. They would just say I don't eat all that stuff." Participant 7 stated, "I don't understand anyone who wouldn't want to learn how to live a healthier lifestyle, but I guess there are some folks out there…but I would want to learn to cook and eat healthy and use healthy ingredients." The main theme that emerged to address RQ3 was barriers for participation in an intervention.

Barriers for Participation in an Intervention

There were seven subthemes that emerged under barriers for participation in an intervention. The subthemes that were presented were simple reasons why AA women would not attend an intervention such as ignorance and laziness, transportation issues, lack of motivation, lack of education, and lack of time. Other subthemes were no incentives and bad reviews.

Ignorance and laziness. Participants felt that AA women who continue to consume traditional soul food would not attend cooking workshops to teach them how to prepare healthy soul food due to "ignorant" and/or "laziness." Participant 3 stated:

Let me say it like this, [AA women] would not go to cooking workshops due to ignorance…because if your mama cooked with ham hocks and whatever other stuff that is not good for you pig fat; then you are closed-minded to cooking it any other way. It's a part of ignorance because if you learn how to substitute mama's stuff for healthier stuff, then it can still make the food tastes just as good.

Participant 11 stated, "It's ignorance, ignorance… [AA women] don't realize how important this is to our health." Participant 18 had this to say:

> People don't know; they are sort of ignorance to the facts. I'm very much like you, give me my butter and my lard, and whatever I need to actually make it tastes like grandma's, but we can compensate in other ways, so maybe it's organic, maybe instead of some frozen fruit, I [get] some pre-sliced organic fresh fruit, …so there are ways for me to compensating for whatever unhealthy thing I've done to the food, but … it's just different even though it's soul food, it's just not the grandparent's soul food.

Participant 20 stated, "Well, I feel like learning more about herbs, cause it's a lot of herbs out there that people are ignorant about; they don't know about them, or what the benefits of certain herbs are. Participant 20 added, "If you don't know better, you can't do better." It was made clear that AA women need to be knowledgeable about the importance of altering the way they prepare traditional soul food, as well as how to alter its preparation.

Transportation issues. It was discussed how AA women have issues with transportation; many of them must rely on public transportation to move about the city. Participant 8 stated, "transportation problems" was an issue. Participant 6 stated that "it's about economics… it's like everyone does not have a car or live in a car, and everyone does not have public transportation." Participant 13 stated that, "Transportation is a problem for some folks. You [have to] have a car or a way to [get there] to get the healthy stuff or even to buy the healthy stuff." Participant 17 stated that, "You would also need transportation to get to any cooking classes to learn how to cook healthy soul food unless

it was on TV." Participant 21 asked, "Where would you go to learn how to cook healthy soul food and how would you get there? She went on to say, "And you would need a car or a way to get to where you can learn how to cook soul food healthy." Participant 22 added, "Right. You [have to] learn how to cook it first."

Lack of motivation. Participants expressed that AA women must be motivated before they would change the way they prepare and consume traditional soul food. Participant 6 stated, "You [have to] be motivated to change; you [have to] want to change for the better. Until then, everything will stay the same." Participant 13 believed that "people must have a willingness to want to change. If they don't want to change, they won't try to learn how to change." Participant 15 expressed her opinion when she stated:

Oh, most definitely I agree, because you know we have to change it, and especially as you get older and you start, not looking like you use to look, not feeling like you use to feel… I know something has gone wrong and I know it has to do with what I put in my body… like last night, I said I didn't want this, but I [ended] up letting it overtake me. And so [yes], having the will to make better choices, changing my mindset, controlling my attitude, and my ability to deal with situations and things, because as I deal with situations and different life situations, I might want some food after that, I'm serious, because some times when I'm going through some things, if I'm not feeling fulfilled, I know that that cheeseburger might do it… I want to make a change in my life, because I've seen women who are about 70, 80, or 90 years old who look like they are 30 because they juice and do healthy things. So I know we [have to] change, we just [have to]

change. We need motivation and a support group, like the ones they have for

alcoholics and smokers.

Participant 25 stated, "We have to have a frame of mind, if we want to live longer…we

have to have motivation, drive, and will power."

Lack of education. Participants discussed how the lack of education would affect

their decision to participate in an intervention to alter soul food preparation. Participant 3

stated, "I just don't believe in excuses, I just don't. You just have to find an option that is

[going to] save your life; keep you healthy, and the only way to do that is through

education." Participant 12 stated that, "Learning how to pass down to the next generation

is very important. Educate the next generation and teach them to prepare soul food

healthy." All participants agreed. Participant 16 stated the following:

And that's really true…but culturally, I do know better, when you know how

other people consume foods and eat food, and prepare things, I think it's about

being educated as well, you have to be educated, you know, you as a parent have

to be educated, if your parents are not educated, then you have to educate your

parents on what you're not going to allow your children to do and eat…So I think

a lot of it has to do with education.

Participant 20 stated:

Well, I feel like learning more about herbs, [because] it's a lot of herbs out there

that people are ignorant about; they don't know about them, or what the benefits

of certain herbs are. So I would try to educate myself on different herbs and add it

to my baking.

Lack of time. Many of the participants stressed the fact that they did not have time to learn how to alter soul food preparation. For example, Participants 9 and 12 stated that AA women "need to make time for learning how to prepare healthy soul food." Participant 12 further stated:

> I would go for it, I would learn, because it's not just eating right; …think about medication. That's not a good thing for anybody to be taking medication for something that you don't have to take medication for. All you have to do is just change your lifestyle of living, it's … [going to] put you at risk. So I would take the time to learn what I can do.... We live in the now. We need to do the things that we have to do to help ourselves along the way; empower yourself and empower others. A cooking class would be ideal, and a lot of people will come, especially if there is food.

Participant 6 stated, "Again, you have to make time in your schedule to attend cooking classes and learn about the different herbs and spices." Participant 17 felt that a cooking intervention would be good for her. She stated:

> For me, I would have to make time to learn how to change the way I prepare soul food. I have a hectic schedule most of the times; there is always so much to do. I ask myself, would I have time to learn about herbs and spices? Could I find a place to go to learn how to cook soul food healthy? Would I be able to get there? Would I have the time or money? All of these things play a factor.

No incentives. Some of the participants rallied around the idea that cooking interventions should provide attractive incentives. Participant 11 suggested the following:

The intervention should provide incentives. One incentive is to prepare healthy soul food during the intervention that looks pretty and tastes good. Those who attended will tell others and the crowd would get larger and larger. But if the food is not good and not appealing to the eye, you will not have anyone coming.

Participant 25 stated this, "OK, getting back down to the taste; if the healthy soul food tastes good, people will come and be receptive to change. But only if it tastes good!" Participant 17 said that, "if people have to pay to attend, they may not come to any cooking classes." Participant 17 had this to say:

I think if we're just getting down to the specifics of adopting and sustaining the practice of healthy soul food, it needs to be a cooking process that is [interactive]; like a taste test, maybe let them give you their recipe and then … make their recipe and then make a healthy version along beside it, and let them taste it and see, because at the end of the day, it will come down to you actually changing [somebody's] mind about eating healthy.

Bad reviews. Some participants suggested that for cooking classes or interventions designed to alter soul food preparation, care should be taken to ensure an inviting atmosphere, cleanliness, and safety. Participant 20's comments were:

If you get bad reviews from your teaching, others will not want to come listen to you. Make sure the atmosphere is pleasant, clean, and most of all, safe. If people don't take anything away from the cooking lessons, they will not be successful at adopting new eating or cooking habits.

Participant 14 stated that "It has to taste good and the person who teaches me must be polite, clean, and easy to work with."

Other Relevant Ideas from Participants

At the end of each focus group, participants could share with the group other ideas regarding adopting and sustaining the practice of preparing healthy soul food that had not been stated. Participant 16 had this to share:

I think what I have to say about that is that, definitely, you have to be open and you have to realize that you don't know everything. [You must] be able to want to get better and do better and to be able to be open to receive information that can possibly change your life and the lives of your children, your grandchildren, and so forth; because these meals are being prepared for them as well. I think it is important to definitely be open to be able to learn and do whatever we [have to] do to do that; go to classes or get on online. You know everything is right on your phone, so you can do that. I eat my oatmeal every day, and as you mentioned about the seasoning, I'm learning to use different flavoring opposed to salt now, because the bottom line is, I have high blood pressure, so I needed to be doing something. As the other group member was saying, "you got it, you know you got it, so you need to do something about it." When you know these things, be honest with yourself. You know you don't exercise, you eat the wrong things, you drink too many pops and not enough water, you party too much, and you watch too much TV. Then you let your children and grandchildren do the same wrong

things. It's time to change. You have to do the best that you can do and be open

and willing and able to make some changes.

