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Black Women's Experiences with Weight and Weight Management

By

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B.A. (University of California, Santa Cruz) 1993

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Spring 2005

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By Cord Randall Valentine

DEDICATIONS

To Juanita Valentine, the greatest mother in the world.

To my family, Pamela, Solia, and Cigan. I love you all very much.

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Chapter 1: A Review of the Weight and Weight Management Literature

Part I. Statement of the problem

In the United States, as well as abroad, overweight and obesity have emerged as growing medical problems, leading to the increased prevalence of numerous preventable diseases. From 1960 to 1999, the percentage of people with excess body weight (defined as a Body Mass Index [BMI] ≥ 25) increased from 44% to 61% among all Americans, while the prevalence of obesity doubled (1). This increase in overweight and in obesity over the past 30 or 40 years cannot be explained by the use of different obesity measurements over this same time period. While it should be noted that some earlier methods of measuring obesity have had little or no scientific basis, current measurement tools are far more valid. The most often used method of determining overweight and obesity is the Body Mass Index or BMI. BMI has been found to be highly correlated with densitometric measures of total fat mass and is a good predictor of elevated blood pressure and glucose levels (2). BMI is computed by dividing one's weight in kilograms by one's height, in meters². Adults with a BMI of 25-29.9 are considered to be overweight; when the index is over 30, the person is said to be obese. In studies of obesity, some researchers have used self-report of body weight [e.g. the Behavioral Risk Factor Surveillance System (BRFSS), the National Health Interview Survey (NHIS)], while others have used measured height and weight [e.g. the National Health Nutrition and Examination Survey (NHANES)]. It has been demonstrated that studies that rely on weight self-report tend to report lower levels of obesity than do studies based on measured data (3).

Rates of overweight are increasing among all adult Americans (4). Yet the problem is not just confined to the adult population, or only to the United States. According to recent

figures, worldwide there are approximately 22 million children under the age of 5 who are overweight (5). In the United States, the figures are equally astonishing and the prevalence has dramatically increased over the past 30 years, with the number of overweight children and adolescents doubling over this time (5) so that the prevalence of overweight children aged 6-19 as of 2002 was 16% (4). Recognizing childhood obesity is important because many of the same comorbid conditions that accompany obesity in adulthood are seen in children who are overweight and obese. Also, people who are obese as children frequently grow up to be obese adults, which contributes to the increased rate of obesity among American adults (5). A discussion of childhood obesity is especially salient to Black women because it is during adolescence that their obesity rates begin to surpass all others (6).

Despite this across-the-board increase in the rates of obesity among American adults, special focus must be given to Black women, for the problem is especially severe among them. In the United States, Black women rank as one of the most obese segments of society, with a prevalence of obesity nearly twice that of white women (4). Not merely confined to a question of aesthetics, the literature has shown that there are concrete social implications to being obese. Children who are obese during childhood and adolescence do worse in school than the nonobese. Adults who are obese have fewer job opportunities and receive less pay than the nonobese. Additionally, obese adults are more likely to remain single or lose their marriage partners and their fecundability may be impaired (7). Perhaps more importantly, overweight and obesity are linked to a host of chronic health disorders, including hypertension, hyperlipidemia, type 2 diabetes mellitus, gall bladder disease, and osteoarthritis (8-11). Additionally, severe levels of obesity among Black women are associated with

increased years of life lost (12). Obesity-related medical conditions rank as the second leading cause of death in the United States (13).

Because a disproportionate number of Black women are obese and overweight, a disproportionate number of them suffer from the aforementioned diseases. As an example, in African-Americans as a whole, high levels of obesity have contributed to a major rise in the prevalence of non-insulin dependent diabetes mellitus (NIDDM) such that their rates significantly outpace those of both Caucasian Americans and other Blacks of the African Diaspora (14). Additionally, Black women who are overweight are at increased risk of developing obesity-related diseases such as hypertension and die at higher rates from heart disease and diabetes (15). To a certain extent, all of these diseases are preventable and with proper measures, the natural history of these diseases can be interrupted and possibly reversed. Studies of obese patients have shown that a 10% weight reduction improves insulin sensitivity in NIDDM, reduces blood pressure in hypertensives, and reduces cholesterol levels in those with abnormal lipid profiles (16, 17).

There are many different weight management options including, but not limited to, pharmacologic, surgical, and behavior modification interventions. Behavioral modification programs include dietary and/or physical activity interventions and this discussion will focus on these types of programs. This category of intervention spans many different types of programs, which vary by what the program covers, where the program is located, the types of weight loss strategies utilized, and many other factors. For example, some programs focus only on exercise (18), some only on educating participants on nutrition and behavior modification (19), while others combine the above approaches with monitoring of various health parameters (20). Still others provide participants with low calorie shakes and pre-

packaged meals in addition to educating them and encouraging them to exercise (21). Some programs are located in clinical settings (21), while others are offered in community settings (20). One program even used a preexisting illiteracy group and then built in a weight management component (19). The duration of the programs can vary anywhere from 8 to 26 weeks (22, 23). The day and time of day the class meets as well as the length of time spent in class also varies, with some classes starting at 6:00 in the morning and lasting 1.5-2 hours (20). Prizes and monetary rewards (19, 20) are sometimes offered. Sometimes programs are free (19, 24), while other times a fee is assessed (20). The list of different types of programs and differences between similar programs goes on and on.

Amidst all of these differences, one major commonality shared by most of these weight-loss programs is that they work; they help the people who attend them lose weight (21). One church-based program saw almost 90% of its participants lose weight over 8 weeks (20). A program that used existing illiteracy groups saw an average weight loss of about 3 pounds over 11 weeks (19), while another program saw an average 4.6 kg loss at the end of a year (25). Whether or not these results seem impressive varies by one's perspective. Regardless of perspective, however, the next bit of news to be reported is unequivocally bad, but especially so if you are a Black woman. Studies have shown that African-American women do not lose as much weight as white women enrolled in the same program (26).

In addition, weight-loss maintenance decreases once participants leave these programs, when participants may stray from caloric intake goals, fail to find the time to exercise, and lose the vigilance and support of the weight management group. During the first year of weight-loss programs, participants typically regain about 50% of their lost weight (27). After five years out of the program, approximately 80% of patients regained all

of their previously lost weight or even surpassed the weight at which they originally entered the program (27). These startling numbers, however, may not provide the complete picture, as the data remains based on only those former participants whom the program successfully contacted for follow up following its conclusion. The gathering of follow-up data even after only six months following completion has proved difficult, with one study achieving a mere 41% six-month follow-up rate. Among these respondents, 35% regained weight (20). Another program, which sought to follow participants for one year, only succeeded in contacting 58% of the intervention group at the end of the 12-month period (25). The control group had a lower contact rate, with an eight-month return rate so low (17%) that participants were paid to return in one year, which 29% did not do (25). In a separate study, which featured a three-year follow up interval, only 25% of participants did not gain weight over the three-year period, while less than 5% lost weight (28).

The reasons behind the success or failure of weight-loss maintenance remain a subject for investigation. Byrne, et. al. specifically examined the psychological factors that might determine whether a patient was a weight “maintainer” or “regainer” at follow-up (27). Weight regainers were less likely to adhere to the weight-loss techniques they learned in the program. They were also more likely not to have achieved their weight goals, to be dissatisfied with their new lower weight, to use their weight to evaluate their worth as a person, to think in black and white, and to use food to improve their mood (27). It appears that maintainers and regainers fall into a perpetuating process as the strategies they use to either keep the weight off or regain weight become engrained as habits. Hence, if behavior modification does not occur during the program, then those people quickly regain the weight

as they retain their old habits (29). Conversely, the longer one continues a behavioral pattern the more likely one is to retain that pattern because it becomes an unconscious activity (29).

The difficulty of weight-maintenance after leaving a program remains an important barrier, as does dropping out of a program prior to completion. Almost all of the different types of weight management programs discussed above invariably report very high attrition rates (19, 21, 23), with one study of hospital-based clinics seeing attrition rates as high as 46% (30). Even when the intervention is designed to require only modest lifestyle changes, attrition exceeded 50% at the end of one year (25). Comparing attrition rates across different weight management programs remains difficult because the programs all vary by how they measure attrition. For some, dropouts are simply those who do not attend the last session (20). For others, attrition rates are determined by the percentage of sessions a participant attended (23). And yet others define attrition as missing a predetermined number of sessions (21). Others use more complicated dropout criteria, for example, Domel et. al.: "Women who attended 3 or more sessions, but fewer than 7 or who failed to attend 1 of the final 3 sessions were considered dropouts" ((19) p.347). Despite these differences in measurement, the vast majority of programs report high attrition rates, possibly indicating some kind of deficiency in the programs themselves.

Additionally troubling, the many different versions of these programs make it difficult to understand their individual and collective weaknesses. A prepackaged meals program might presumably ease some of the stress and troublesomeness associated with a weight-management program and might consequently increase retention rates. As an example of the ease of utility of this approach, 29 of 45 subjects in one study chose to receive extra days of prepared low-calorie meals (25). However, the attrition rate of a prepackaged

meal weight reduction program still surpassed 30% (21) so perhaps this is not an important factor in participant retention. These programs also differ by cost and one can convincingly argue that offering a free program can have either positive or negative effects on the program's attrition rate. As an example, there were two cohorts in a program designed to treat morbid obesity. In the cohort that did not have to pay for the program, the dropout rate was 21%. However, in the other cohort of patients that was asked to pay \$25/week for the program, the attrition rate was 62% (24). Raghuwanshi also demonstrated that factors such as attendance and weight loss requirements could also adversely affect completion rates (24).

