Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by African American Women

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Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by African American Women

A Dissertation by

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ACKNOWLEDGEMENTS

When I was a boy, I thought like a boy, I acted like a boy, and I spoke like a boy. When I became a man, I started thinking like a man, I started acting like a man, and I started speaking like a man. This doctoral journey helped me think, speak, and act like a researcher without personal opinion; I can be unbiased. I was born in the Republic of Congo. My father, a former police officer, has 20 children by 12 different women. I am number 11. I never liked school, but I love education. My mother, who was a schoolteacher, always told me that only education could free a man. My father taught me at a young age that education is key to a successful journey. My grandmother taught me about entrepreneurship at the age of four years old. My great-grandmother, Mama Miyamou who passed away, always believed in me before I believed in myself. She was proud to tell people in our village, “one day my great-grandson will be somebody.”

Today, as I am looking back, it took a village to raise a skinny, hyperactive, young boy, and they turned me into a successful leader. I owe a debt to those who never gave up on me. From a child soldier to a United States Marine to a successful entrepreneur, and now a doctor. Many thanks to God, who spared my life and kept pushing me west to end up in America. I, also, want to take a moment to thank the American people who gave me a chance after I was rejected all over the world. America gave me shelter when I needed a place to live and gave me clothing when I was cold. America gave me food when I was hungry, and most of all, America gave me freedom and opportunity to achieve my greatest potential.

The road to greatness was never easy. Who would have ever thought that this skinny, young Black boy would be called Dr. Tchicaya Missamou. Not even in my
wildest dream could I imagine it. Many people in my life have contributed to my success. My wife, Anna, and my three beautiful children, Yana, Marie, and Allan, have given me the strength. To the members and staffs of my organization, The Warrior Fitness & Wellness Camp in Santa Clarita, my second family who accepted me for who I am and never tried to change the skinny, vicious boy from the Congo, I want to say I love you from the greatest depths of my heart. To the people of the Congo, who lost hope due to civil war, I want to say your battles have not gone unnoticed; the bravery of the people of the Congo has given me the will to never give up. To them, I hope to make you proud. To my mother and father-in-law, I want to acknowledge that without your support it would be very difficult for me to be here today. To my chair, Dr. Larick, thank you for your leadership. To Dr. Woo, thank you for teaching me the importance of attention to details. To Dr. Obed, thank you for showing me the way to humility and leadership. Lastly, to Dr. Herpin, no words can describe how much I appreciate your mentorship in this journey. To my classmate and cohort mentor your support and guidance is deeply appreciated.
DEDICATION

I would love to dedicate this piece to my aunt, Mama Nicole; she was 13 years old when she took me as her son when everyone else had abandoned me. She never had children of her own – I was her son. She gave me everything she had to give a son. She helped me escape the Congo during the civil war as I was forced to be a child soldier. She helped me when I was homeless in Belgium and found me shelter. She helped me and supported my journey to America. When I returned to the Congo and was arrested and incarcerated, at much risk to herself, she smuggled in a cell phone, so I could call America for help. I will never have the words or power to repay all she gave, and still gives to me. Throughout my life, it has always been Mama Nicole by my side. I believe she would lay down her life for me. I cannot express how much I love and honor this woman. To her, I owe my life.
ABSTRACT

Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by African American Women

by Tchicaya Missamou

Purpose. The purpose of this mixed-method study was to understand and describe the impact of Bracken’s (1992) six domains of self-concept (affect, academic, competence, family, physical, and social) on weight loss as perceived by African American women.

Methods. This study employed a sequential mixed-methods exploratory design. A web-based survey was administered with 66 respondents, followed by in-person interviews with 10 participants. Data were collected from African American women who participated in a fitness and weight loss challenge and lived in the greater Los Angeles Area.

Findings. The extent to which each domain affected participants’ ability to lose weight was mixed. The competence domain was rated slightly higher than the other domains in terms of affecting participants inability to lose weight. Also, there was general consensus the academic domain had little impact on weight and weight loss compared to the other domains.

Conclusions. Based on the findings from this study and the literature review, it was concluded that weight and weight loss were not connected to the academic or social domains of self-concept for African American women. It was also concluded that the family and competence domains affected weight and weight loss to varying degrees and in different ways. Additionally, it was concluded that weight and weight loss was
connected to the emotional domain of self-concept with direct link to genetic predisposition passed on from generation to generation dating as far back as slavery.