Discrepant Cases

Any information in the raw data which deviated from the research questions or

contradicted the themes that emerged from the data during data analysis was considered

discrepant (Creswell, 2009; Lincoln & Guba, 1985; Patton, 2015). There were discrepant

cases found in the raw data. As I was combing through the transcripts, I italicized all

divergent information and explained why this information did not support the research. I

eliminated this information because the subject content was not relevant to answering any

of the research questions. For example, Participant 15 talked about her mother's

unwillingness to receive medical treatment and in home care as a result of having a

stroke. Participant 17 talked at length on how her religious background allowed her to

persuade others to do her will. In both of these cases, as the moderator, I redirected

participants back to the current discussion by restating the interview question. This

helped to keep the focus group interview session on track.

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Summary

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This chapter, I provided a description of the focus group setting used to conduct

the four focus group interview sessions. Responses from the sample population ($n = 25$)

provided in-depth information to answer the three research questions. Then, I explained

the data analysis process, followed by evidence of trustworthiness which included

credibility, transferability, dependability, and confirmability. I used three research

questions to guide this research study. In research question 1, I wanted to know the

perceptions of obese AA women regarding altering traditional soul food preparation. I

discovered that the participants loved the way traditional soul food tastes and that

traditional soul food was a part of their lifestyle. Many of the participants felt that high

caloric soul food was a part of their heritage and it placed joy in their hearts.

For research question 2, I explored what factors obese AA women perceived

would be helpful to maintain new healthier eating behaviors for themselves and their

families. The study participants suggested six factors to answer this research question,

which were: (a) the taste, (b) availability of recipes to use, (c) low cost of healthy

ingredients, (d) accessibility of the ingredients, (e) learning how to substitute various

herbs and spices, and (f) food waste. Participants from all four focus group sessions felt

that if these factors were addressed, then AA women would be willing to change because

they are aware of the apparent risks associated with obesity.

Finally, for research question 3, I investigated the barriers which could limit

participation in an intervention designed to develop healthier eating habits for obese AA

women. It was suggested that if AA women do not eat soul food, they would be hesitant

about participating in an intervention. Overall, all participants agreed that if they were

able to taste healthy soul food and it tasted good, they would participate in a cooking

intervention and modify the way they prepare and consume traditional soul food.

In Chapter 5, I will present the interpretations of the findings, the limitations of

the study, the recommendations for further research, and the implications for positive

social change. Then I will describe the methodological and theoretical implications which

will include recommendations for practice. I will conclude Chapter 5 with a summary of this research study.

Chapter 5: Discussion

Introduction

The purpose of this qualitative descriptive study was to gain a better

understanding of the perceptions that obese AA women have about altering the way they

prepare traditional soul food to a healthier soul food. African American women were

found to have the highest incidence of obesity worldwide; therefore, they have a greater

risk of developing chronic illnesses and diseases associated with type 2 diabetes; liver

and gallbladder disease; cardiovascular diseases; and various cancers (AMA, 2013;

United States Department of Health and Human Services Office of Minority Health,

2016). Despite the many studies that have been conducted on obesity over the last twenty

years, the obesity rate continues to rise among AAs (Callahan, 2013).

I conducted this to address the gap in the literature regarding alternatives for

preparing traditional soul food. Additionally, the information collected from this study

would inform future research as to what factors would need to be addressed in

interventions based on the information gathered from this research. I purposefully

selected obese AA women to participate in four focus group interviews who were able to

answer my research questions.

The first key finding from this study was that obese AA women were willing to

alter their preparation of traditional soul food to create a healthier soul food only if the

healthier soul food was tasty. Traditional soul food was considered a part of the AA

heritage which enhanced family values. Although obese AA women realized that

consuming traditional soul food caused unfavorable health conditions, the taste of

traditional soul food outweighed any unfavorable consequences. Obese AA women felt that soul food should be prepared and consumed so that family members could celebrate one another; bringing joy, smiles, and love to each other. However, obese AA women acknowledged that altering the preparation of traditional soul food was needed to improve their health and to reduce chronic illnesses.

The second key finding from this study was that any alterations of soul food preparation must taste good for obese AA women to adopt a healthier style of preparing soul food. I found that obese AA women did not know that preparing a healthy soul food was possible. Obese AA women need recipes and accessibility to low-cost ingredients to prepare healthy soul food. I discovered that obese AA women did not believe in wasting food; therefore, the altered soul food dishes must be appealing to their taste to avoid food waste.

The last key finding from this study was that obese AA women identified several barriers that would hinder their participation in an intervention designed to teach them how to alter the preparation of traditional soul food. I found that obese AA women felt that ignorance and laziness were two main obstacles to attending an intervention. Obese AA women must be motivated to change, understand the value of changing unhealthy eating behaviors, and make time to learn how to provide a healthy lifestyle for themselves and their families. Transportation to and from the intervention site was also an issue.

In Chapter 5, I will restate the purpose of this study, the rationale for conducting this study, and provide a summary of the key findings. Next, I will state my

interpretations of the findings, including how the findings will add to the knowledge base

in the field of social sciences and psychology. I will present the limitations of this study

and recommendations for further research studies. I will describe the implications for

positive social change and conclude with a summary which highlights the fundamental

nature of this study.

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Interpretation of the Findings

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I was able to collect data for this research study from participants who identified

their perceptions regarding altering traditional soul preparation and barriers to

participating in an intervention designed to alter how obese AA women consume and

prepare traditional soul food. Findings from this research study suggest that several

factors may influence obese AA women to alter soul food preparation and change their

eating habits. Additionally, the findings suggest barriers to consider when designing an

intervention to teach healthy soul food preparation. For a broader look, in Appendix K,

there is a chart that lists each research question, the themes under each research question,

and quotes from participants that validate the findings for each theme that emerged.

Findings from Research Question 1

The themes that emerged from the analysis to answer Research Question 1 were

taste, family values, and consequences, which included improved health and reducing

chronic illnesses. Participants from each focus group indicated that taste was an

important factor in determining whether they would consider altering the preparation of

soul food. I gathered that taste was important to participants and that preparing soul food

was a part of their family traditions and values. This confirms what Belle (2009) stated in

her study that AA women will always prepare and consume traditional soul food because

it tastes good and it is a part of the AA culture. The results of this study are aligned with Belle's (2009) and Beagan and Chapman's (2012) study results that AA women would not stop preparing and consuming traditional soul food due to hereditary concerns. Specifically, Beagan and Chapman (2012) noted that AA women felt that their heritage would be lost if they gave up traditional soul food.

The experiences that AA families gained from preparing and consuming soul food were regarded as family values to pass down from generation to generation. This is in line with the research from Broady and Meeks (2015) and Thompson (2015) which concluded that AA women pass down soul food recipes from generation to generation, which AA women prepare and consume regardless of socioeconomic status. Consuming soul food was only one part of the experience of family values; being together once or twice a year and family members sharing their recipes was part of the occasion. This study confirms Belle's (2009) study that AAs enjoy the flavor of traditional soul food, especially during gatherings with friends, family, and members of the community.

While many of the participants from each focus group were aware of the consequences of consuming traditional soul food and the chronic illnesses associated with consuming foods high in calories, fats, and sugars, participants appeared to associate their chronic illnesses such as hypertension, diabetes, and obesity as unrelated to eating traditional soul food. All participants felt that they were healthy and did not realize that a BMI of 30 and above was overweight or obese. While most AA females during the 1950s were large, their appearance was viewed as positive; indicating that AA women who were obese cooked good soul food dishes (Chen et al., 2012). As a result of this study,

obese AA women think that people with excess weight are healthy and small people are unhealthy. However, obese AA women know that consuming high caloric soul food is detrimental to their health, but if done in moderation, it is acceptable and not considered unhealthy.