Study design also complicates the process of understanding the weaknesses of weight management programs. Academics who perform these studies rarely choose qualitative methodologies to find out, in the participants' own words, exactly why these weight loss programs have high attrition and low weight maintenance rates. Rather, the causes for high attrition rates have been studied mainly by looking at the demographics of the dropout population and then trying to find some commonalities. For example, in one review article that focused on attrition, one-third of the variables used to study attrition were demographic in nature with psychological and behavioral variables composing a smaller percentage of variables studied (31). Clark et. al., found that subjects who were young, depressed, smokers, did not exercise, had a high systolic blood pressure, and had a relatively low BMI had higher attrition rates than the converse (23). Socioeconomic status (SES) has also been studied as a possible explanatory demographic variable for high attrition rates. A comparison of inner-city women and affluent suburban women enrolled in weight management programs found that the affluent women succeeded at a rate twice that of the inner-city women (24). Furthermore, the study discovered that the retention strategies that

may prove effective for an affluent population, such as financial outlay, do not appear effective for poor inner-city populations (24). Another study focusing on demographic criteria examined race, marital status, and gender. After multivariate analysis they found no association between being African-American, being divorced, or being female and attrition rates (21).

However, the lack of association between race and attrition remains highly controversial. Sue found that Blacks were less likely to complete therapeutic services than other race and gender groups (32). In two studies of weight reduction programs, it was found that Black children were more likely to dropout than other ethnicities (33, 34). Furthermore, if they remain in the program, African-Americans lose less weight and regain more weight after the completion of the programs than whites (26, 35). In addition, Black women may be less likely to attend the weight management courses to begin with, for a variety of possible reasons, including "fewer black women than white women perceive themselves as overweight; the percentage who perceive themselves as overweight decreases as education and income levels decrease; poverty creates barriers to attending classes; and the learning environment creates stress for adults who fear disclosure of their illiteracy" ((19), p. 346).

The literature showcases demographic profiles and educated guesses that purport to explain why Black women do not do as well in these programs as other groups, but disturbingly, the literature rarely includes personal statements from the dropouts as to why they left the program. In one of the rare studies of this type, Racette found that participants left the program because of "lack of time, failure to comply with the recommended changes, illness, loss of a loved one, and pregnancy"((25), p. 350). Also, in some retrospective studies, it was found that poor problem-solving skills, low self-efficacy, unrealistic weight

goals, and enduring lots of pain with perceived little gain were found to be possible attrition factors (27).

Remaining in weight management programs and maintaining weight loss poses difficulties for all groups, but, as discussed above, it appears to pose the greatest difficulty for Black women. This may partially lie in that fact that most weight management programs are designed for the predominant participant population, and in most settings this is Caucasians. Kumanyika, Morssink, & Agurs have argued that certain strategies used in weight management programs, including "goal setting, competitions, a strong emphasis on personal autonomy and self-management, [and] personal assertiveness" ((26), p.171) may not be as compatible for African-Americans as they are for the white middle class. Black women may not adhere to the programs because they do not identify with these dominant paradigms. Even Honas, who found no association between race and attrition, concluded that the special attention paid to "social, racial, and gender cultural sensitivity issues [may have] inspired [African-American, divorced, female] patients ...to remain in the weight-loss program" ((21), p. 892). Kumanyika, Morssink, & Agurs suggest that the "special attention" paid by programs geared toward Black women may be more peer- and family-oriented, not focus on thinness, have a long-term commitment (even after the program is over) from the provider, offer greater support, and incorporate physical activity into daily life activities (26).

That weight management programs are failing Black women and, as a result, preventable diseases are afflicting Black women at very high rates, is alarming. A large percentage of Black families are headed solely by Black women. The reasons for the surge in female single head-of-household families are varied and include a decrease in the available numbers of Black men (as increasing numbers of Black men are killed by violent crime and

AIDS, incarcerated, or lost to miscegenation), a re-conceptualization of family structure, the inability of Black men to find jobs to provide for their families, and a lack of feeling of family responsibility, among others. Regardless of the reason, the result is that increasingly isolated Black women are leading families. If their ability to care for their families is compromised by poor health, the welfare of thousands of children is compromised. Also, because they often are the head of a household, Black women are often responsible for the socialization and the transmission of knowledge in their families. Studies have demonstrated that both obese and non-obese children with a single overweight parent had a higher risk of being obese in adulthood ((36). Genetics is one possible explanation, but the environmental factors are more compelling. Eating healthily and exercising regularly are learned behaviors. If Black mothers are not eating correctly, are not exercising, and are in poor health, what sort of message are they sending to their children about good health habits? The more inclusive question would be, if our society does not care enough for the welfare of Black children to provide them with nutritional education, access to healthy foods, and the ability to play and exercise in a physical environment that is safe, how do we expect them to combat the rising tide of obesity. Regardless of with whom the responsibility lays, the health of future generations may be in danger if they do not receive the information that being obese has deleterious effects.

Part II. Background and Development of the Health Problem

Understanding the problem of obesity among Black women requires a review of the history of American Blacks, most of whom's descendants came to the Unites States by way of forced migration; as human cargo huddled together in the dank, dark, fetid underbelly of slave ships. What is not as obvious, and what has not been thoroughly researched, is how

this initial migratory experience may be implicated in the long-term health of African-Americans.

Although the ancestors of Black Americans originally came from Africa, tracing this genetic lineage has not proven useful in understanding related weight issues. Comparing rates of obesity among Black American women to the rates among African women remains ineffective given the inability to verify from which region Blacks ultimately came; to lump all Blacks together based on colonialist-described borders would deny the unique cultures and experiences of the multitudinous African tribes. However, a certain small percentage of obesity can be directly attributed solely to genetics. Neel first proposed the “thrifty gene” hypothesis wherein certain genotypes had a survival advantage over others because they could better utilize food intake (37). Subsequent studies have confirmed that BMI is under genetic control (38). One study demonstrated that genetics affect African-American adolescents more than whites when it comes to obesity (39). Some have argued that the reason that this may be the case is that a dearth of resources on the African continent led Africans to be genetically predisposed to store greater amounts of energy consumed as body fat as a means of combating scarcity (40).

Until recently, the African continent did not experience the problem of obesity. Obesity was a question of resources and no one, save a select few, had the resources to overindulge. Some communities considered large bodies a sign of social status because they demonstrated that one had the resources to provide for one’s family (41). This may be one reason that in African culture, obesity in Black women is regarded with far less disfavor than in the case of white women (42). Accordingly, there is only limited incentive for obese African women who live in rural environments to lose weight. As individuals migrate to the

city, the situation changes. Urban dwellers who are better educated and enjoy higher socioeconomic circumstances have lower rates of obesity than their poorer, rural, less educated counterparts.

Another reason for the historically low rates of obesity in African peoples was their high level of daily physical activity, in which both male and female Africans traditionally worked in the fields. Recently, an increasingly global economy has improved the availability of resources while also leading to a more widespread mechanization of labor. So while rural and urban African men and women used to be very physically active, rates of physically activity have now decreased, especially in urban areas (42). As a result, obesity has been on the rise in Southern African countries. “As will be appreciated, obesity is not a problem in populations in most African countries. However, in Southern Africa, the prevalence is extremely high in women in South Africa, and is rising, especially in those living in adjacent countries, as in Botswana, Namibia and Zimbabwe” ((42), p. 369).

The global economy also has led to the export of western food and food retailers to many Third World countries and throughout the African continent. So far this influx of McDonald’s-style franchises has led to only a slight alteration in the traditional diet among rural Africans. However, the picture is quite different in the cities, where the easy availability of such food may be leading to increased levels of obesity. As one author noted, “The masses simply want more of palatable and of energy denser foods” ((42), p. 371). The desire for more fattening foods combined with a decrease in physical activity levels have conjoined to cause rates of obesity among Southern Africans in general, and women specifically, to skyrocket. Currently, the rates of obesity among African women are at

historically high levels and growing at such a speed that they are approaching those of Black American women.

In the United States, many of these same factors – dietary changes, decreased physical activity, and cultural influences – may be root causes of increasing levels of overweight and obesity. In the last 40 years, from 1960 to 2000, the prevalence of obesity has more than doubled among US adults, going from 13.4% to 30.4% (4). Obesity among Black women has not been rising as fast as among other ethnic and gender groups (43), but the percentage of Black women who are overweight is astounding. Almost half of the adult Black women in the United States are obese (44), and this percentage is increasing (43, 45). Furthermore, as Black women get older they are more likely to become obese than white women (46).