**Recommendations.** Based on the findings from this study and the literature review, it was recommended additional efforts be made to education and target the African American community to support a healthy lifestyle. It was also recommended that government agencies and industries redefine their standards to support a healthy weight for African American women.
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CHAPTER 1: INTRODUCTION

Throughout history, being overweight was desirable because it indicated both health and wealth (Cassidy, 1991). Due to limited food resources in ancient times, finding enough high-caloric food to meet nutritional needs was a challenge for everyone. Having enough food to be overweight was one of the first indicators of wealth. As such, it was not surprising that obesity remained a sign of health and wealth in countries suffering from high rates of malnutrition, gut parasites, infectious diseases, and other wasting conditions due to lack of food resources. Being thin indicated a person’s inability to find an adequate amount of food and losing weight was associated with sickness and a cause of concern. Eating well was a sign of prosperity because it required the financial resources to purchase food. Only the wealthy could afford an abundance of food and this luxury reinforced their social status and good health (Cassidy, 1991).

Historically, a higher percentage of body fat among rulers and leaders helped them survive famines whereas the thinner, general population was more likely to succumb to disease during those times (Bradley, 2011).

With the advancement of technology in some societies, food became more abundant as farming was industrialized. This provided more people with enough food, but also increased excessive weight gain (Schlosser, 2009). However, the common belief that weighing more equaled prosperity was slow to change. As living conditions and access to food improved, a high-caloric diet was no longer a challenge. The abundance of food and decreased daily physical labor enabled people to consume more calories than necessary (Schlosser, 2009). Individuals met and surpassed their nutritional needs with a high-caloric diet at an alarming rate, which became a global threat affecting countries all
over the world (World Health Organization [WHO], 2000). In many countries, being overweight was no longer viewed as a sign of health and wealth. Rather, obesity was viewed as a health problem that spread across the globe.

Children and adults in countries around the world are affected by the epidemic of obesity and weight gain. In the United States (U.S.) alone, nearly 78 million adults and 13 million children suffered from health and emotional effects associated with obesity (Karnik & Kanekar, 2015). About 70% of the U.S. population was considered overweight or obese according to the National Health and Nutrition Examination Survey 2009-2010. The survey revealed the frequency of being overweight or obese varied among different racial-ethnic groups (Karnik & Kanekar, 2015). A study conducted by Bombak (2014) revealed that more than 37% of U.S. adults suffered from weight gain or obesity. African American women had the highest rate of obesity within this population (82%), compared with 76% for Hispanic women and 64% for Caucasian women (Bombak, 2014). For men, the highest rate of excessive weight and obesity was 82% among Hispanic men, compared with 74% for Caucasian men and 70% for African American men (Thorpe et al., 2015).

Compared to women of other ethnicities, African-American women have a higher mortality rate from diseases related to obesity (Allison, Edlen-Nezin, & Clay-Williams, 2014; Cohen, Rehkopf, Deardorff, & Abrams, 2013; Jackson et al., 2013; WHO, 2000). Diseases linked to obesity included hypertension, diabetes, cancer, heart disease, and poor mental health. It was recommended the population be educated about the health risks of weight gain, including the importance of proper nutrition and exercise (WHO, 2000). Studies showed the African American female population is at the greatest risk, so
it is critical they be educated about the benefits of weight loss and exercise (Allison et al., 2014; Cohen et al., 2013; Jackson et al., 2013; WHO, 2000).

Obesity is determined by the body mass index (BMI), which measures body fat based on calculations using a person’s height and weight; an overweight adult was considered obese when his or her BMI was higher than 25 (Bener et al., 2013). In comparison, an individual with a BMI under 18 was considered underweight with the normal BMI range between 18 and 25 (Bener et al., 2013). The WHO (2000) subdivided obesity into three categories: a BMI between 25-29.9 was classified as overweight, 30-39.9 as obese, and above 40 as severely or morbidly obesity.

Many weight loss programs designed for the Caucasian population were not suitable to the African American counterpart (Huey, 2013). Physiologically, African American women differ from Caucasian women (Foster, Wadden, Swain, Anderson, & Vogt, 1999). For example, obese African American women have a much slower resting energy expenditure (REE) compared to obese Caucasian women. A lower REE delays the body’s response to both successfully losing weight and maintaining the weight loss (Foster et al., 1999). These differences put the African American female population at greater risk of becoming severely obese, and Kenney, Wilmore, and Costill (2015) recommended an educational weight loss program designed for their specific needs.