Findings from Research Question 2

The themes that emerged from the analysis to answer Research Question 2 were factors for eating healthy such as tastes good, recipe availability, low cost for healthy ingredients, accessibility of the ingredients, substituting herbs and spices, and food waste. The results of this study confirmed the literature from Jurkowski et al. (2014) and Lee and Lien (2015) that the main factor that influences obese AA women to continue to prepare and consume traditional soul food is the taste. Obese AA women love and desire the rich taste of traditional soul food.

There was no research found that addressed the availability of healthy soul food recipes, but according to the research data in this study, if tasty recipes for healthy soul food were available, AA women would alter their recipes. In line with Belle (2009), this study found that obese AA women will always prepare and consume traditional soul food because it is inexpensive. It was bought out in this study that healthy foods were more expensive than unhealthy alternatives and easily accessible. The research from Lee and Lien (2015) found that the best way to reduce childhood obesity was to provide healthy alternatives such as fresh fruits and vegetables for snacks and prepare healthier meals using healthy ingredients. In this study, fresh fruits and vegetables and the ingredients used to prepare healthy soul food were noted as being higher in cost. This confirms Li et

al.'s (2015) study that, in many AA communities, fresh fruits and vegetables are hard to access or too expensive to purchase.

There was no research found that addressed substituting herbs and spices to replace unhealthy ingredients such as lard, shortening, sugars, salt, and fats. I also did not find previous studies that addressed issues of food waste. I thought it was interesting that in this study, participants were open to learning about substituting herbs and spices but were concerned about the accessibility and cost of them. However, they were not as open to trying new recipes that may not taste good. The food would be wasted (discarded) if no one would eat it due to unsavory taste; they stated that they could not afford to waste food like that. Lavelle et al. (2016) did confirm that participants viewed barriers to cooking using raw ingredients as time constraints, saving money, easy preparation, food choices, and fear of preparing the food inadequately.

Findings from Research Question 3

The themes that emerged from the analysis to answer Research Question 3 were the barriers for participation in an intervention such as ignorance and laziness, transportation issues, lack of motivation, education, and time, no incentives, and bad reviews. There was no research found on ignorance and laziness, lack of motivation, or bad reviews, but these factors were very prevalent in this study. During the focus group sessions, I found that obese AA women were not knowledgeable about the negative effects of consuming traditional soul food. It was stated that laziness was the reason why many AAs consume unhealthy foods; especially snacks. They felt that purchasing processed snacks and foods at a local grocery store or buying burgers from a fast food

eatery were more convenient and cost-effective than preparing snacks and foods using fresh fruits and vegetables.

From the research, I found many interventions that were conducted on healthy food consumption but none of them addressed incentives that would increase participation. However, Rodgers et al. (2016) used mobile technology (e.g., iPhone or Smartphone) to encourage healthy eating to reduce obesity. Although the results of their study were not favorable, Rodgers et al. (2016) acknowledged that using the technology was a creative way to enhance participation in healthy eating intervention, but more research needed to be done to increase adherence. As far as bad reviews are concerned, it was found in this study that people will not attend interventions if the site was unclean, unsafe, or the researcher and the staff were unpleasant.

The results of this study also confirm studies conducted by Jurkowski et al. (2014) and Lee and Lein (2015) that an environmental factor that hinders AA women from eating healthy is the lack of healthy foods within AA communities, as well as the cost of healthy foods. It was noted in the research that AA communities are more prone to having fewer grocery stores that provide a wide variety of fresh fruits and vegetables, whole grains, fresh fish and other seafood, and low-fat dairy products, and if healthier alternatives are available, they are considerably higher in cost and lower in quality (Bower et al., 2015; Broady & Meeks, 2015; Cozier et al., 2014; Nederkoorn, 2014).

This study also confirms that the AA population needs to be educated on substituting unhealthy ingredients with healthy alternatives, so they would understand the importance of changing the way they prepare and consume traditional soul food. Because

obese AA women are going to continue to prepare and consume traditional soul food, then it may be advantageous for them to be educated on how to prepare traditional soul food in a healthy manner to reduce obesity and unfavorable health conditions. The results of this study confirm the information from Lavelle et al.'s (2016) study that obese AA women need to learn how to cook in large quantities and freeze the products for later use. They also need instructions on how to prepare tasty soul food dishes in a healthy manner.

Other relevant ideas that were illuminated during this study were that obese AA women should be open to alternatives that would benefit them. They must be open to receive information that can change their lives and the lives of their families. When AAs make an informed decision to do better, they will be open to learn and do the things (such as going to cooking classes) that create positive social change in their communities. With today's technology, information can reach the multitudes with a touch of a button or click on the mouse. When people are diagnosed with health conditions such as high blood pressure, Type II diabetes, obesity, and heart diseases; they need to be honest with themselves and learn ways to alleviate their problems. If AAs are not preparing or consuming healthy foods, then they must realize that their mortality and morbidity are at risk and it is time to change.

Findings from the Theoretical Framework

I used the empowerment model and the HBM to frame this study based on evidence from the research needed to address altering the preparation and consumption of traditional soul food. Using the premise of the empowerment model and the HBM to guide this research study, I collected and analyzed data from obese AA women who

prepared and/or consumed high caloric soul food and resided on the Southside of Chicago, Illinois. Based on the findings from the literature, empowerment alone would not be sufficient to ensure a successful intervention; instead, there is a need to integrate both empowerment and health literacy in the intervention because one without the other would prove ineffective (Schulz, 2014; Schulz & Nakamoto, 2013; Shu-Fang et al., 2016; Sharif & Blake, 2010).

The empowerment model was appropriate to frame this study because, based on the information collected from this study, obese AA women were not knowledgeable and did not have access to the resources that would be needed to create change without community support to alter the way they prepare and consume traditional soul food to reduce obesity. According to Geller et al. (2015), the empowerment model is designed to help individuals make decisions about their health to enhance healthy behaviors, improve health status, and reduce health inequalities in their community. Amirrood et al. (2014) and Davison et al. (2013) found that the empowerment model was effective in helping participants to alter their unhealthy eating habits to reduce obesity and the key to ensuring women made healthy food choices for themselves and their family was to empower them to take an active part in their life. In this study, the empowerment model was effective in helping obese AA women to feel a sense of control, to have options to choose from, to have the ability to connect with others, and to have a sense of security. I observed that during all focus group sessions; there were on-going discussions among the members who helped participants to increase their health literacy; thus, empowering each other to want to do better.

Aligned with Geller et al. (2015) and Amirrood et al. (2014), it was evident in each focus group session that participants began to think about their obesity and the direct effects of consuming traditional soul food. Participants openly expressed their health issues and the health problems other members of their families were dealing with. The discussions enhanced their understanding of the research problem and motivated them to want to make informed decisions about their health to improve their health and reduce chronic illnesses in their families. In the first focus group, the discussion went on like this; Participant 3 stated:

> You can grow vegetables in your backyard. Eating healthy is a choice. I mean you can choose to, I have a new neighbor across the street, I mean she got so many vegetables right there [in her backyard] that it's ridiculous; it's a whole grocery store. So I think it's a matter of choice…. She works, but she still goes and get the seeds and put the seeds in the ground in her back yard and grow her greens [and other] vegetables. She even said that she was growing peas [and beans], I didn't even know you could grow [vegetables] in your back yard, like peas and string beans.

Participant 1 commented and asked, "What if you don't have a back yard? What if you live in the projects or something and couldn't afford the good soil to grow the vegetables?" Participant 6 suggested this:

> Ok, I got something to throw back at you, then you go to the city, ask them if they can donate one of those lots out there that's sitting up doing nothing, and get the

community to go in there and plant some vegetables and the [community] block

shares it.

Participant 3 stated, "You just have to find an option that is [going to] save your life,

keep you healthy and the only way to do that is through education" and Participant 6

added, "You [have to] be motivated to change; you [have to] want to change for the

better. Until then, everything will stay the same."

In the second focus group, the discussion went on like this; Participant 9 stated:

I think what would keep you away from wanting to change is fear. I keep saying

that because a lot of people are afraid of change…they're just afraid of change.

They're so use to the custom way of doing things…but instead of saying, let's

live in the now, [we need to] do the things that we have to do to help [ourselves]

along the way; empower ourselves, [empower] our parents, [empower] our

children, and empower our friends.

Participant 8 added:

 I think what the fear is, as far as the food is concerned, is the taste. They're afraid

of losing that taste. You know mom use to cook it this way, and if I change it, it's

not going to taste the same. Well, change is sometimes a good thing; the healthy

soul food may even taste better.