Despite the importance of cultural influences or acculturation in the prevalence of obesity among Black women, this issue has not been studied extensively, if at all, perhaps due to the common but erroneous assumption that all native-born Americans share a common culture. While in anthropological texts assimilation and acculturation are used to describe two different phenomena, the two terms are often used interchangeably. In this paper, acculturation will be used to describe the process of psychosocial change that occurs when a group or individual acquires the cultural values, language, norms, and behaviors of a dominant society. Acculturation usually is measured in terms of language acquisition, from the language spoken at home to the one spoken with friends to the language in which one thinks. However, when viewing the acculturation of one English-speaking subgroup into another, different group, a more representative measure must be chosen. In the United

States, the level of acculturation of Blacks into white society can be measured, in some respects, by one's earning power.

It has been demonstrated that the prevalence of obesity among Black women declines with increasing income and increasing educational attainment (19). Although over the past 40 years the difference in obesity rates between high socioeconomic groups and low socioeconomic groups have drastically decreased, a disparity still remains (47). Some have argued that this may be due to the increased education level and increased knowledge of a healthy diet and the benefits of exercise (24). I argue that there are other issues at play, namely acculturation. While anthropologists maintain a strict separation of the terms acculturation – cultural change that occurs in response to extended firsthand contacts between two or more previously autonomous groups – and assimilation – the social process of absorbing one cultural group into harmony with another – most medical literature use the two interchangeably. Following this precedent, this discussion will use the term acculturation in a broad sense of cultural adaptation. In order to understand this issue in terms of African-Americans and obesity, the context of the Black middle class must be examined. When compared to whites, the Black middle class is more like the white lower-middle class (48). Families that reside in Black middle class neighborhoods experience more poverty and violent crime than their economically equivalent white counterparts (48). As Black families move from lower class to middle class and seek to leave lower income neighborhoods, they have little choice but to move into mostly white neighborhoods. In this new, more affluent environment, Black women may adopt some of the cultural ideals of the white population, such as the stereotypical thin female. As one study noted, adults from higher socioeconomic backgrounds are more concerned about their weight (49). In Blacks,

acculturation no longer happens in terms of an international transmigratory experience, it occurs as one migrates from low to high socioeconomic status; out of the Black community and into the white one. As has been previously demonstrated with Africans and as will be further substantiated with Black Americans, there is a cultural tolerance and acceptance of larger female body sizes when compared to white people. Perhaps the decrease in obesity among upper income Blacks is due to the loss of this cultural belief through acculturation. However, times are changing and no one, it seems, not even those in high socioeconomic groups, are immune from the obesity epidemic. In fact, in the last 3 decades the rate of increase in the prevalence of obesity in high SES groups dramatically outpaced that of lower SES groups (47). With increasing rates of obesity among all Americans, perhaps the strength of the traditional white American view, one that embraced thinness, is weakening.

Part III. Social Portrait of the Health Problem

The prevalence and incidence of obesity differs along national, socioeconomic, gender, and ethnic lines, among many others. As discussed previously, Southern African nations, including South Africa, Zimbabwe, Botswana, have higher rates of obesity than other regions of Africa, such as Tanzania and Gambia (42). In addition, countries as far ranging as Great Britain, Australia, Jordan, Brazil, China, Mauritius, and Western Samoa have experienced spikes in their rates of obesity (8, 42). Overwhelmingly, the literature identifies the United States as having the world's highest rates of obesity.

Except for Asian-Americans, the prevalence of overweight and obesity in the United States is higher in minority populations, especially Black Americans, than in white Americans (50). In addition to Black Americans, rates of obesity are alarmingly high in

Native-American groups and Asian Pacific-Islanders, though few studies have been conducted on these populations. As noted earlier, differentiating between Black Americans on the basis of ethnicity is difficult, if not impossible, due to the way in which Africans were initially brought to the United States. It would be helpful for future studies to focus on recent immigrants from Africa in order to determine if they have different incidence and prevalence levels when compared to native-born Black Americans.

In addition to international and ethnic differences are possible regional differences within the United States, perhaps a secondary function of socioeconomic status. As stated previously, obesity is inversely proportional to socioeconomic status. So one would expect that poorer regions – e.g. inner city and rural areas – would have far higher rates of obesity than the affluent suburbs. Ramsey conducted one of the few studies to address these regional differences in obesity, in which she found that rural women were poorer and had higher obesity rates than suburban women (51). Indirectly, the existence of a “stroke belt” indicates possible regional differences in obesity rates. The stroke belt includes the states of Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia, all southern states with large populations of urban and rural Blacks. Blacks in the stroke belt have disproportionately high rates of stroke, which are intimately tied to hypertension and overweight (52).

Other factors that may affect the prevalence of obesity include marital status, religious affiliation, and age, which has attracted the most attention. The prevalence of obesity is highest in the 40-59 year old age group (4), but the fastest increase in obesity rates has occurred among 18-29 year olds (53). A recent disturbing trend has been the increase in obesity among young children. There has been an approximate doubling of the rate of

overweight and obesity among Black girls during the 10 years between ages 9-10 and 18-19 (54). Some data also suggest that the prevalence of obesity is higher among single women than married women (55), but these findings remain inconclusive (56).

Part IV. Causal Factors

In the simplest of terms, one's body weight is determined by the difference in the number of calories consumed and the number of calories burned: what one eats versus how much one exercises. Let us first examine physical activity and how it is implicated in obesity among Black women. Physical activity can be conceived in two ways: leisure-time physical activity and occupational physical activity; high rates of either means a lesser likelihood of obesity. For example, being employed in a highly active occupation reduced the likelihood of obesity by 42% even without participation in any leisure-time physical activity (57). Similarly, leisure-time physical activity was also shown to have protective effects (57). Studies have shown, however, that the prevalence of both types of physical activity have been decreasing among all ethnic and gender groups (2). But not all groups started at the same baseline. In general, women have lower activity levels than men and Blacks have lower activity levels than whites. Additionally, Black women exercise at much lower rates than their white counterparts (58). This low level of physical activity may lead to high rates of obesity and heart disease among Black women (59). Like the prevalence of obesity, the ethnic differences in physical activity rates began to be seen in childhood, with Black girls being the least active subgroup (60).

With relation to food consumption, studies have shown an overall increase in the amount of sugary and energy-rich foods consumed by Americans, as well as a decrease in the number of meals consumed but an increase in the amount of snacking (61). A phenomenon

contributing to the overall increase in the snacking rate is television viewing, which is directly associated with snacking. At least one study has shown that Black women spend inordinate amounts of time in front of the TV (62). In addition to the changing eating patterns at home, there has also been an increase in the amount of calories consumed outside the home. Between 1977 and 1996, Americans increasingly ate more often at restaurants and fast food establishments instead of at home (61). These restaurants typically serve more energy dense foods and in larger serving sizes, which customers feel obligated to completely consume. Whether in restaurants or in the home, dietary consumption of Blacks appear markedly different from that of whites. Despite scarce data, African-Americans may have traditionally eaten more high-fat foods, according to Gwendolyn Pla, Ph.D., who teaches nutrition at Howard University. The source of this desire for high-fat foods may be rooted in the southern upbringing that a lot of Blacks received (63).

Is there more to the “southern roots” theory than just eating large amounts of high fat foods? Why has a southern upbringing traditionally been so damaging, in terms of body composition, to the people who have lived there. The south has traditionally been a heavily agriculturally dominant place and perhaps the levels of obesity here have something to do with this history. Working in the hot fields for many hours at a time was backbreaking work that required a high-density caloric intake to make it through the days, weeks, and months from planting to harvesting. So workers in the south, particularly the poor Blacks who toiled the fields needed large, calorically dense amounts of food. Then, one can speculate, as the south began converting fields to factories, the people lost attachment to the agricultural origins of food – they began to think that food came from fast food places and not from the fields. Perhaps this distancing led them to devalue the food that they ate. Or, maybe, it was

the rural to urban migration, as previously discussed in African populations, that was the culprit. As Blacks left the southern fields for the urban north, either through ease of access or through acculturation, the adoption of processed foods was accelerated, their diet became poorer, and they began to put on weight.

All of the above ideas are interesting, theoretically, but they all revolve around the concept of overeating. It has been consistently demonstrated that overeating and decreased physical activity have been strongly implicated in the obesity epidemic, but there are also other factors at play. Though it has been argued that race is a sociological construction, the role of genetics in obesity has been extensively studied. It has been demonstrated that Blacks have a lower resting metabolic rate than whites (64), indicating that Blacks do not burn calories as well as whites. In addition, preliminary studies indicate that cortisol, a hormone that is elevated during the stress response, may be involved in abdominal obesity (65). It could be argued that Blacks live with greater stress and hence have higher cortisol levels, which may explain their increased levels of obesity. Another genetic argument revolves around leptin, a hormone that regulates satiety, or fullness. It has been shown that in a study of people with wide-ranging body types, extremely obese people were the most likely to be resistant to the effects of leptin, which may mean that they do not recognize when they are full, and that leptin resistance is a heritable trait (66). Perhaps, this genotype is more prevalent among Blacks.

Still other arguments can and have been made in order to explain the high rate of obesity among Black women, including inadequate access to health education and treatment services, early age at first childbirth, poverty, lower educational attainment, and earlier

menarche. There are also cultural factors to consider, such as traditional preference for high fat foods and greater acceptance of larger body sizes among others (46, 67-71).