Research indicated that physical activity and proper nutrition had many positive health benefits, including managing weight, sustaining emotional well-being, lowering blood pressure, and decreasing the risk of diabetes (Kenney et al., 2015). However, most of these research studies were based on the Caucasian female population; the research did
not always apply to the African American population and the specific factors affecting its members’ weight loss (McTigue et al., 2003).

For the past three decades, many studies were conducted on weight loss; yet, the African American community was not properly represented. Yancey et al. (2004) noted it was critical to learn more and create a weight loss study tailored to African American women to help them combat obesity. The results of this study could help identify the contributing factors to current obesity rates and the methods to educate the target population, health care providers, and community leaders to decrease obesity, improve health and quality of life, and maintain weight loss among African American women.

**Background**

**Historical Factors of Physical Health**

Obesity is not new and could be found in many cultures throughout the decades, centuries, and millennia. Obesity used to be considered a sign of success, power, and wealth (Cassidy, 1991; Jayawardena, Byrne, Soares, Katulanda, & Hills, 2014). Human obesity was depicted in art in the New Age period between 8000 and 5500 B.C. with statues that included abdominal obesity and sagging breasts as what was considered desirable at that time (Littre, 1839). People in these ages believed that extra weight helped people withstand infectious diseases. However, the ancient Greeks knew the health risks of obesity. For example, physician Hippocrates acknowledged that unexpected death was more common in people who were naturally fat (Littre, 1839).

In today’s fast-paced world where individuals are often on the go, practicing healthy eating is a challenge. The Mayo Clinic Website (as cited by Jensen & Ryan, 2014) explained that for an individual to maintain a healthy diet, their food intake should
include a variety of foods in the right portions from each food group, and this varied depending on the person’s sex, age, weight, and other considerations such as pregnancy or health conditions. Healthy eating supports all body functions, such as improving the ability to fight off diseases, learning function, and decision-making processes (Drewnowki & Specter, 2004). Unfortunately, many people ignore or neglect the important steps necessary to control weight and maintain a healthy lifestyle; when health and diet were ignored, they led to obesity, hypertension, diabetes, heart disease, high cholesterol, and cancer (Bull, Eakin, Reeves, & Riley, 2006; Hu, 2013; Katz & Meller, 2014; Nestle, 2013; Roberson et al., 2014).

A healthy diet is a contributing factor in being physically fit and healthy. Studies validated the belief that a healthy lifestyle prevented or helped manage chronic diseases (Bartley, 2016; Langford et al., 2014; Myers et al., 2015; Sarafino & Smith, 2014; Wells, Evans, & Cheek, 2016). Eating right and physical activity was found to improve overall health in the following areas:

- Decreasing fluctuations in weight
- Reducing the risk of heart disease
- Reducing the risk of cancer
- Reducing the risk of developing diabetes
- Increasing bone density and muscle strength
- Fighting depression and other mental health illnesses
- Increasing longevity
- Increasing physical balance
- Improving happiness (Ogden, Carroll, Fryar, & Flegal, 2015)
In contrast, the lack of a healthy diet and exercise led to obesity, which in turn, created a domino effect of health problems that could lead to death (Ogden et al., 2015).

**Obesity**

Obesity is a global epidemic dating back to the Roman era, and evidence suggests obesity is increasing at a disturbing rate (Hruby & Hu, 2015). Though obesity is not contagious, it rapidly affects more and more people in developed and developing countries around the world, including adults and children (WHO, 2000). Despite predictions, the full extent of the health problems caused by obesity will only become evident in the future. However, obesity is already one of the biggest contributors of preventable chronic diseases and healthcare costs in the United States. Healthcare costs related to obesity were estimated to range from $147 billion to nearly $210 billion per year (Crawley & Meyerhoefer, 2012). Obesity was also identified as a source of exorbitant costs relating to employment; job absenteeism associated with obesity cost approximately $4.3 billion annually and lower productivity while at work cost employers $506 per obese worker per year (Shi & Singh, 2015).