Participant 12 summed it up by saying, "Learning how to pass down [healthy soul food

recipes] to the next generation is very important. Educate the next generation and teach

them how to prepare [delicious, healthy] soul food."

In the third focus group, the discussion went on like this; Participant 19 stated:

And the biggest thing is about texture and taste. If the texture and the taste [are] there, most times, people will go for it. But if the texture isn't there, then the seasoning is bland, and no one is going to want it.

Participant 15 responded by saying:

Well, unless you were raised eating like that. Like my daughter just had a baby, so he's going to be a vegetarian until he's three years old. But if you're not raised like that, now you [have to] wait on somebody else to teach you that. When you know better; you do better. Things progress, so how you may not have eaten, you teach your children how to do better.

Participant 16 remarked:

We, as a parent, have to be educated. If your parents are not educated, then you'll have to educate your parents on what you're not going to allow your children to do and eat. Show them how you cook your soul food healthy for your children.

In the fourth focus group, the discussion went on like this; Participant 24 stated, "I feel like [the younger] generations should start cooking healthy, like now, so that future generations wouldn't use some of the same bad habits that their ancestors did with their cooking." Participant 21 added, "I like my food to taste good, to have the seasonings in the food." Participant 20 explained:

Well, I feel like learning more about herbs, [because] it's a lot of herbs out there that people are ignorant about; they don't know about them, or what the benefits of certain herbs are. So I would try to educate myself on different herbs and add it to my [cooking]. Where would people get these herbs? How available are [these

herbs] to the people in our communities? I have never seen any herbs at the corner

market. Not even fresh vegetables.

Participant 22 responded by saying:

True, but you could bake your food, broil it, or grill it. You don't have to use

regular salt, sugar, lard, and all that [unhealthy stuff]. You could use the herbs to

put on there and it will make it taste good. You just need to know what herds to

use and how much to use to get the desired taste.

Participant 25 added, "So, we have to change our mindset." Participant 24 agreed by

saying, "If we don't, we'll have health issues eating high-fat soul food…like heart

problems." Participant 20 added, "I say clogged arteries." Participant 23 added, "And

high cholesterol." Participant 22 agreed and said, "You are right; you are [going to] be

sick." Participant 25 added, "Again, we have to change our mindset for better health and

less sickness." Therefore, the results of the focus group sessions in this study were very

similar to those of other researchers; participants empowered each other, coming up with

ways that they could prepare soul food in a healthy manner (Amirrood et al., 2014;

Davison et al., 2013; Geller et al., 2015). Additionally, participants expressed how they

could empower their parents and their children for generations to come.

The HBM was selected to frame this study because of the constructs of the HBM.

There was no research found which specifically addressed the perceptions of AA women

to gather useful information that can be used to develop interventions to help AA women

alter the way they prepare and consume traditional soul food. However, several studies

were conducted using the HBM (James et al., 2012; Kim & Zane, 2016; Rahmati-Najarkolaei et al., 2015).

James et al. (2012) used the HBM to find that participants believed that they were obese because of their culture and genetics and not the foods they ate. However, participants realized that if they lost weight, they would have a healthier life, eliminate health-risks, and enhance their physical appearance (James et al., 2012). Additionally, participants needed motivation, adequate information on dieting, and community support (James et al., 2012). Similar to James et al.'s (2012) study results, during the focus group sessions in this study, participants made comments, talked about their experiences, and shared their beliefs and knowledge on obesity and their love for traditional soul food. James et al. (2012) used the information collected from the focus groups to design and execute interventions to address their research issues which coincided with my plans of developing interventions to address obesity as a result of consuming traditional soul food. In line with James et al. (2012), I will develop themes from the HBM components to construct a healthy soul food intervention. The HBM will be used to shed light on why participants decided to alter the way they prepare and consume traditional soul food for better health.

Kim and Zane (2016) and Rahmati-Najarkolaei et al. (2015) found that the HBM was effective in predicting how individuals react to their perceptions; if individuals perceived negative consequences as a result of their actions, they would be willing to change their behaviors. Additionally, if participants resided in communities which promoted proactive health care, participants would be more likely to change unhealthy

behaviors. The findings from this study were consistent with those of Kim and Zane (2016) and Rahmati-Najarkolaei et al. (2015). For obese AA women to alter the way they prepare and consume traditional soul food, they must perceive that eating unhealthy soul food contributes to their mortality and decreases their quality of life (Glanz et al., 2008).

During the focus group discussions, all participants perceived the benefits, barriers, and self-efficacy of preparing and consuming healthy soul food. Since these obese AA women perceived that eating the traditional soul food had a direct impact on their health, if they altered the way they prepared and consumed soul food, it would improve their health and reduce chronic illnesses. Participants realized that barriers would have to be removed to alter the way traditional soul food is prepared. Participants must have accessibility to affordable foods that can be prepared in a healthier manner while maintaining its taste. Finally, participants believed in their ability to successfully alter their soul food preparation in a healthier manner; thus, increasing their self-efficacy (Becker et al., 1977; Clemow, 2004; Glanz et al., 2008). However, they expressed that they would need recipes and other resources to teach them how to alter their soul food preparation to ensure good taste.

Limitations of the Study

I had to address some of the limitations that were listed in Chapter 1 while conducting this study. One limitation was that all participants might not have the same level of concern for eating healthy as others which could introduce controversy among the participants. Initially, participants did not have the same level of concern regarding healthy eating behaviors as others; however, this did not cause controversy among the

participants. Although participants shared different views concerning the preparation and consumption of traditional soul food, they expressed their thoughts openly so that barriers to altering the way obese AA women prepare and consume high caloric soul food could be identified.

Another limitation of this study was prospective participants needed to be recruited culturally, sensitively, and privately (Chang et al., 2017; Sharp, Fitzgibbon, & Schiffer, 2008). Sharp, Fitzgibbon, and Schiffer (2008) conducted active recruitment of obese AA participants. Their recruitment process was conducted by the researchers who ventured out into the community, giving flyers to women who appeared to meet the inclusion criteria (AA, overweight, and over 18 years old), and they explained the study, the purpose of the study, and the confidentiality of the study to prospective participants. To alleviate this limitation in this study, I spent about two hours at each location handing out flyers to prospective participants; explaining the purpose of the research study in a sensitive manner including the confidentiality of the study. I was culturally sensitive, empathic, and excited when explaining the research study to prospective participants I changed the location for recruitment and placement of flyers to include locations which were more private and serviced predominately AA women on the Southside of Chicago.

There are biases that existed in this study which could alter the results of this study's findings such as (a) moderator bias, (b) sensitivity bias, (c) social acceptability bias, (d) mood bias, (e) dominant respondent bias, and (f) consistency bias (Doody et al., 2013; Drury et al., 2014; Gill et al., 2008; Nagle & Williams, n.d.; Pannucci & Wilkins, 2010). In this study, there were no moderator or sensitivity biases during the focus group

interview sessions. I was cognizant of eliminating these two biases by establishing

rapport with each participant and ensuring that participants were comfortable in the focus

group setting. As recommended by researchers, I refrained from making a negative facial

expression or negative gestures during interview sessions (Drury et al., 2014; Gill et al.,

2008; Nagle & Williams, n.d.; Pannucci & Wilkins, 2010). Additionally, I always spoke

clearly to participants, allowing them to be open and honest while discussing their

opinions and perceptions. Within every focus group interview session, there was one

participant who tended to dominate the group discussion. This is referred to as dominant

respondent bias. When this occurred, I invited other participants in the focus group

interview session to share their thoughts and feelings. At times, participants would

respond to questions similar to other participants. When these incidents occurred, I used

probes to illicit a true response from the participant. For example, when a participant

repeated the same response as another participant, I probed the participant by saying,

"OK, your opinions are important, please explain more." There was no evidence of

sensitivity bias, social acceptability bias, or mood bias observed during focus group

sessions.