The advent of the Fat Rights movement has seen a tendency to avoid explaining obesity in terms of overeating and under exercising. Undoubtedly, the genesis of the obesity epidemic involves a lot of factors, but the argument for these two factors playing a primary role is compelling. This is not an exercise in blaming the victim. There are very real obstacles to Black women getting the exercise they need and consuming healthy foods. One of these obstacles, oddly enough, is marital status. The question of marriage is an especially important one in the Black community, because although there is a slight increase in the overall number of single-parent families headed by women in the United States, the statistics for Black Americans are far more extreme. The number of female-headed households has nearly doubled, from 28.3 percent in 1970 to 42.8 percent in 1988 and to 43.8 percent in 1989 (72), and a disproportionate number of these households fall below the poverty line (73).

Marriage may actually serve as a protective factor against obesity, in that it provides a financial cushion and allows for the division of household labor, and thus greater leisure time. Both the level of financial resources and the amount of available leisure time have been implicated in determining women's ability to exercise (59). In other words, exercise tends to be an activity of the wealthy, who may enjoy greater leisure time and the disposable income to purchase relatively frivolous items such as fitness club memberships.

Though no-cost, outdoor options exist, safety concerns may inhibit their use, particularly in inner-city neighborhoods where residents may fear violence. The lack of park space and walking paths poses an additional problem. According to one community

organizer from a low-income neighborhood in Portland: "We have less parks and less park space than any other part of the city" ((74), p. 1). In existing parks, there is often a shortage of programs because there is a lack of resources. Because physical activity is inversely proportional to being overweight (75), lack of access to safe parklands, especially in inner cities, may contribute to the growing obesity epidemic.

Discrimination and racism, which may play a role in the allocation of park space, may also play a role in the economic subjugation of Black families that are headed by women. Discrimination has relegated Black women to low-paying and dangerous jobs (76). Discrimination may also play a role in keeping the numbers of Black women attending universities relatively low compared to the number of white women who attend college (77). As a consequence, Black women do not enjoy the same earning power as whites (78). In most Western countries, including the United States, the prevalence of obesity varies across socioeconomic classes (79). By keeping Black women confined to the lower rungs of society, the system is perpetuating the condition of obesity.

The lower income earned by Black women also keeps them confined to poor and unsafe neighborhoods. The external environment may cause them to give less encouragement to their children to go out and play, for fear that play may turn into trouble. Being constantly on guard, as may be expected from one who lives in a dangerous situation, may lead to environmentally-induced stress, in addition to the stress of work. Environmental stressors may cause compensating behavior by eating to feel better about oneself without worrying about becoming overweight or obese (63). It may also be possible that poor, Black women indulge in food because after having been denied things for so long they may want to experience the "good life" and food gives them temporary, partial access (80). Also, because

of poor wages and unstable employment, Black people may develop a hoarding instinct so that in times of plenty they gorge themselves, leaving them with an energy store when resources are scarce.

One final way that socioeconomic status may contribute to the levels of obesity among Black women is the relationship between fast food and income. Major corporations of fried and high-fat foods often conduct marketing campaigns aimed at low-income populations in general, and Black people specifically (81). Fast food companies may target their products to a lower income audience on the assumption that these populations must work more, and thus have both less time and greater responsibilities, which may prevent them from preparing balanced meals at home. Fast food is appealing both for its taste and its low cost (67), making it especially enticing to low-income families. The high preponderance of fast food establishments in poor, inner city neighborhoods underscores this trend. In many ways this targeting of bad foods to poor Blacks is similar to tobacco advertising. Billboard advertising, especially on public transportation, is more prevalent in low-income communities where Blacks often reside (82). As with cigarettes, the point of fast food advertising is to get them hooked, at a young age, by bombarding them with enticing images and ready access, and then you keep them hooked as adults.

The issue, however, goes beyond fast food. Food marketers rarely sell health-conscious products in low-income neighborhoods, yet they heavily market liquor, cigarettes, sugar and “snack cakes” (83). Large corporations like Kraft or Best Foods do not display efforts to teach consumers about nutritious alternatives to junk foods. Instead, these companies use their marketing might to target poor communities and reinforce the poor eating habits of inner-city residents (83).

Furthermore, few chain grocery stores are willing to operate in poor areas out of fears of the violence that necessarily follows poverty. In their stead rise independently-owned stores that lack the sales volume and bulk purchasing power of chain stores. As a consequence, the food items at these stores are more expensive than items purchased in the suburbs. A 1995 study of Detroit area grocers found that city shoppers paid higher prices for a less nutritious choice of foods than suburban shoppers because of a lack of large supermarkets in low-income neighborhoods (84). Fewer nutritious choices mean fewer fruits and vegetables. Fresh fruits and vegetables are more than 50% less likely to be found in the inner city than they are in the suburbs (84). Partially because of this, the amount of fruits and vegetables consumed is much lower in low socioeconomic groups than in high socioeconomic groups (85). In addition to independently-owned grocers, poor neighborhoods are peppered with convenience stores and liquor stores, establishments that are even less likely to stock fresh foods. Instead their shelves are filled with prepackaged and processed foods, which are dense in calories and their consumption may thus also be linked to the prevalence of obesity.

Socioeconomic conditions may also predict where and how Blacks are able to access health care. Blacks who are poorer and lack health insurance tend to seek care only in an emergency (86). Without a regular physician, preventative care remains ineffective. Poor Black women may not receive the educational message about the dangers of their weight or they may lack the resources to attend self-help groups. While lack of access to healthcare has not been proven to be a factor with regard to obesity, it has been demonstrated that a regular source of healthcare decreases the prevalence of smoking among Blacks (87).

Smoking cessation has also been listed as a factor that contributes to obesity (88), though it cannot be the sole contributing factor (89). As stated previously, genetic factors have an established link to the development of obesity, but it is implausible to think that the sharp rise in obesity over the past three decades is due primarily to a shift in the genetic code. No one explanation seems to provide an adequate answer. Perhaps they should be considered together along with the distinct cultural features of Black Americans.

Part V. Impact of Cultural Features

As stated previously, Black Americans are culturally distinct from their white counterparts. One example of this difference is in how Blacks view body size, especially in what they view as a range of acceptable body shapes for women. Studies have shown that although Black women tend to be heavier than their white counterparts, they report that they are less dissatisfied with their weight (90). In addition, they perceive themselves to be thinner than they actually are (91). Furthermore, studies have shown that when compared to white women, Black women had a heavier ideal body size (92). These findings for Black American women were similar to studies of women in Southern Africa.

Black men also seem to prefer their women to be heavier than their white counterparts. In one study, Black men chose larger ideal female silhouettes and were less tolerant of very thin silhouettes than white men (93). In another study, Black men preferred a substantially heavier ideal female body size than whites (94). A third study found that Black men were more willing to date women with a heavier than ideal body size than white men (92). The findings for both Black men and women seem to indicate a cultural acceptance of large body size in the Black community.

Considering the data presented it would seem that obese and overweight Black women would feel no incentive to lose weight, especially with regard to findings that overweight Black women do not feel that they are overweight (95). However, the data are not clear and at times are contradictory. For example, one study found that Black women were interested in losing weight so that they can look attractive and wear fashionable clothes (96). Another study, however, found that obese Black women wanted to lose weight so that they may lead healthier lives; being thin was not necessarily a major concern. The women's ideal body type that of a full-figured, healthy woman. Their thoughts about living healthy lives were not constrained by thin figures that have become the White ideal (63). I therefore argue that most obese Black women feel a need to lose weight for a variety of reasons, including appearance and health, but that they are not willing to lose significant amounts of weight simply to conform to the norms of white culture. This belief may put obese and overweight Black women at odds with the medical community, which often has as its sole goal to get the patient's BMI below 25. Tragically, this viewpoint may alienate all overweight and obese women from doing any amount of exercise and weight loss, which may be effective preventing certain health conditions even if done in only moderate amounts (17).

The World Health Organization (WHO) first utilized BMI in 1985 as a measurement of body weight. Since that time, BMI has become the standard measure in the United States and abroad. Despite the variety of environments in which the BMI is utilized, its standards for appropriate weight levels were and still are employed along very strict lines. A BMI from 25 – 29.9 is overweight and anything over that is obese. For overweight and obese Black women, a BMI of under 25 may not fall under the cultural ideal of thickness (versus

thinness) to which they subscribe. Though they want to lose weight for health reasons, these women may not consider the goal of a BMI less than 25 to be appropriate.

Studies have shown that, indeed, these Black women may be correct in this supposition. Deurenberg, et. al, found that Blacks with the same BMI as whites have lower levels of body fat (97). Similarly, one study found that Black women of all BMI levels had a decreased incidence of hypertriglyceridemia than white women who had a BMI of 30 (98). Pursuant to these findings, there has been talk of using different BMI cut-off points for different population groups.