As living conditions improved in the 20th and 21st century, research showed that in some cultures, weight gain was still a sign of beauty, wealth, and prosperity without taking into consideration the health consequences (Addo et al., 2009). Obesity spans across America with more than 300,000 Americans dying of obesity-related diseases each year (Center for Disease Control and Prevention [CDC], 2016). Though many populations are affected by obesity, the most prevalent population is African American women; studies showed that 60% of African American women were overweight compared to 33% of Caucasian women (CDC, 2016).
Obesity in the African American community can be traced to slavery. The food introduced to slaves remain part of the African American diet. These foods include pig’s feet, intestines, meat, and cornmeal (Covey & Eisnach, 2009). In times of slavery, working male slaves were given more food per day than females to help maintain their energy levels and endurance while working in the cotton fields (Bailey, 2015; Dirks, 2016; Miller, 2013; Planck, 2016; Whit, 1999). This typically included a peck of cornmeal and four pounds of salt pork, which was equivalent to 4,240 calories per day, and were cooked with buttermilk, sugar, and salt (Covey & Eisnach, 2009). These high calorie foods later became the foundation for a portion of the African American diet known as soul food. Female slaves who were also mothers had to share their smaller food portion with their children, making the amount of food inadequate; fathers who worked near their families found themselves sharing their food portion with their wives and children prior to leaving to the cotton fields (Covey & Eisnach, 2009).

In the African American culture, being overweight was and remains a sign of beauty. Many African American men prefer thick women verses skinny and fit women (Candid, 2007). African American men perceive a heavier figure in a woman as a sign of wealth. Since food was scarce and rationed in difficult times, the African American culture adopted this belief. Studies showed that cultural beliefs were a major influence on obesity in the African American community (Cachelin, Thompson, & Phimphasone, 2014; Clair, Daniel, & Lamont, 2016; Lofton, Julion, McNaughton, Bergren, & Keim, 2016; Nichols, Newman, Nemeth, & Magwood, 2015).

Factors such as income, stable and affordable housing, healthcare, and access to quality education impact an individual’s life expectancy (Drewnowski & Specter, 2004).
In African American communities, the lack of resources; access to affordable, healthy food; and safe places to be physically active contributed to higher rates of obesity and related illnesses (Avendano & Kawachi, 2014). In comparison to Caucasian adults, African American adults were nearly 1.5 times more likely to be obese; approximately 47.8% of African Americans were obese (37.1% for males and 56.6% for females) compared to 32.6% of Caucasians (32.4% for males and 32.8% for females; Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

Different cultures hold unique perceptions of beauty. African American women are at higher risk of obesity compared with any other culture because their perception of beauty contrasted medical standards for a healthy weight (Huey, 2013). African American women are more satisfied with their bodies compared to women of other cultures, despite having a higher body mass. African American women have less negative ideology about being overweight. Thus, they are more likely to remain overweight, but less likely to become entangled in forms of eating disorders or behaviors to lose weight (Huey, 2013).

**Educational Factors**

Higher levels of education related to lower obesity rates. Studies showed that when the head of the household had less than a high school diploma, 24% of the males and 22% of the females were obese (CDC, 2012). These numbers dropped significantly to 11% of males and 7% of females being obese when they had a college degree or higher. Women over the age of 25 without a college degree were more likely to be obese than women over 25 with a college degree (CDC, 2012). In addition, only 22% of
African Americans, in comparison to 54% of Asians, held a degree in 2015 (U.S. Census Bureau, 2015), making them even more susceptible to obesity

Cultural and Social Factors

Many African American women in the United States are descendants of Black Africans; their ancestors were Black African slaves brought to America (Gomez, 1998). This history continues to influence obesity rates today as African Americans have the highest obesity rates in the U.S., with 57% among African American women (Ogden et al., 2015). Soul food remains a famous part of the African American diet, but is high in sugar and trans-fat, often fried, and contributes to the obesity problem (Edwards, 2003). Transferring this traditional way of cooking from generation to generation made soul food an integral part of the cultural heritage of the African American community. Unfortunately, poor eating habits continued with this tradition. Alarmingly, research showed the damaging effects of regular consumption of high-salt, high-cholesterol, and sugary foods on health and the prevalence of hypertension, diabetes, and cardiovascular disorders. Regrettably, food choices among African American women were strongly driven by their heritage, regardless of any health consequences. It was more than food; in some cases, it was part of the African American identity (Edwards, 2003).