Implications for Positive Social Change

Despite the growing concerns of obesity-related illnesses affecting four out of five

obese AA women in the United States, obesity continues to increase at an alarming rate

(CDC, 2017). The goal of this study is to empower obese AA women to try something

new and learn to work collectively with their peers to create social change. Additionally,

the results of this study will educate the community, clinicians, healthcare providers, and

other researchers with alternatives to address the obesity epidemic in a culturally sensitive manner among the AA population. For example, findings from this study and previous studies implicated that AA women viewed obesity as normal and a part of their genetic make-up (Agyemang & Powell-Wiley, 2013; James et al., 2012; McCormack & Grant, 2013; Ng, 2015). To eradicate this disease, all constituents must work collaboratively to provide health fair interventions, educational and cooking workshops, health literature, and hands-on taste test within AA communities for adults and children. The findings from this study may create positive social change by equipping healthcare professionals, community leaders, and other researchers on how to address obesity in a culturally sensitive manner within the AA communities. In the next section, I have outlined my recommendations.

Recommendations

I plan to use the findings from this qualitative descriptive study to develop interventions and programs to reduce the obesity epidemic among the AA population. I will share these findings with the general AA population, clinicians and healthcare providers, and policymakers. Based on the findings of this study, I am making five recommendations for action: (a) for researchers to incorporate healthy soul food interventions in AA communities, (b) for researchers to include empowerment in interventions to increase knowledge and health literacy, (c) for clinicians, healthcare providers, and other researchers to inform the AA population on alternative ways to prepare traditional soul food as a means to reduce chronic illnesses and lower obesity rates among the AA population, (d) for policy makers (such as community leaders, state,

and city officials) to officiate policies to regulate the accessibility and cost of healthy

foods in corner markets and eateries within inner city communities, and (e) for other

researchers to examine the effectiveness of healthy soul food interventions as

recommendations for practice.

Incorporating Healthy Soul Food Interventions in AA Communities

The general AA population would benefit from a cooking program which will

allow them to taste soul food prepared in a healthy manner. This is in line with Riley et

al. (2016) and Shin et al. (2015) which concluded that taste testing of healthy foods was

important. Belle (2009) stated that AA women will always prepare and consume

traditional soul food because it tastes good. The findings from this research contrasted

with Belle's (2009) study results. I found that if AA women were able to taste a healthy

soul food dish after it was altered, and it tastes good, they would be willing to alter their

preparation of soul food. Shin et al. (2015) conducted a multi-level healthy eating

intervention in Maryland to increase participants' choice of healthy foods through

advertisement, promotion, and taste testing of healthy foods by store owners.

Additionally, from this study, I found that interventions must provide incentives for

participants such as free transportation, free food with handouts such as healthy soul food

recipes, videos demonstrating the preparation of healthy soul food, and samples of herbs

and spices that participants can use to prepare the altered soul food. Therefore, I plan to

incorporate healthy soul food interventions at community centers in AA communities

which would include discussions on the consequences of eating traditional soul food,

healthy eating, and interactive cooking workshops and encourage other researchers to do

the same. In collaboration with owners of community grocery stores and corner markets in AA communities, I will provide taste-testing of healthy soul food to community members to further encourage them to alter the way they prepare traditional soul food. I will ensure that the healthy ingredients that were needed to prepare sample dishes will be made accessible to consumers in the community at affordable cost.

Including Empowerment and HBM in Interventions

Several researchers used the empowerment model to increase knowledge, improve self-efficacy, decrease unhealthy thoughts, and enhance self-esteem about healthy eating habits of the participants (Amirrood et al., 2014; Davison et al., 2013; Jurkowski et al., 2014). Amirrood et al. (2014) found that the empowerment intervention was effective in empowering 89% of the participants to alter their unhealthy eating habits to reduce obesity and concluded that the key was to empower women to take an active part in ensuring good health for themselves and their families. Davison et al. (2013) and Jurkowski et al. (2014) concluded that interventions that incorporate empowerment which empowers parents to help design and implement the interventions would enhance self-efficacy and promote healthier eating habits for children because they are the ones who prepare food for their children.

Likewise, several researchers used the HBM to help participants understand the consequences of consuming the traditional soul food so that they would be motivated to change unhealthy behaviors (Becker et al., 1977; Boston University School of Public Health, 2016; Clemow, 2004; Glanz et al., 2008; Sapp & Weng, 2007; Schulz, 2014; Schulz & Nakamoto, 2013; Shu-Fang et al., 2016; Sharif & Blake, 2010; Wood & Neal,

2007). Findings from this study confirmed that when participants perceived that eating unhealthy soul food contributes to their mortality and decreases their quality of life, they would be willing to change their unhealthy behaviors. The findings of James et al. (2012), Phillip (2014), Sui et al. (2013) and Rahmati-Najarkolaei et al. (2015) were also consistent with the findings in this study in that the HBM was effective in predicting how individuals react to their perceptions. Amirrood et al. (2014) posited that family empowerment training should consist of several educational classes to enhance health within the family. Therefore, I plan to include family empowerment in the interventions to increase knowledge so that AA women would be empowered to change unhealthy behaviors. Once participants are empowered and perceive the consequences of consuming traditional soul food, they would be more willing to alter their soul food preparation for themselves and their families.

Several researchers found that both (the empowerment model and the HBM) were needed to create change (Schultz, 2014; Schulz & Nakamoto, 2013; Shu-Fang et al., 2016; Sharif & Blake, 2010). Therefore, I will also include the constructs of the HBM in the interventions. My goal is to work with AA women to eliminate faulty beliefs and barriers regarding altering soul food preparation and consumption. I plan to promote health education and enhance self-efficacy by focusing on participants' engagement in healthy behaviors. Again, participants will need motivation, recipes for healthy soul food preparation, adequate information on healthy soul food preparation, and community support to change unhealthy behaviors. As reported by James et al. (2012), the HBM

would help to illuminate the reasons why participants decided to adopt and maintain healthy soul food preparation for better health.

Provisions from Clinicians, Healthcare Providers, and other Researchers

Clinicians and healthcare providers must provide medical or therapeutic services to the AA population to inform their clients on alternative ways to prepare traditional soul food as a means to reduce chronic illnesses and lower obesity rates among the AA population. Clinicians and healthcare providers, as well as other researchers, must help to increase health literacy and education of AAs. Additionally, other researchers need to conduct further research incorporating interventions using the findings from this study to reduce obesity, improve health, and reduce chronic illnesses among the AA population. Any interventions should integrate the empowerment model and the HBM to motivate AA women to advocate for needed change in their communities. The empowerment model would help to empower community members to help design and implement healthy soul food interventions throughout US cities to improve health and reduce chronic illnesses.

Provisions from Policy Makers

Policy makers (such as community leaders, state, and city officials) should incorporate policies that (a) provide fresh fruits, vegetables, and herbs in communities such as community gardens, (b) ensure city parks and recreation centers are safe for exercising or physical activities, and (c) regulate the accessibility and cost of healthy foods in corner markets and eateries within inner city communities. Researchers have found that the best way to reduce childhood obesity was to limit children's consumption

of fast foods, and provide healthy alternatives such as fresh fruits and vegetables for

snacks, and prepare healthier meals using healthy ingredients (Bower et al., 2015; Broady

& Meeks, 2015; Cozier et al., 2014; Jurkowski et al., 2014; Laxy et al., 2015; Lee &

Lein, 2015; Nederkoorn, 2014; Oexle et al., 2015; Resnicow et al., 2004; Schmied et al.,

2015). Empowered community members would have the support they need to advocate

for needed change. A collaborative effort among community members, policy makers,

owners of food providers, researchers, and clinicians and health care providers would

successfully promote positive social change within the AA communities to tackle the

obesity epidemic.

Recommendations for Practice

Because there was no research found regarding healthy soul food interventions to

help AA women alter the way they prepare and consume traditional soul food, my last

recommendation is that further studies need to be conducted to examine the effectiveness

of healthy soul food interventions within other AA communities. Research should be

extended to include different geographic areas throughout the US and abroad because the

obesity epidemic is a global problem. Also, different racial and ethnic groups of different

socioeconomic levels who prepare and consume traditional soul food should be

examined. Overall, I believe that individuals would be willing to change the way they

prepare traditional soul food if it tastes good.