Amid discussions on evolving ways to measure obesity, and in the face of the onslaught of a weight-centric society, the culture of Black women has remained strong. In fact, researchers have hypothesized that their acceptance of larger body sizes serves as a protective factor. Black women are less likely than white women to suffer from eating disorders such as bulimia and anorexia (99). This trend may be tied to acceptance of larger body sizes or related to the history of food scarcity in the Black community and the desire not to waste valuable resources. This cultural acceptance of larger body sizes may also serve as a buffer against the constant bombardment of the media of the white ideal body habitus, through which print and television advertisements society broadcasts what it finds to be acceptable. Overwhelmingly, what is shown to be acceptable is thin, not curvy (100); white, not Black. Black women have not allowed this message to overly affect them. They have demonstrated that, even when they are overweight, they are secure in their bodies, satisfied with their appearance (80) and continue to evince high self-esteem. They are of a mind to “be happy with what God gave you” ((15) p. 235). So far, the strength of their cultural ideals has allowed them to resist the messages they hear that “thin is in” and to preserve their self-

esteem and their sense of dignity. With the preponderance of obese Black women in the United States and worldwide, some ask whether this steadfastness, which has brought Black women a sense of mental health, has come at the expense of their long-term physical health? This question ignores the other factors that have contributed to the obesity epidemic among Black women. A more constructive question would be “Knowing what we know about the cultural, socioeconomic, and political issues that affect Black women, how do we use this knowledge to better design programs that will decrease the prevalence of obesity and, hence, the prevalence of preventable diseases that result in high morbidity and mortality in the Black community?”

Chapter 2: A Study of Thoughts and Attitudes Regarding Weight and Weight Management Among Overweight Black Women

Part I: The Current Study: An Introduction

The objective of this study was to gain a better understanding how Black women feel about their bodies, the level of support they feel they get from their friends and family members, and what factors may influence a Black woman’s desire to participate in and/or drop out of a structured weight management program. After a thorough review of the literature, which suggested that the culture and attitudes of Black society led to increased acceptance of a wide range of body types and a focus on “making do with what you’ve got,” I hypothesized that the Black women in the study would feel comfortable in their own bodies, regardless of their weight. I also hypothesized that this comfort with their bodies would be reinforced by their friends and family members. I hypothesized that this comfort level would lead to fewer weight loss attempts, a weak professed desire to attend a weight management program, and high attrition rates from such programs. Finally, I hypothesized that weight management programs, which I suggested in chapter one are designed with a

Caucasian audience in mind, would turn off African American women from attending. It is hoped that pertinent data from the study will be used to design and implement effective, culturally-sensitive, disease-management programs in order to decrease the prevalence of obesity, heart disease, and hypertension among African American women.

Part II. Methods

Because the general nature of the questions posed minimal harm to the study participants, this research was deemed exempt from full Committee review by the University of California, Berkeley, Office for the Protection of Human Subjects. A qualitative study using in-depth interviews was used to discover how African American women felt about weight, body image, and weight management program design. Please see the appendix for the full interview instrument. The data from the interviews were then analyzed using grounded theory developed by Glaser and Strauss. Grounded theory methodology involves using categories that emerge from the data rather than using preconceived categories to identify key themes.

Participants

In qualitative studies, the emphasis is placed on purposive sampling. Purposive sampling seeks participants with specified characteristics, experiences, and/or behaviors who represent one or more perspectives deemed relevant to research goals. In this instance, the common characteristics are that all of the women are African-American and self-identify as overweight. Additionally, to be eligible for the study, the subject must speak English, not be pregnant, and be over the age of 18. The final sample for the interviews were made up of volunteers who fulfilled the above criteria and who responded to an open invitation.

TABLE I: THE PARTICIPANTS	
Subjects*	Brief Biography
Caroline	A 39-year-old, single parent who works as a secretary.
Cassie	A 43-year-old mother of 5 children. She is a recovering drug addict who originally hails from Louisiana.
Catherine	A 57-year-old female on disability with fibromyalgia.
Dallas	A middle-aged mother of a 12-year-old son.
Deandra	Originally from New Orleans, Deandra is the mother of a 10-year-old daughter. She has back problems and dreams of losing 50 pounds.
Debra	Debra, the mother of a 22-year-old daughter, is a recovering drug addict.
Delilah	A 47-year-old single mother of 2 children.
Dolores	A 44-year-old single mother of 4 children. Originally from Mississippi, she has sickle cell anemia and is a recovering drug addict.
Dontonia	Dontonia is a middle aged, minister's wife. She is originally from the South.
Glenna	An elderly, widowed grandmother of one. She is a former schoolteacher and systems analyst.
Kendra	A 40 year old originally from Minnesota. She is an ordained minister and her mother taught nutrition to kids.
Mahogany	A 28-year-old mother of a 5 year old. She lives with brother and boyfriend.
Rachel	Rachel is one of seven siblings, all girls, though she is the only one who is big. She is a 65-year-old single mother of one child.

Ruth	Ruth is a middle aged woman who is unemployed and on disability. She wants to lose at least 30-40 pounds.
Sherry	A 29-year-old married mother of two children. She is on disability.
Tonia	Tonia has been married for 4 years. She is the proud grandmother of one. She attends church regularly.
<i>*All names are pseudonyms.</i>	

Procedures

The interview guide consisted of 12 open-ended, core questions developed by the primary researcher with assistance from Ms. Joanne Ikeda and Dr. Judith Warren Little. Some of the interview questions had optional prompts. The principal researcher conducted a semi-structured interview that lasted 30 minutes to 1½ hours at a location of the participant's choosing. All subjects were asked to respond to the 12 core questions. However, given the individuality of all participants and the nature of qualitative interviewing, interview questions beyond the core set of questions varied from one participant to the next depending on the themes that came up during the interview. In addition to audio-recording all of the interviews, the primary researcher took field notes.

The majority of participants were recruited from the University of California Cooperative Extension Nutrition Education Program, which serves a low-income population. A total of nineteen African American women from the East Bay gave their fully informed written consent to be interviewed and to have their interviews audio-recorded. Subjects received \$35 for their participation in the interview.

Data Analysis

Due to equipment malfunction, only twelve of the nineteen interviews were audible enough to be transcribed. These verbatim transcripts were the primary data used in the content analysis. However, field notes from four of the seven interviews that were not transcribed were also used in the analysis. Initially, two randomly selected transcripts were jointly reviewed and analyzed by the primary researcher and by Dr. Susan Ivey using the principles of Grounded Theory to identify categories from each individual interview. The primary researcher then reviewed the remainder of the interviews himself using the previously identified categories and adding others when appropriate. I thoroughly reviewed all of the categories on multiple occasions to ensure that they were clear, distinct, exhaustive, and mutually exclusive. After reviewing all transcripts several times, the transcripts were then inductively coded using QSR NVivo 2.0 qualitative analysis software and central themes were identified. In reporting the findings, individual comments are used to demonstrate the general themes that emerged from the transcripts.

Part III. Results

The results presented below follow the lines of the initial research questions, but they also tended to go in unexpected directions. The main themes identified included the participants' health knowledge, what they saw as the cause of their overweight, how they perceived their bodies, what consequences came from their overweight, the criticisms they received from their peers, their previous weight management attempts, and what they expected from an ideal weight management program.

Health knowledge

The health knowledge of participants was judged by the principal investigator. They were said to have good health knowledge if they mentioned the benefits of fruit and

vegetable intake, regular exercise, and limiting the amount of processed or fast food.

Women who did not specifically mention all three of these items were deemed to have inadequate health knowledge. Using this criteria, ten of the sixteen women in the study showed a fair amount of health knowledge. They seemed to recognize what made good nutritional habits and what were good exercise habits.

DALLAS: Yeah. I was going - me and D - will start going there [the Farmer's Market] shopping and trying to see how it works the best. I've been trying to buy produce and fresh vegetables instead of canned vegetables lately. We're eating a lot of healthy foods, vegetables and plenty of water, less sodas, and juice.

MAHOGANY: I mean just be active, do exercise and check your meals and eat a little more healthy. I mean you can be healthy at 200 pounds. I mean athletes, they be up there to 200-400 pounds and they're healthy. It's just how you do your body. If you give it good food you'll get good outlook.

For five of the sixteen women, this knowledge came from health professionals such as their doctor.

KENDRA: [My doctor] definitely said, "You need to exercise," which I already knew that, that I needed to exercise. And then he would say how I needed to exercise and he talked about walking and making sure my cardio was up, riding a bike - all those types of things that was going to keep my metabolism moving so I would be able to drop the weight you know burn the calories and drop the weight.

Six of the sixteen women received this knowledge after enrolling in a weight management program.

RUTH: And also, the [weight management] instructor, she has told us how to eat properly and drink plenty of water. And the water makes you full where you won't want to eat more, and eat more fruits and vegetables instead of snacking like the candy bars. And also potato chips; she told us to eat pretzels instead of chips. And a lot of healthy things -- like crackers.

Cause of overweight

The reservoir of health knowledge that these women possessed allowed them to recognize what led them to become overweight. Most of the women recognized that

overweight comes from a combination of overeating and not exercising enough. Six of the sixteen women felt their excessive weight was due to eating too much food at any one time.

CATHERINE: But I would have like maybe a cup of oatmeal when really that's a whole lot. That's a whole lot. I've always had a huge appetite but I'm learning to cut down on oatmeal. I actually measure my oatmeal in the morning. And I learned that an 8-ounce glass of juice is really too much. And okay where else did I overeat? Just all over.

Eleven of sixteen women also identified eating the wrong foods as a contributor to their weight gain.

CASSIE: I like to eat sweets. I'm trying hard. I'm working on that one. Not so much the chocolate or the cakes or the pies or the candy. For me it's cookies.