Living in rural areas is another cultural factor associated with obesity. Poverty and the lack of healthy retail food outlets limited access to healthy foods and contributed to poor nutrition (Ogden et al., 2015). For African American women, living in low-income neighborhoods where grocery stores were not prevalent and living conditions were poor was related to weight gain and obesity. Evidence showed that even in poor neighborhoods, African America families earned less money than Caucasian families
(Ogden et al., 2015). Due to poverty and the lack of access to healthy food choices, African American were forced to buy high-caloric, well-advertised foods, which were usually less expensive than healthy foods (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

Other factors like discrimination and the media influenced obesity. Studies showed women who experienced discrimination and racism were more likely to become obese (National Center for Education Statistics, 2016; Ogden et al., 2015). Additionally, news and social media influenced weight gain within the African American community (Harriet, 2015). Commercial Hip Hop and Rap videos present Black women in a sexualized, cut-up, objectified manner. The breasts, lips, and backside were shot at close-up angles and blended with other women’s body parts sending the message women were interchangeable and their purpose was sexual stimulation (Journal of Black Studies, 2010). The influence of such sexualization and objectification transcended African American culture and was seen as a lifestyle blueprint by which young girls aspired to live (JOBS, 2010). African American women responded to what was represented through all forms of media, but were less influenced by thin models (Balaji, 2010). If the representation aligned with their cultural values, they were more likely to follow suit (Emerson, 2002). With larger body sizes were popular in African American culture, increasing numbers of African American women resorted to elective surgery to attain this image (Malcolm, 2016). Plastic surgery and body augmentation was up dramatically from 1997, and procedures for African American women jumped 56% (American Society for Aesthetic Plastic Surgery, 2016).
**Weight Loss**

Weight loss is defined as a decrease of the body mass caused by the loss of body fluid, fat, and muscle, and occurred when the body burned more calories than it consumed (Stuhldreher, Deangelo, & Moglia, 2016). One pound of body fat contains 3,500 kilocalories (Rolfes, Pinna, & Whitney, 2014). An individual with a relatively sedentary lifestyle should consume between 2,000-2,500 kilocalories to maintain a healthy body weight, as excess calories turned into fat. A daily deficit of 500 kilocalories is needed to lose weight (Rolfes et al., 2014). Healthy weight loss is attained through both diet and exercise.

To manage a healthy weight, a diet plan must include fresh fruit, vegetables, whole grains, lean meat, fish, eggs, poultry, and nuts while maintaining regular calorie needs (CDC, 2016). Additionally, studies showed that exercise increased health and fitness; individuals who exercised by combining cardio training and weight lifting increased muscles mass and decreased body fat (Neferu, 2016).

The lack of physical activity and a poor diet contribute to the increasing rate of obesity among African American women. The level of physical activity in African American women could be correlated to socio-cultural barriers, such as a concern with hygiene involving their hair after exercise; African American women indicated that exercise made their hair smelly and they preferred keeping their hair clean by not exercising (Huebschmann, Campbell, Brown, & Dunn, 2016).

**Theoretical Background – Self Concept**

Self-concept is defined as how a person views him or herself physically and mentally (Stangor & Lange, 1994). Throughout early childhood, children begin to
develop self-concept as they become aware of and evaluate their internal state and external environment (Bem, 1965). Interactions with parents also contribute to the development of self-concept. For example, various emotional outbursts could be labeled and reinforced as appropriate or inappropriate according to a parent’s reaction; in that sense, cultural norms influence behaviors and self-concept (Greenbert & Murphy, 2016).

Self-concept, the way people perceive themselves, includes an individual’s beliefs about his or her personality traits, values, goals, and physical characteristics, as well as the fact that he or she exists (Stangor & Lange, 1994). Individual differences in self-concept are important predictors of social behaviors and actions among other people. Stangor and Lange (1994) defined three broad categories of self-concept. The first related to physical existence and traits, such as being tall or blond. The second aspect of self-concept was the personality traits or adjectives one attached when talking about him or herself, such as intelligent or determined. The third aspect of self-concept was externally reflected in the social aspect of self; the other members of the group or the sense of group membership largely dictated the social aspect of a person’s self-concept (Stangor & Lange, 1994).