<center>**Summary and Conclusion**</center>

Obesity continues to be a growing concern throughout the entire world affecting

all racial and ethnic groups, with AA women having the highest prevalence of obesity

globally (AMA, 2013). This research study was conducted so that I could gather useful information from obese AA women who were knowledgeable to provide relevant suggestions that will allow me and other researchers to develop interventions to address the mortality and morbidity rates among the AA population as a result of consuming traditional soul food. The perceptions of obese AA women regarding altering traditional soul food preparation were taste, family values, and consequences. Participants perceived that to maintain new healthier eating behaviors for themselves and their family were tastes good, availability of recipes to use, low cost of healthy ingredients, accessibility of the ingredients, learning how to substitute various herbs and spices, and food waste. Barriers identified by obese AA women that could limit participation in an intervention designed to develop healthier eating habits were ignorance and laziness, transportation issues, lack of motivation, lack of education, lack of time, no incentives, and bad reviews.

The AA women who prepare and consume traditional soul food do not know how to prepare soul food in any other way except the way they were taught by their parents and grandparents. According to the perceptions and beliefs of obese AA women, if traditional soul food can be prepared in a healthy manner and it tastes good, they would be willing to alter the way they prepare traditional soul food. The obese AA women in this study believed that if they prepared soul food in a healthy manner, they would experience improved health and reduced chronic illnesses associated with eating foods high in calories, fats, and sugars.

To be an agent of societal change would mean that I have a responsibility to share my research findings (utilizing scientific information) to support my ideas and beliefs.

The results from this study can be disseminated among Hispanics, non-Hispanic Blacks, and non-Hispanic Whites to inform the community at large how they can address obesity among all populations who prepare and consume high caloric soul food. I plan to summarize the findings from this study and submit them for publication to the Journal of Healthy Psychology; the Journal of Women's Health, Issues, and Care; the Journal of Social Change upon graduation. I also plan to present the findings of this study at the Women's Veterans Administration Clinic and the Illinois Counseling Association Conference in 2019.

My goal is to help eliminate health disparities among the AA population utilizing cultural specific interventions to decrease mortality and morbidity among this population. One way to do this is by teaching AA women to prepare healthy soul food. The healthy soul food intervention will be interactive where AA women would physically prepare and taste healthy soul food dishes. Healthy soul food recipes and samples of herbs and spices would be given to participants along with flyers explaining how to access healthy soul food ingredients. To further advocate and campaign for positive social change, I will meet with community leaders, social service agencies, healthcare providers, and clinicians to create community initiatives and community support systems to collectively eradicate the obesity epidemic.

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Appendix A: Recruitment Flyer

Volunteers are Needed

African American women over the age of 18 years old with a BMI over 30 who cook or consume traditional soul food.

Do you struggle with healthy eating, excessive weight, and or lack of physical activity?

Do you enjoy working with others to make a difference in your Community?

If so, then I need you to volunteer to participate in a group interview regarding exploring ways in which traditional soul food can be prepared in a healthy manner!!!

If you are interested, Contact:

to see if you qualify to participate in this group interview.

No special training, education, or experience needed; flexible times and dates.

Volunteer today and inspire for a lifetime!
(Refreshments provided and Uber transportation included)

Appendix B: Recruitment Announcement

Hello,

My name is Patricia Young and I am a doctoral candidate at Walden University. I would like to invite you to participate in a **Focus Group** interview about ways of preparing traditional soul food in a healthy manner. The group interview should last approximately two hours.

The group interview will provide you an opportunity to:

- Share with other African American women who prepare and consume traditional soul food.
- Make a contribution to your community by taking part in a group interview which may change the way traditional soul food is prepared, and
- Give a voice that will be heard.

If you would like to participate in this focus group interview and meet other African American women for an evening of fun and making a positive impact within your community, please see me, Patricia Young, in the _designated area_ for more information immediately after service.

Thank you.

Appendix C: Pre-Screening Eligibility Questionnaire (PEQ)

(For researcher's use only)

Date of Application: _____

How did you hear about the focus group?: _____

_____

_____

_____

Demographic Information:

Age: _____   **Race:** _____   **Gender:** _____

Height: _____   **Weight:** _____   **BMI:** _____

Questions:

Do you prepare traditional soul food?   Yes   No

　　　How often? _____

Do you consume traditional soul food?   Yes   No

　　　How often? _____

Do you reside on the Southside of Chicago, Illinois?   Yes   No

　　　Address: _____

　　　Phone Number: _____

Name of Participant: _____

Appendix D: Confirmation Letter for Focus Group Participants

Date

Dear _____,

I enjoyed our phone conversation. Thank you for taking an interest in my research study and agreeing to participate. Your opinions and ideas regarding altering the preparation of traditional soul food will be valuable information for my study. Your responses to the questions that will be asked during the focus group interview will be appreciated and your name will be kept anonymous. Transportation will be provided to you to and from the focus group interview. Refreshments will also be provided.

Date of Focus Group Session:

Time of Focus Group Session:

Location of Focus Group Session: San Justin's Kitchen
157 W 75th St, Chicago, IL 60620

If something comes up that keeps you from attending the focus group interview, please call me at xxx-xxx-xxxx.

Sincerely,

Appendix E: Focus Group Protocol

Date:	Focus Group Number:
Time:	Number of Participants Present:

Instructions for interview:
Arrive early and set up room for focus group.
- *Set up table for refreshments.*

- *Arrange chairs and put out consent forms.*

- *Set up flip chart and markers. Have masking tape to post on wall.*

- *Lay out name tags.*

- *Make sure both tape recorders are plugged in, tapes inserted, and ready to record.*

- *Greet participants as they arrive and have them to fill out their name tags and help themselves to refreshments.*

- *After 30 minutes, close the doors and start with opening session.*

Say: Hello, my name is Patricia Young. I am a Doctoral candidate at Walden University, working on my dissertation. How is everyone? Did you enjoy the refreshments? Is everyone comfortable and relaxed? The weather is _____ today. I want to welcome each of you and I am excited about our discussion.

Let's start by reviewing the informed consent form that you have in front of you. I have provided you a copy of the consent form so that you can follow along with me and so that you will have a copy to keep for your records.

When everyone has the consent form, begin

Say: My plans are to develop interventions that would help African American women change the way they prepare and consume traditional soul food (cooking vegetables with bacon, ham hocks, salt pork, fat back, pig tails, etc.; frying foods such as chicken, okra, fish, French fries; and sugar sweetened beverages such as sodas, cool aid, tea). I need to gather information from you that will help me and other researchers to design workshops that will be effective in changing the way traditional soul food is prepared to a healthier soul food. Your thoughts and ideas will be useful to me in developing interventions that

will appeal to AA women in an effort to reduce obesity and obesity-related illnesses. This interview will last no longer than 90 minutes. The interview will be tape recorded to ensure accuracy of the information that you give me during the interview.

Say: The risk and discomforts that may be involved when taking part in the group interview are: (a) disagreements or embarrassment among group members may occur, (b) other group members may repeat what was stated in the group interview, (c) participants may be uncomfortable answering questions in the group environment, and (d) participants may feel coerced to participate due to group dynamics. The benefits that are associated with the study are that: (a) you will have the opportunity to voice your opinions regarding altering the way you prepare and consume traditional soul food; (b) you will help me to identify barriers to altering the preparation and consumption of traditional soul food; and (c) and you may enjoy the socialization with your peers from your community. This research may help me and other researchers to understand the benefits of consuming healthier soul foods to reduce obesity within the African American population.

Say: I will do everything that I can to protect your privacy. Your identity will not be revealed in any publication resulting from this research. Your group will be assigned an identification number which will be used to report the results of this study to protect the identity of group members. After all information is analyzed, all information about your group will be shredded. All other data (non-identified data) will be collected, properly stored on a portable flash drive, and placed in a locked filing cabinet in my home office. The collected data will be analyzed accurately and the results will be used to answer the research questions. You will be sent a summary of this group interview approximately 10-14 days after this meeting by email or postal mail. Once you review the summary, you may want to add additional information. You can do so at this time by calling me or emailing me.

Say: I want to remind you that this group interview will be audio-taped as indicated in the informed consent form. Are there any questions? *Answer any questions asked.*

Say: Your participation in this study is strictly voluntary and you may leave at any time with no consequences. You have agreed to participate because you have signed an informed consent form and returned it to me. You will keep the copy of the consent form that you have for your records.

Say: I am going to ask a few questions and you are encouraged to answer each question by sharing your ideas and thoughts openly and honestly. Before we begin, let's go over some rules that must be followed while participating in this interview. The rules are as follows:

- After questions are asked, group member will have the opportunity to voice their thoughts and I will record notes for clarification of statements that are made.