A lack of exercise was also seen to be the culprit in weight gain by five of these women.

DEBRA: I used to walk a lot. I'd ride my bike. I would swim you know I was just basically more active. Now I'm more sedentary where I just do things like read and write. And you know I'm not very active as far as getting out and doing things. I could be much more active. I should be much more active.

Six of these women indicated that their poor eating habits and a lack of exercise became more pronounced after they had their children.

DEANDRA: I was eating but it seemed like before I had [my daughter] you know I could never gain weight - never. I was always 135...it's just after the Caesarean I just gained weight. And then the birth controls pills made me start getting big and that's why I don't take them to this day. They started it off.

The pressure of balancing personal time with family time became more pronounced after the children entered into the equation.

CAROLINE: If you're a single parent and you're working when you get home I don't have time to go the gym you know; I don't have a lot of that spare time that other people have. And by the time I get home you have to sit down with your child; you have to start the dinner; you have to start the homework. So there's not much time left over. And in this day and age you just can't leave your kids at home alone anymore while you just go hang out at the gym.

Nine of the sixteen women stated that mental health issues, including stress and depression, were a factor in their weight gain.

GLENNA: It seemed like at night I guess I was lonely so I would eat. And it was just before bedtime and I know that's the worst thing you can possibly do.

TABLE II: HOW THEY BECAME OVERWEIGHT	
Eating wrong things	10/16
Lack of exercise	8/16
Eating too much	8/16
Medical issues	5/16
Childbirth	4/16
Quitting drugs	2/16
Other	3/16 (early puberty, genetics, aging)
<i>Participants may have identified more than one reason that they became overweight.</i>	

Body image/perception

One of the inclusion criteria for entry into the study is that the women self-identify as overweight. As MAHOGANY put it "Oh yeah. I know I'm overweight." However, the response to identifying as overweight varied between individuals. Six of the people were really bothered by overweight.

CATHERINE: But after I gained all of that weight that's the first thing I noticed. And no one wants to be out of shape. I stopped wearing my clothes in. As you can see I wear my shirt out. Even though I've lost quite a bit I still wear my shirt out because I'm still not shaped the way I desire. I want to be neat. ...But I want to be able to just look at myself and not feel ashamed and think, "Okay everyone else is noticing what I notice." That makes you embarrassed.

However, seven women, despite being overweight were content with themselves. As an example, DEBRA, who wanted to lose weight, still recognized that she possessed valuable qualities.

DEBRA: I feel like I'm still a beautiful, Black woman regardless of what size I am. But it is not good to be overweight. I wish I was just normal, regular size. Like a regular size 12.

In spite of their own issues with their weight, seven of the sixteen participants negatively judged women who were larger than themselves or saw larger women as a warning sign of what may result if the participants did not change their behaviors. In response to the question, "What do you think when you see a women who is larger than you?" these two women answered as follows.

CASSIE: I guess it would depend. If she's in proportion to that weight then it's not bad; it's not a bad thing. But when you get to looking obese and you're not taking care of yourself and it's hanging everywhere I think that that is an eating problem. Just get away from the table; get out of the house you know.

CAROLINE: I don't think anything, I don't, 'cause I can relate. Although sometimes when I really see a really big one I'll say, "Oh shit! Maybe I should stop eating!" (chuckles)

Consequences of overweight

Many women in this study realized that being overweight can have significant consequences. Seven women mentioned that these consequences can be related to one's health.

CAROLINE: And I also know that your health is you know also an issue in terms of the weight. Like I have high blood pressure related to the weight so...

SHERRY: Just because I have my certain limits of things that I can't do and I figure if I was a little bit - if I wasn't as heavy I'd be able to do. Like walking up the stairs and the problems of - if I could walk up the stairs without huffing and puffing then I would consider myself to be a little bit more healthier.

However, the ramifications of excess weight can also extend beyond health issues.

MAHOGANY: As you do see - I mean they say, "Don't judge a book by its cover." Because you could be the most nicest most beautiful person that you could talk to and you could discriminate just because they're big proportion or something.

SHERRY: But they don't understand that when you're heavier it's not as easy to keep yourself up as it is when you're smaller. Clothes cost more because there's more material.

Criticism from others

TABLE III: CRITICISM FROM OTHERS	
Positive comments about weight	Negative comments about weight or suggested to lose weight
4/16	14/16
<i>Participants may have received both positive and negative comments about their weight.</i>	

One consequence of being overweight was that they had to deal with the comments of strangers, family and friends.

DEBRA: [My family] said, "Look at you you're getting so fat! God, you've gained so much weight! Look at you! Look at how big you are!" "What you been doing?"

DALLAS: I used to use [my dad's] phone for a message phone and I would ask him if anyone called me and he would say, "Yes Jenny Craig." (Laughs) And then when I was a baby I was a preemie and he always made little jokes and comments like, "Where's my little baby?"

SHERRY: There was an incident where I went to the grocery store and just making my groceries. And I have snacks and stuff like that and she's asking me, "You're really going to buy all that? You do not need that."

Occasionally, these comments would have a motivating effect on the person. But these comments were very negatively received by 56% (9/16) of the participants.

DEBRA: [When people make comments] it makes me feel horrible. It makes me feel defensive. I want to be defensive. Or either I will come back with a comment as to how skinny they are. It's never just - I mean why say anything at all? Why even comment?

Prior weight management attempts

The participants had tried a variety of weight loss attempts. Several of them used their nutrition knowledge to diet on their own, while others joined structured weight management programs. The weight management techniques that women undertook themselves included modifying food intake and exercise, following commercial diet plans,

and taking diet pills. Thirteen out of sixteen women increased their level of physical activity, eight of sixteen modified their eating habits, while eleven of sixteen participants tried a commercially available diet in order to lose weight. In this study, commercial diet plans are differentiated from structured weight management programs in that the former do not include group meetings. Of the commercial diet plans tried, some were well-established (e.g. Slim-Fast, Atkins, etc.), while others were less well known (e.g. cabbage diet, honey and apple cider vinegar diet, etc.). Seven of the sixteen women had either tried diet pills or stated that they would like to try diet pills.

DEBRA: At one time in my life too I took this pill that this girl had given me. She said that she was using it for a diet. I was in my 20's; I'm 50 now. But it worked really well and it didn't like hype me up or anything; it was just a real easy pill to take. And it worked like you know I didn't eat for days. I forgot what it was called. But it didn't amp you up and make you all hyper like that. It was real mellow but it just really worked.

The structured weight management programs that were most frequently cited included Weight Watchers and a program run by West Oakland Health Center. Of those that tried the structured programs, several likes, dislikes, and barriers to participating in the programs were enumerated. Types of barriers included access to childcare, hours, fear of public opinion, and finances.

MAHOGANY: It was really the time plan on the Curves because at the time I tried it I was going to try it but it was the money. I wasn't able to get into the program.

Another barrier to attending and/or remaining in a weight management program was ease of utility. Five of the sixteen women mentioned how the weight loss method that they chose to follow was too burdensome.

MAHOGANY: Because mostly women ...feel exercise is like hard work.

TABLE IV: PREVIOUS WEIGHT LOSS ATTEMPTS

Subjects	External Aids			Modified Habits	
	Commercial Diet	Weight Management Program	Diet Pills	Ate Differently	Increased Exercise
1. Caroline	X	X		X	X
2. Cassie	X	X	X	X	X
3. Catherine		X			X
4. Dallas	X		X*	X	X
5. Deandra	X	X	X	X	X
6. Debra		X	X		
7. Delilah	X				X
8. Dolores	X		X		
9. Dontonia	X	X			X
10. Glenna		X		X	X
11. Kendra	X			X	X
12. Mahogany	X		X	X	X
13. Rachel	X	X			X
14. Ruth		X			X
15. Sherry	X	X	X		X
16. Tonia				X	
Totals	11/16	10/16	7/16	8/16	13/16

**Wanted to try them.*

Conceptualization of a perfect program

These women had many ideas on how a program should operate. Issues that they considered important to address in an ideal weight management program included length of the program, type of program (individualized versus group), the attributes of the instructor, programmatic content, and what changes they expected to occur after completing the program.

Open ended duration – Fifty percent of the study subjects thought that the program should be never-ending. They felt that entering into a weight management program had the potential to be a life-changing event. Consequently, any such program should be available to them for their entire lives.

CATHERINE: You know what? For the rest of my life I really want to have connection with a lifestyles class. Because I've just - it's really like an activity to me now. It's something that's going to help me. And one hour a week is not going to rob you of anything; it's only going to help you. So I think I really want to get in - stay involved in healthy lifestyles.

SHERRY: I wouldn't even give it - I wouldn't even say that it's just six months and then you're out. I would say that they would build a friendship and this would be life-long.

Group support and sense of community – Eleven of sixteen women wanted the community and support that comes from being involved in a group program.

DEANDRA: I think it is easier losing weight. It's better when it's a group. Cause everybody's like, "Yes, we're losing weight! Girl you lost that weight! Look at you!" And that makes a person feel good. Cause like you can't really see if you lost weight cause you see yourself all the time.

GLENNA: We have called people, "Where were you? Where have you been? What are you doing" Things like that. "I've missed you." Or send them a little birthday card - anything. Or 'We miss you' card. Just anything to let them know, "Okay you're not here but we'll be looking for you." And let them know that we want them back.