With one of the earliest theories of self-concept, psychologist Carl Rogers (1961) divided self-concept into three domains. Self-image, one of the domains, was the way a person perceived him or herself, which did not always correspond to reality. If an individual had a positive self-image, his or her perspective of self could be inflated. In contrast, those with a negative self-image had tendencies to exaggerate weaknesses. Rogers (1961) also viewed self-image as a mix of personality traits, physical characteristics, and social roles. Self-esteem was defined as the value one attaches to
self, regardless of reality, and was developed from a combination of how others reacted to a person in social settings and the way one compared him or herself to others. High levels of self-esteem were also reinforced by positive feedback from others (Rogers, 1961).

In 1985, Linville’s theory of schemas, or categories, related to the self did not divide self-concept into specific groups or domains. Rather, his theory took a more singular, holistic approach that applies to how self-concept was formed based on individual’s own personal traits and attributes. Thus, self-concept was considered highly individualistic, varying from person to person, without specific categories or domains. Linville (1985) posited that self-schemas reflect the number of roles people have in their lives (e.g., child, parent, teacher, aunt) and people conceptualize themselves in numerous ways based on broad experiences within their various roles and relationships.


Building off prior theories examining self-concept as multidimensional, Herdman (2011) described seven self-concept patterns:
1. Social self: occupation, family situation, social groups
2. Personal identity: description of self, strengths, and weakness
3. Physical self: any concerns about body, likes-dislikes
4. Self-esteem: feelings about self
5. Threats to self-concept: illness, change in roles
6. History of related physical and/or psychological problems
7. Relevant physical education data: general survey

However, Herdman’s (2011) patterns were closely aligned with the domains of self-concept originally developed by Bracken (1992). Bracken (1992) described self-concept through six different domains:

- Social—the ability to relate to others and interact in social settings
- Competence—the ability to meet one’s physiological needs
- Affect—awareness of self when acting emotionally
- Physical—feelings about overall appearance including looks, health, and physical condition
- Academic—failure or success regarding education
- Family—how one resonated with family differences

Although there are similarities among the different theories examined, Bracken’s (1992) structure of self-concept took a more holistic approach with his categorization of knowledge and the communication and interaction among the different domains. Several distinct evaluative judgments of personal attributes are distributed through the domains and the multidimensional approach provides an explanation of how the various domains of self-concept affect ways people evaluate themselves (Harter, 1999). The information
from Bracken’s six domains of self-concept was described as more detailed and therefore more effective (Waugh, 2000). As such, Bracken’s (1992) theory of self-concept was selected as the theoretical framework for this study.

Examining obesity within the framework of self-concept inevitably leads to the incongruence of how African American women perceive their bodies compared to established health and societal norms. As Rogers (1961) emphasized, when self-concept was closely aligned with the physical reality, then congruence existed and self-alignment with reality was present. Multiple factors influenced incongruence, such as culture, historical heritage, social reality, and level of education.

Self-concept of body weight is defined as the degree to which the perceived weight and the measured weight correlate (Mueller, Hurt, Abu-Lebdeh, & Muller, 2014; Sánchez, Dijkstra, & Visser, 2015; Yang, Turk, Allison, James, & Chasens, 2014; Zaccagni, Masotti, Donati, Mazzoni, & Gualdi-Russo, 2014). When it came to body weight and self-concepts, it was found that the individual’s perception and actual weight did not always correspond. For example, overweight African American women were more likely to consider themselves to be a normal weight when compared to other ethnic groups (Mueller et al., 2014). As such, it is important to understand how African American’s perceptions of self-concept relate to weight loss and fitness.

**Gap in the Research**

The study of self-concept within the domain of physical health has major importance because different domains are affected when one’s health is threatened. Gender differences in self-concept were explored by Marčič and Grum (2011), where men and women were equally satisfied with individual domains such as appearance,
physical fitness, and intelligence, but females showed a better overall self-concept and were more satisfied with themselves in the social and relationship domains, especially with partners and family. Rojas, Brante, Miranda, and Pérez-Luco (2011) explored the self-concept of Caucasians with morbid obesity who underwent bariatric surgery. According to the authors, the participants reported increased feelings of attractiveness and satisfaction, also affirming they felt more secure, agile, and accepted (Rojas et al., 2011). Even in a weight loss study that included Caucasian and African American women, self-perception was a focus of the study for only the Caucasian women (Annessi, 2007). Changes in body satisfaction were expected to account for the greatest amount of variance for Caucasian women whereas for African American women, the study focused on their belief in their ability to achieve a weight lose goal (Annessi, 2007).