- Main points will be posted on the chart to help with the flow of the interview.
- There are no right and wrong answers, just different viewpoints.
- You must listen to one another and respect the opinions of others, even if you do not agree with their point of view.
- Please be respectful to one another.
- Only one person speaks at a time.

Are you ready to begin?

If so, turn on tape recorders and begin.

Focus Group Questions and Probes:

Opening Questions:

A. What is the first thing that comes to mind when I say, soul food preparation?
  Potential Probe: *Explain what you mean?

B. What is the first thing that comes to mind when I say, healthy soul food preparation?
  Potential Probe: *Explain that further.

C. How would you describe your preparation of soul food?

  Potential Probes: *How often do you cook this way?

  *Who eats this soul food that you prepare?

Interview Questions:

IQ1: What are your perceptions towards eating foods which are high in fat, sugar, and calories?

  Potential Probes: *How much do you enjoy eating these foods?

  *Why do you enjoy eating these foods?

  *Based on what I heard from the group, I wrote down

  _____. Did I miss anything?

IQ2: What positive aspects of soul food do you value?

  Potential Probes: *Could you explain further?

  * I heard someone say _____ and I also heard
    someone say _____. Does anyone want to add
    anything else on that topic?

IQ3: What issues do you perceive would result from eating foods which are fried and contains high levels of fats and drinking sweetened beverages?

> *Potential Probes:* * Could you explain further?
> * I heard someone say _____ and I also heard someone say _____. Does anyone want to add anything else on that topic?

IQ4: What do you perceive would keep you from learning how to prepare soul food which is healthy?
> *Potential Probe:* *What are the chances of you attending workshops that teach you how to prepare healthy soul food?
> *What would be some of the barriers which will prevent you from attending a workshop to prepare healthy soul food?

IQ5: What do you perceive would be the benefits of preparing soul food in a healthy manner?

> *Potential Probe:* *Explain that further.
> *Okay. Does anyone want to add anything else?

IQ6: If someone taught you how to prepare healthy soul food, what would keep you from adopting this style of cooking?

> *Potential Probe:* *What other factors would keep you from cooking healthy soul food?
> *Let me clarify what has been said…………………Am I correct?
> *Are there any other suggestions?

IQ7: What else would you like to share with the group regarding adopting and sustaining the practice of preparing healthy soul food?

> *Potential Probes:* *What factors would help you to cook healthy soul food?
> *Why do you feel this way?
> *This what I heard. _____. I also heard _____. Is this correct?
> *This was our last question. Is there anything else that anyone would like to share on that?

Debriefing
Say: This is the end of the interview. Thank you so much for participating in the study and have a great day. *Turn off tape recorders, unplug them, and remove tapes. Gather all materials and clean up the research site.*

Protocol was adapted from the protocol suggested by Creswell (2015).

Appendix F: Research and Focus Group Questions

Focus Group Question #s	Focus Group Questions	Research Questions that the Focus Group Questions Address	Source of Each Questions
1	What are your perceptions towards eating foods which are high in fat, sugar, and calories?	What are the perceptions of obese AA women regarding altering traditional soul food preparation?	Phillips et al., 2016; Virudachalam et al., 2016
2	What do you perceive would be the physical changes from eating foods which are fried and contains high levels of fats and drinking sweetened beverages?	What are the perceptions of obese AA women regarding altering traditional soul food preparation?	Phillips et al. (2016) Virudachalam et al. (2016)
3	What do you perceive would be the emotional changes from eating foods which are fried and contains high levels of fats and drinking sweetened beverages?	What are the perceptions of obese AA women regarding altering traditional soul food preparation?	Phillips et al. (2016) Virudachalam et al. (2016)
4	What do you perceive would keep you from learning how to prepare soul food which is healthy?	What barriers could limit participation in an intervention designed to develop healthier eating habits for obese AA women?	Researcher Generated Question
5	What do you perceive would be the benefits of preparing soul food in a healthy manner?	What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?	Faber & Dube (2015) Cozier et al. (2014) Jurkowski et al. (2014)
6	If someone taught you how to prepare healthy soul food, what would keep you from adopting this style of cooking?	What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?	Lanigan (2012) Nederkoorn (2014) Reyes, Peirano, Peigneux, Lozoff, & Algarin (2015)
7	What else would you like to share with the group regarding adopting and sustaining the practice of preparing healthy soul food?	What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?	Lee & Lien (2015) Nickelson et al. (2014)

Appendix G: Focus Group Guidelines

This focus group will be conducted in phases:

PHASE 1: BEFORE THE FOCUS GROUP

1. Fill out a focus group interview guide questionnaire to guide the group discussion interview in an effort to gain information to answer the research questions.
Each question is asked and probes should be used to provide in-depth responses when needed. Ensure that participants remain on topic and be respectful towards one another.

2. Determine how many focus groups you want to run
   a. Multiple focus groups will enable the researcher to compare and identify themes which emerge from each discussion.
   b. Focus groups should run between 60 and 90 minutes.

3. Identify your participants
   a. Determine how many participants you want in each group. Each focus group should have between six and ten participants. Fewer than six participants may limit the conversation and yield poor data while more than ten can be unwieldy.
   b. Develop a list of key attributes to seek in participants based on the purpose you have identified.
   c. Secure names and contact information and send invitations.

4. Generate your questions

   a. Based on the purpose and goals of the focus group, identify no more than five questions.
   b. Revisit the questions to make sure that they will yield the kind of information you are seeking.
   c. Order the questions from general to specific.

5. Develop your script

   a. Part one: welcome participants, explain purpose and context, explain what a focus group is, and make introductions. Explain that the information is confidential, and no names will be used in the final analysis. You will either have a note-taker or record the proceedings.

   b. Part two: ask your interview questions; remember to use probes and follow up questions to explore the key concepts more deeply.

c. Part three: close the focus group – thank participants, give them contact information for further follow up if requested, explain how you will analyze and share the data.

6. Select a facilitator

a. The facilitator should not be someone who directly oversees the issue or topical area you are exploring. This may make participants less open to sharing their thoughts or concerns.
b. The facilitator should be knowledgeable about the topic at hand and can be a grad student or staff member from the same department.
c. The facilitator should be able to keep the discussion going, deal tactfully with difficult or outspoken group members, and make sure all participants are heard.
d. The facilitator should ask the questions and probes, but not participate in the dialogue or correct participants.

7. Choose the location
a. Choose a location which is comfortable, easily accessible, and where participants can see one another.
b. Choose a setting which does not bias the information gathered.
c. Consider providing food or snacks.

PHASE 2: CONDUCT THE FOCUS GROUP

1. Bring materials:
a. Notebook/computer or tape recorder to record proceedings
b. Flip chart paper if no board is available
c. Focus group list of participants
d. Focus group script
e. Name tags
f. Watch or clock

2. Arrive before the participants to set up room, refreshments, etc.

3. Introduce yourself and the note-taker (if applicable) and carry on the focus group according to the script.

4. Conduct the session, being mindful of the following:
a. Set a positive tone.
b. Make sure everyone is heard; draw out quieter group members.
c. Probe for more complete answers.

d. Monitor your questions and the time closely – it is your job to make sure you are on track.

e. Don't argue a point with a participant, even if they are wrong. Address it later if you must.

f. Thank participants and tell them what your next steps are with the information.

PHASE 3: INTERPRETING AND REPORTING THE RESULTS

1. Summarize each meeting

a. Immediately after the meeting, the facilitator should write up a quick summary of his/her impressions.

b. Transcribe the notes or audio recording of the focus group. This should be done as soon as possible after the focus group has been conducted.

2. Analyze the summaries

a. Read the notes and look for themes/trends. Write down any themes which occur more than once.

b. Context and tone are just as important as words. If comments are phrased negatively or triggered an emotional response, this should be noted in the analysis.

c. Interpret the results

d. What are the major findings?
    1. What recommendations might you have?

3. Write the report

a. Your report should include your purpose, outcomes, process, findings, and recommendations.

4. Make adjustments/take action on what you learned

a. Schedule a meeting to discuss the implications.

b. Highlight the main themes, issues, or problems that arose in the focus groups. Discuss how you will address these.

c. Prioritize the results and make action plans for the most important priorities.