An instructor with whom they can identify – The instructor was a very important part of the program. They wanted a Black woman, who was not skinny, and who was supportive, who knew of the travails that they had been through.

CATHERINE: You have to have some type of experience in life that will link you to the person. You have to be personable. Because if you're not personable no one cares. They just won't show up. I'm speaking for myself. And nine times out of ten another female is the same way. So you've got to be personable, you've got to have the right attitude; you've got to be friendly and be able to deal with all types of personalities.

MAHOGANY: It wouldn't be overweight but she'd be a full figure type instructor that's healthy in all aspects but she's showing them, "Hey I have a little weight on me. We can do it together." You don't have to have the basic skinny person that's fit and healthy. You can get out there, have a proportional person. But she's healthy, she's trained to do what she's doing and get out there. I mean I guess if you see a person looking like you and doing these, you'd be more enthused to do it because you go, "Hey, she's not a small person. She's not sitting there skinny and teaching us big girls how to do this. She's a big girl. She's showing us we can do it too."

SHERRY: Not a skinny girl! (Laughs) I don't want to see any skinny people! I guess someone else who is about the same - well not the same size but someone who's caring; someone who is understanding and someone who is either - if she's skinny then I would say she was once heavy and she lost the weight. Because she would have to understand what Black women - she would have to be Black. Because she is going to be the only one that understands what it's like to be a Black woman that's heavy. So that way she would come in there with the same attitude that everyone else has, or that we're going through at that time because she's already past that. But I would rather her to be one that's not scared to say - give us a pat on the back and say, "Good work! Good job!" Or "You look great today." Something like that and not to say, "I saw you were eating a candy bar." Because there are going to be times you're going to slide but not to knock you and be there to help lift you up and not to kick you down.

Content beyond weight management – In addition to what one would normally expect a weight management program to address (i.e. food preparation, eating habits, exercise), the women felt that the program had to tackle other factors – including mental health issues and life skills training – in addition to, or even prior to, dealing with weight loss.

KENDRA: A lot of Black women are oppressed, depressed. They tend to overeat because of those reasons. They tend not to want to live or push beyond the norm of

the comfort zone. And I think that with just those elements of depression and being oppressed and stuff, that's what is creating people having weight problems, obesity and different things like that. I think that if we had more support systems, support groups, a lot more programs that would help us deal with again it goes back to the mental capacity of a lot of things that we hover of different situations and experiences that we go through throughout our lives, that if we had more of a support mechanism and programs or some types of things that would gear us away from the negativity of a lot of situations that Black women have to contend with or deal with. And we had more induced information or programs about - or programs, just programs that would say it's okay to go through this and that, but let's get that under control and let's look at the real picture here. You don't need to overeat. There's ways you can handle your situation so you don't have to sink deeper and deeper into depression and things like that. And you can maintain your weight; you can maintain your appearance. A lot of people will go through a depressed situation, or oppressed situation and their whole appearance will come down. Sometimes they tend to lose weight; sometimes they'll gain weight. It just depends on how that affects their body you know body structure. And a lot of times they'll smoke or they'll do different things that will enable their body from being all that it can be so that it looks to be on the positive side of health you know. So like I said basically I would strategically plan a program that is designed to help depressed women of color so that they don't feel like they're in situations or going through situation alone. It's almost just like a drug rehabilitation. It's almost the same thing as that. But you're dealing with the mental capacity of whatever situations that they may have, or experiences that they may have been challenged by in life.

Expected change beyond weight loss – Once they completed the program they expected to lose weight. Seven of the sixteen women wanted to correct the health conditions due to their weight. However, fourteen subjects felt that this program was going to be a life-changing event so that the change would extend beyond their physical realm and into the mental/spiritual realm. In the words of CASSIE, she expected “Everything [to change]. For one, the way I feel about myself.”

DEBRA: When I'm done I've learned how to not eat because of stresses that I'm going through; how not to let my children stress me out to make me overeat; how not to become depressed and lay in the bed and eat because I'm depressed. I know more about how to deal with the problems that I'm facing and not use food as an answer. More or less I would be learning how to deal with the answers that I really need to get. If it's finances then I need to learn how to handle my finances. That's what the problem is. Or because I don't know how to handle my finances then I lock myself up in the room with a gallon of ice cream and spend all the money on ice cream and then after that's done I've gained like 30 pounds. And I could have dealt with it by

having somebody help me figure out how to budget my money better or help me figure out how to get a tutor for my kid or whatever. You gotta go to the source, man. You gotta find out what the source is.

TONIA: Everything. I'm going to have a whole new attitude. I'm going to feel better about myself. I'm going to be energized and I'll be more physically fit.

Part IV: Discussion

The etiology of obesity and overweight is a complex phenomenon. This seems to be especially true among Black women, who make up the most overweight segment of U.S. society. This study described what participants felt was the cause of their overweight, the consequences that came from being overweight, and what they felt could be done to combat this spreading epidemic among Black women. Major themes that emerged from the data included health knowledge, level of support, and change expected from participating in a weight management program.

As previously demonstrated, the interview participants seemed to have a firm grasp on nutrition and diet information. However, the health benefit that this knowledge gave them was marginal at best. On the one hand, a lot of these women appeared to have a solid foundation of knowledge about the types of food that should be eaten, how food should be prepared, and what constitutes adequate amounts of exercise. It is apparent that this information, which has been proffered by the United States Department of Agriculture (USDA) and that some women learned in previously taken weight management classes, has been inculcated. Unfortunately, this knowledge did not translate into behavioral change nor did it seem to prevent the participants from trying diets of dubious efficacy. The number of women who tried "fad" diets and/or diet pills was alarming. Reasons for the high prevalence of their use seem, at least partially, to be a consequence of the American culture of advertising and our inability to accept the concept of delayed gratification. The use of "fad"

diets and diet pills appear to be driven by marketing that effectively targets low-income populations. Phrases that have been the mainstay of television diet advertising such as "This is not for the casual dieter," from the CortiSlim® commercials were also parroted by some of the study subjects. Consequently, while it seems that the message from the USDA and its food pyramid has been heard, the women in this study also have been following the messages from the various diet products manufacturers. These competing messages appear to have created an internal battle with which these women are struggling. Whose message is more convincing? Or, is it a question of which message is easiest to follow? The participants in this study may have felt that the food pyramid guideline is a puritanical message given by the government that has to be rigidly followed. The information being received about the food pyramid may be that one must have extraordinary self-control to eat the suggested 2-4 fruits and 3-5 vegetables each day and not to eat too much of the forbidden items that reside atop pyramid. Such a perceived rigid structure may not take into account the binges through which some of the women in this study have gone. Contrasted with the puritanical message of the USDA is the alluring message put forth by the manufacturers of diet products. Many of the commercial weight diet programs are seducing people who already are pressed for time, perhaps, with a message that all you need is a magic pill to cure what ills you. For people desperate to lose weight, the idea that all they would have to do is to take a pill to make the weight disappear is a captivating one. The pills are like a lottery ticket that will buy one's way out of their impoverished life. Despite the knowledge that the chances of a diet pill being effective in managing one's weight is incredibly slim, for some, the thought of forgoing the hard work it takes to lose excessive weight by simply popping some pills, is too tempting to resist.

Knowledge, then, is not enough to change the patterns of one's behavior, be they eating, exercise, or thought patterns. One must also have the motivation and the support that allows one to travel a long and difficult road in order to complete a task that may not be all that palatable. Beginning and following through with an exercise or dietary modification process is a difficult thing to do. Paraphrasing one subject, for such a process to be successful it must be ingrained in the form of a habit. However, in order to allow the participant to accumulate the time needed to make the behavior habit forming, steps need to be taken in order to retain subjects in a particular program.

One area that participants felt could contribute to increased retention rates is increased amounts of support. Support was conceptualized as being provided by the way the program was designed, but it also was to come from the program instructor and from fellow program members. Many interviewees had started a program and lost weight, but lacking adequate support and aftercare, regained previously lost weight or even exceeded their prior weight. As participants conceived it, support needs to be lifelong, it needs to be provided in a positive and upbeat fashion, and in an environment that is accepting and understanding of the many potential pitfalls that occur with attempts at behavioral change.

Programmatic support was pictured as being very extensive. More than one participant felt that the program should last a lifetime or that the program should end only when the *participant* felt that she was finished. This conceptualization of how a program should end may have a lot to do with the high attrition rates of Black women from typical weight management programs. These women feel that they are finished when they feel finished, not when the program says that they should be finished. Because healthy living is a lifelong process, perhaps a true end to the program would never occur. The women in this

study did not wish to be commodified, spit out at the end of a predetermined amount of time to struggle on their own to control their impulses, remember to eat correctly and get the right amounts of exercise. It seemed that some subjects view the perfect weight management program as a family that one would enter into and, of course, one does not normally voluntarily leave a family relationship. The women, in this family-like atmosphere, would receive lifelong assistance with their struggle with their weight. This type of extremely long-term follow up and support at a cost that is amenable to low-income Black women may not be financially feasible for a for-profit, unsubsidized program, but it is something that these women are seeking.