Regarding overweight African American women, a study showed this population was probably taught to believe their weight was normal, which influenced their self-concept (Hoytt & Beard, 2012). Rahman and Berenson (2010) found African American women misperceived the norms of body weight, despite having the highest rate of obesity in the United States. Another study indicated little was known about goal weight even though self-concept of weight correctness was a significant variable of weight loss behavior and diet (Chang & Christakis, 2003). Furthermore, the Ethnic and Racial Differences in Body Size Perception and Satisfaction, a statistical analysis conducted by the U.S. Census Data (2006) indicated there was an over-representation of non-Hispanic Caucasians in weight loss studies, and inversely indicating there was a lack of weight loss studies on people from other racial and ethnic backgrounds. Overall, there is a lack of general research connecting studies of self-concept and weight loss within the African
American female community and a lack of research conducted by African American researchers familiar with the culture of African American women (Kumanyika et al., 2007).

**Problem Statement**

Over 300,000 deaths per year in the United States alone are attributed to diseases related to obesity (Arterburn et al., 2013; Bauer, Briss, Goodman, & Bowman, 2014). Studies showed that the African American population is the most impacted by diseases related to obesity (Tuomi et al., 2014). Obesity is also the leading cause of deaths among this population (Bauer et al., 2014). Obesity affects African American females more than African American males (Ogden et al., 2015). According to statistics, 64% of women who died suddenly of coronary artery disease had no previous symptoms. A comparison between ethnicities revealed that 7.6% of African American women had coronary disease compared to only 5.8% of Caucasian woman and 5.6% of Hispanic women (CDC, 2016). Most African Americans are unaware of the dangers of obesity despite its impact on a great portion of the American population (Candib, 2007).

Obesity was found to be a contributing factor in reducing longevity and increasing the chances of developing hypertension, heart failure, diabetes, and coronary artery disease, with African American women being at greater risk in comparison to Caucasian women (Allison et al., 2014; Assari & Lankarani, 2015; DeSantis et al., 2016; Espey et al., 2014; McTigue et al., 2014; Montane, Cadavez, & Novials, 2014; Yoon et al., 2014). Not surprisingly, additional research showed that a healthy weight and increased quality of life could result from regular exercise and a balanced diet (American Diabetes Association, 2015; Myers et al., 2015; Sahoo et al., 2015; Sarafino & Smith, 2014;
Seligman & Csikszentmihalyi, 2014). The fight against the obesity epidemic must include an examination of the contributing factors for the rising rate of obesity among African American women and the creation of a program especially geared toward their health needs and concerns (Dietz et al., 2015).

According to several studies, the greatest impact on a woman’s ability to lose weight was her own self-concept (Buston & Emlen, 2003; Fox, 2000; Kirtley & Weaver III, 1999; Van Velsor, Taylor, & Leslie, 1993). Many women were motivated by their self-image to start the weight loss journey through exercise, but they did not change their eating habits (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). Proper perception of body image for health and beauty was vital component for motivating appropriate interventions and successful weight loss, and proper self-concept among African American women would help reduce the risk of weight gain and obesity (Duncan et al., 2011). The difference between their self-perceived body image and reality interfered with their ability to see the need for initiating weight loss (Johnston & Lordan, 2014). A curvy figure is perceived as a sign of beauty and wealth in the African American culture, and self-concept focused more on physical beauty than health factors (Cassidy, 1991). As such, African American women are in an unfavorable position when it comes to weight management and weight loss (Ray, 2014). Overweight women with positive self-images were often unaware their BMI exceeded healthy limits and posed multiple health risks (Lee, Lee, Guo, & Harris, 2011).

African American women are unaware that even though they are confident about their appearance, they are still at risk for multiple health conditions (Duncan et al., 2011). Educating African American women about a healthy BMI and its importance could help
reduce the risk of weight gain and obesity (Lee et al., 2011). Additionally, helping African American women develop self-concepts better aligned with health standards could increase their motivation to lose weight (Beruchashvili & Moisio, 2013).