Appendix H: Protocols for Recruiting Participants

Telephone Responses from Flyers

I will place flyers throughout the AA communities on the Southside of Chicago. Volunteers who respond to the flyers will contact me by phone. Here is my telephone protocol that will be used to recruit participants:

Hello, my name is Patricia Young and I am a doctoral candidate at Walden University. First, I would like to know how you found out about the focus group interview. I will be conducting a research study for my dissertation and I would like to get ideas from African American women (18 years old or older) who prepare and consume traditional soul food. Your ideas will help me to design interventions or strategies to help African American women to change the way they prepare and consume traditional soul food to a healthier soul food to reduce obesity and obesity-related diseases. To take part in this study, I must secure a consent form from you indicating that you would like to participate in this research study. If you are interested in participating in this research study, I would like your name and address so that I can send you a consent form describing the details of my research study along with a self-addressed, stamped envelope for you to use to return the form to me. Once you receive the consent form, please feel free to call me or email me regarding any questions or concerns, I will gladly answer your questions. If you still want to participate in this study after reviewing the consent form, please sign the form and return it to me in the envelope that will be provided. Once I receive your signed consent form, I will call you to gather information to determine if you qualify to participate in the study which should take approximately 15

to 20 minutes. I am requesting that you mail the form back to me whether you sign it or

not. Thank you very much.

Name: _____

Mailing Address: _____

_____

Face-to-Face Responses from the Churches

Interested individuals will meet with me in the designated area at the church. This will be my church recruitment protocol:

Hello again, my name is Patricia Young and I am a doctoral candidate at Walden University. I will be conducting a research study for my dissertation and I would like to get ideas from African American women who are 18 years old and older who prepare and consume traditional soul food. Your ideas will help me and other researchers to design interventions or strategies to help African American women to change the way they prepare and consume traditional soul food to a healthier soul food to reduce obesity and obesity-related diseases. To take part in this study, I must secure a consent form from you indicating that you would like to participate in this research study. (*I will pass out consent forms to each interested individual*). If you would like to participate in my research study and contribute to making a difference within your community, please read over this consent form. If you decide to participate in my research study, here is a self-addressed, stamped envelope to return the signed consent form. I am requesting that you mail the form back to me whether you sign it or not. If you decide to participate in my research study, and you have questions or concerns regarding your participation, please feel free to contact me by phone, text, or email and I will be happy to answer any of your questions. Thank you for taking an interest in my study.

Follow-up Call for Recruitment

Once I receive signed consent forms from prospective participants, I will call the volunteer and say:

Hello _____. I have received your signed consent form. Do you have

about 5 minutes? Do you have any questions regarding this study before we get started?

At this time, I would like to ask you a few questions to see if you qualify to

participate in this research study. How did you hear about the focus group interview?

_____

_____

What is your **Age**?_____ **Race**? _____ **Gender**?_____

Height: _____ **Weight**: _____ **BMI:** _____

Do you **prepare** traditional soul food?   Yes   No

How often? _____

Do you **consume** traditional soul food?   Yes   No

How often? _____

Do you **reside** on the Southside of Chicago, Illinois?   Yes   No

***If she does <u>not</u> qualify, say*:**

You did not meet the criteria to participate in this study because (*explain the criteria that she did not meet*). For example, if the perspective participant does not reside on the south side of Chicago, I will explain to her that all participants must reside on the south side of Chicago because the research site is conveniently located on the Southside of Chicago).

***If she qualifies, say*:**

Ms _____ you met the criteria to participate in this research study.

Again I would like to inform you that your participation will be strictly voluntary and at any time you may leave the group interview or simply just quit, no explanations are needed. In other words, you may leave at any time during the interview and it is okay. Now I would like to expound on my role as the researcher and the risks and benefits to you participating in a focus group interview.

My role as a researcher is to ensure that you are comfortable, to ensure that your identity is not revealed, to ensure that your group interview site is safe and secure, and to ensure you arrive at the focus group location safe. Uber transportation will be provided, if needed. As stated in the consent form, there are risks and discomforts involved when taking part in the group interviews which are:

- Disagreements or embarrassment among group members may occur,
- Other group members may repeat what was stated in the group interview,
- You may be uncomfortable answering questions in the group environment, and
- You may feel coerced to participate due to group dynamics.

There are benefits if you take part in this study. You will receive these benefits:

- Your ideas will be heard,
- you may have fun talking with other women in your community, and
- you may begin to understand why it is important to change the way you cook soul food.

As for your role as a participant in this research study, you must agree to attend one group interview what will last about 2 hours at San Justin's Kitchen located at 157 West 75th Street on the Southside of Chicago. You must agree to have the group interview tape recorded to make sure I get the information correct. I want you to feel free to share your ideas and opinions; there will be no right or wrong answers.

No one will receive any money for taking part in this study. You will have refreshments during the interview as well as paid Uber transportation to and from the meeting, if needed.

Your privacy will be protected. Your name will not show up on any reports from this study. After the focus group interview, your personal information will be destroyed.

Ms. _____, do you have any questions or concerns?

I have times and dates of the four focus group interview.

Schedule of Times and Dates

Focus Group Interview #	Dates	Times
1		
2		
3		
4		

Please select 2 dates and times that is most convenient for you. (*I will circle the times and dates that the participant selects*).

Ms _____, you are scheduled to attend the focus group interview on

_____ at _____ or _____ at _____. The focus group interview will be at San

Justin's Kitchen located at 157 West 75th Street. Will you require transportation to and

from the focus group? **Yes   No** (*circle one*)

Within 2 to 3 days, you will receive a confirmation letter regarding your scheduled focus

group interview. Please feel free to contact me at any time by phone, text, or email if you

have any problems or concerns.

Thank you Ms. _____ for your time and I look forward to meeting

with you.

Have a good day.

Appendix I: Word Cloud from Nvivo 11

Word Frequency Query

Appendix J: Research Questions with Themes and Validation from Participants

RQ1: What are the perceptions of obese AA women regarding altering traditional soul food preparation?	
Altering Soul Food Preparation Themes/Subthemes	**Validation from Participants**
Taste	P25: OK, getting back down to the taste; if the healthy soul food tastes good, people will come and be receptive to change. But only if it tastes good.
Family Values	P4: It's something that the people look forward to; it puts a smile on your face.
Consequences Improves Health Reduces Chronic Illnesses	P25: If we eat healthy, we will live longer. P22: If you eat really healthy, you might reduce diabetes and high blood pressure.
RQ2: What factors do obese AA women perceive would be helpful to maintain new healthier eating behaviors for themselves and their families?	
Factors for Eating Healthy	**Validation from Participants**
Tastes Good	P18: I would be open to eat healthy, I mean if you can make it healthy, fine. If it tastes good, I am going to eat it. If it doesn't, I won't eat it; no how healthy it is.
Recipe Availability	P12: We don't have any other recipes. Where are these tasty soul food recipes?
Low Cost for Healthy Ingredients	P18: Tell me where I can find low cost ingredients.
Accessibility of the Ingredients	P20: How available are they to the people in our communities? …I have never seen any herbs at the corner market. Not even fresh vegetables. They have a few apples, bananas, and oranges. But they have plenty of fried chicken though, and it is cheap.
Substituting Herbs and Spices	P22: You just need to know what herds to use and how much to use to get the desired taste.
Food Waste	P24: I rather fix it unhealthy than throwing food away.
RQ3: What barriers could limit participation in an intervention designed to develop healthier eating habits for obese AA women?	
Barriers for Participation in an Intervention	**Validation from Participants**
Ignorance and Laziness	P14: For me it's laziness and procrastination.
Transportation Issues	P13: Transportation is a problem for some folks. You [have to] have a car or a way to [get there] to get the healthy stuff or even to buy the healthy stuff.
Lack of Motivation	P6: You [have to] be motivated to change; you [have to] want to change for the better. Until then,

	everything will stay the same
Lack of Education	P3: You just have to find an option that is [going to] save your life; keep you healthy, and the only way to do that is through education.
Lack of Time	P12: [We] need to make time for learning how to prepare healthy soul food.
No Incentives	P11: The intervention should provide incentives.
Bad Reviews	P14: It has to taste good and the person who teaches me must be polite, clean, and easy to work with.
Other Relevant Ideas	**Validation from Participants**
	P16: [You must] be able to want to get better and do better and to be able to be open to receive information that can possibly change your life and the lives of your children, your grandchildren, and so forth.