Support was also identified as something that the participants wanted from the program instructor and the make-up of the instructor – both the physical attributes and the personality – seemed to play an important role in her ability to provide support. Harkening back to a family-style environment, participants seemed to want the instructor to be almost like a motherly figure. Like their own mothers, the instructor should be a Black female. The instructor should also provide encouragement and remain upbeat and positive when an inevitable failure occurs. The instructor should also maintain contact with the participants even after the class session may have ended. Like the concept of a life altering change that drove the desire to have lifetime program follow up, the instructor should also be involved in the *life* of each participant.

Finally, most of the women wanted the support of their fellow program members. However, there seemed to be some internal conflict on this issue as some of the women were hesitant to include other Black women in their struggle to lead healthier lives. For example, Sherry felt that Black women are cruel, but she also stated that an ideal program should be a

group program so that she could get the support and encouragement that she desired. Perhaps, having felt the sting of the judgment of others, these women were wary of letting others in on the pain they experienced. However, many participants negatively judged women who were larger than them. Perhaps this is where the conflict originated. By conceiving of a group weight management program the women seemed to be saying that if they all got together in a safe place and talked about their issues they could learn to be supportive and caring toward one another and learn how to not be so cruel.

One reason that women seemed to be seeking so much support from the program is that they are not receiving sufficient support from their friends and family members. It has been posited that there is this greater acceptance of larger body sizes in the Black community. While this may be true in some respects, it is clear that the friends and families of the study participants – often in malicious and vehement ways – made it clear that they did not unequivocally accept these women's size and weight. This unwillingness to accept their loved ones, regardless of their size, may be making the obesity matter even worse because for many women lack of support from friends and family led to depression. Being depressed then caused them to overeat. Perhaps, because they do not get the support that they desire from their families, they seek to create a caring environment in their ideal weight management program. It is almost as if the women need to create a new family because their existing families know them as fat and cannot get past that fact.

As stated previously, the issue of mental health – i.e., depression, stress, self-acceptance, self-love, etc. – and its effect on one's eating habits came up in 56% of the women's narratives. Mental health was brought up both as a factor that led to weight gain and as a consequence of excessive weight gain. Overeating due to mental turmoil occurred

frequently among these women. But, mental health seemed to contribute to excess weight in a broader context. It was as if the women were saying “I’m so stressed right now I can’t even begin to think about my weight.” Paraphrasing the words of one participant, Black women need to love themselves first before they begin the hard work of behavior change. Whether deep-seated or bubbling at the surface, at some level the women seemed to recognize that mental health issues held primacy over their physical being. Without one’s mental status intact, it is all but impossible to go through life as a functional human being. It has been demonstrated that Blacks utilize mental health services less frequently than whites (101, 102). One possible reason for the underutilization of mental health services is the stigma associated with use of the services. By using a holistic approach and integrating mental health services into a weight management program, these women would get the services that they need and desire.

Another theme, one intimately tied to the issue of mental health and eating habits, that arose from the study is what these women expected from a successful weight management program; they wanted complete, global change. When asked what has changed in them at the completion of their idealized program, the statement that echoed through many of the transcripts – even in those where mental health was not explicitly mentioned to be an important part of who they were as an overweight Black woman – was “My whole attitude has changed.” These women wanted to be reinvented. Lowering one’s weight and being free from illness played a part in this reinvention, but it did not seem to be integral. To use another metaphor, I cannot help but think of a butterfly and the cocoon; for these women I imagine that their excess weight is the caterpillar, the program is the cocoon, and the newly emerged butterfly is their new metamorphosed self, a self that is stronger, more confident,

and more self-assured for its participation in the program. Perhaps this is what is missing from typical weight management programs. These women are expecting to be *changed*. They do not just want to lose the weight. Perhaps this is why some of them are so disappointed/disillusioned with traditional avenues of weight loss. These programs may not concentrate on the transcendental aspect of the process of changing one's body.

Earlier I used the metaphor of a person seeking a family as what they sought in their weight management program. Another metaphor, and perhaps a more accurate one, would be that they were seeking a church and its congregation. Traditionally, church has played an important role for African Americans by providing them with religious guidance and also providing a forum in which to address political, educational, and health care problems (103). It was this well-rounded rendition of a church that the women seemed to be seeking from their weight management program. The women in this study wanted a caring, supportive environment, but they also wanted help with any mental health issues they may be having, and for some, they wanted spiritual guidance as well. While church-based programs have been used to provide weight management services, the question of whether they have better outcomes than traditional secular programs is dubious/inconclusive. However, like secular programs the idea of completion in church-based programs may be incongruous with the needs and expectations of Black women. These women do not "complete" church, some are regular go'ers while some are more sporadic, but attending church and leading a spiritual life is not something that is to be done and crossed off of a list. Measuring attrition by the number of sessions one attends over a set period of time or whether the person attends the last session does not give a true measure/result of the effectiveness of the program in generating individual change. Structuring weight management programs to have a distinct

beginning and end may not be effective and may detract from the powerful changing process that could be occurring in churches. This general approach to designing a program – one that focused on the whole person – mind, body, and spirit – and had extensive follow up – can be successful in a secular environment for those who are not religious so that the greatest number of people can receive the potential benefit from a well-designed program.

In addition, this type of program may not only be effective for Black women, but it may be applicable to different races of people. A recent study of low income White women found that disordered eating habits (e.g. stress eating) were common, there were real barriers to the women adopting healthier lifestyles, and the goal of weight loss was subservient to financial, emotional, familial, and health care goals (104). The authors of this study came to similar conclusions: that programs that address financial, emotional, and nutritional concerns may be most effective in controlling weight among poor White women. Additional research, with greater numbers of participants and a mixture of low-income Black and White women, is necessary to determine if these preliminary findings have general applicability.

Limitations

Perhaps the greatest limitation of this study is the small number of transcripts upon which the analysis is based. In qualitative research, the sample is often small because the nature of qualitative research demands intensive and prolonged contact with participants, yielding an enormous amount of data per person. I originally intended to interview 20 subjects, which given the time constraints of the Master's thesis, I felt was appropriate. However, due to equipment malfunction there are only 12 complete transcripts and four sets of field notes available for analysis thereby reducing the power of my findings.

Specific questions regarding the demographics of the study population were not taken. The only demographic information included in the study is that volunteered by the participant in response to another question. Therefore, though the principal researcher interviewed all of the participants, for the most part in their homes and so has an idea of their socioeconomic status (SES) and made the judgment that the majority of the participants were low income, one cannot say for certain anything about the economic status of these participants. And, it is known that socioeconomic status plays a role in perception of body image. Furthermore, in developed countries SES is inversely correlated with body weight (19).

An additional limitation of this study is that it was a convenience sample that excluded very few people from participating in the study. Consequently, people with disabilities that may have contributed to their weight gain were included in the study. This inclusion may bias the finding of what factors led to the weight gain in the study population as a whole. However, since this study attempted to discover the perception of the effects weight gain has on the lives of Black women and how they deal with their own weight, the inclusion of people with disabilities may have very little impact.

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Appendix A: Study Interview

1. First, could you tell me a little about yourself?

PROMPTS:

- A. What is your age?
- B. How many years of school have you completed?
- C. Are you married, or in a steady relationship?
- D. Do you have any children?

2. I would like to know how you would describe your body?

PROMPTS:

- A. Do you feel that you are overweight?
- B. Do you consider yourself an attractive woman?
- C. Do you feel that you have a healthy body?

3. (If she views herself as overweight) How do you think you came to be overweight?

PROMPTS:

- A. Do you feel that your weight gain is due to lack of time, lack of exercise, poor eating habits, and/or lack of access to exercise equipment?

4. What, if anything, have your family members and friends said to you about your weight?

5. What, if anything, has your doctor said to you about your weight?

6. How do you feel that large women are viewed in the African American community?

PROMPTS:

- A. When you see a large Black woman, what are some of the thoughts you have about her?

7. What have your experiences with weight management and/or weight loss been like?

8. Have you ever enrolled in a weight management class? If so, what did you like about the program? What didn't you like about the program?

Now I'd like to see how you feel about how weight management programs are designed.

9. As you may know, African-Americans have higher rates of high blood pressure, diabetes, and heart disease than the general population. If you had a chance to design a program that would improve the health of African-American women, what would that program look like?

PROMPTS:

- A. Would it be a group program, a class, or individual counseling?
- B. Would it be advertised as specifically for African-American women?
- C. What would be covered in the program?
- D. How many sessions would it be?

- E. How often would the class meet?
- F. How much would the class cost to attend?
- G. Would there be an ongoing support group after the program ended?
- H. Who would lead the program? Think about a health professional who has helped you improve your health. What was that person like? How did s/he help you?

10. Imagine that you completed your ideal weight management class, what has changed about you?

PROMPTS:

- A. Have you lost weight?
- B. Do you fit into your clothes better?
- C. Are you more attractive?
- D. Have you lowered your blood pressure?
- E. Have you controlled your diabetes?

11. Which type of program would you prefer; one that focused on healthy living, that is, reducing your blood pressure and your risk of diabetes and heart disease, or one that focused on losing weight? Why?

12. We would like to know how to design weight management programs that are more appealing and effective for African-American women. Is there anything else that you can tell me that would be helpful for you so that you could lead a healthier lifestyle?