**Purpose Statement**

The purpose of this mixed-method study was to understand and describe the impact of Bracken’s (1992) six domains of self-concept on weight loss as perceived by African American women.

**Research Questions**

This study focused on the impact of self-concept as it pertained to weight loss for African American women utilizing the six domains of self-concept developed by Bracken (academic, affect, competence, family, physical, social). The specific research questions guiding this study were:

1. How does the affective/emotional aspect of self-concept impact weight loss and fitness as perceived by African American women?
2. How does the academic aspect of self-concept impact weight loss and fitness as perceived by African American women?
3. How does the competence aspect of self-concept impact weight loss and fitness as perceived by African American women?
4. How does the family aspect of self-concept impact weight loss and fitness as perceived by African American women?
5. How does the physical aspect of self-concept impact weight loss and fitness as perceived by African American women?
6. How does the social aspect of self-concept impact weight loss and fitness as perceived by African American women?

7. What elements of Bracken’s six domains of self-concept do African American women perceive as having the greatest impact on weight loss and fitness?

**Significance of the Study**

In the U.S., diseases related to obesity claim roughly 300,000 deaths per year (Arterburn et al., 2013; Bauer et al., 2014). Studies conducted by government agencies reached the conclusion that African Americans are the highest risk population, followed by Hispanics and Caucasians (Cunningham, Kramer, & Narayan, 2014; Odgen et al., 2015; Pulgarón, 2013; Skinner & Skelton, 2014; Sturm & Hattori, 2013). Although obesity rates are increasing tremendously across all races and genders, African American women face some of the most rapid rising rates of obesity (Arterburn et al., 2013). During the past 10 years, the frequency of diseases related to obesity amplified from 10% to 19% among African American women as compared to an increase from 12% to 17% among Caucasian women (DeSantis, Ma, Bryan, & Jemal, 2014).

Research studies by African Americans raised significant concerns over rapidly increasing obesity rates (DeSantis et al., 2014). Also, cultural variables and traditional beliefs impacted African American women’s body image (Allisson et al., 2014; Lynch & Kane, 2014; Stockton et al., 2009). In the African American culture, an overweight woman is culturally viewed as sexy, confident, and healthy (Self-Reported Health Perception, 2014). As such, African American women have a higher weight acceptance and less pressure to be thin than Caucasian women. According to researchers, African American women perceive their weight status differently from healthcare experts who
view obesity within this population as taken carelessly (Sutin & Terracciano, 2013). To increase awareness of obesity, healthcare experts must be understanding and sympathetic to different cultural beliefs and ideals, especially among the African American population.

This study was significant because it focused on how self-concept impacted obesity and weight loss in African American women. Long-term weight loss programs and guidelines must be designed to meet the specific needs of African American women (Fletcher, 2014). To accomplish this, healthcare providers, government officials, and community leaders must understand African American women’s self-concept and how it relates to beauty, health, and obesity. Currently, most weight loss studies done with African Americans focused only on short-term outcomes (Fletcher, 2014). Findings from this study could help decrease diseases related to obesity by adding the essence of the African American women’s experiences and perspectives to the literature.

**Definitions**

**Academic Domain.** The self-concept domain related to one’s ability to learn and success in an academic setting (Bracken, 1992).

**Affect Domain.** The self-concept domain related to one’s emotional state (Bracken, 1992).

**Competence Domain.** The self-concept domain related to one’s ability to meet his or her basic needs. (Bracken, 1992).

**Family Domain.** The self-concept domain related to one’s family and the support received from family (Bracken, 1992).
**Obesity.** A disorder of that occurs over time as more calories are consumed than the number of calories burned resulting in a high level of excessive weight (Reilly, 2007).

**Physical.** The self-concept domain related to how one feels about his or her body and physical qualities (Bracken, 1992).

**Self-Concept.** Internalized feels of how one views him or herself physically and mentally, including beliefs about personal traits, values, goals, and physical characteristics (Stangor & Lange, 1994).

**Social Domain.** The self-concept domain related to how one feels about his or her ability to socialize and interact with others (Bracken, 1992).

**Weight Loss.** Decreased body mass resulting from when an individual burns more calories than consumed.

**Organization of the Study**

Chapter I introduced the study and presented the background, problem statement, purpose, research questions, and significance. Chapter II provides a comprehensive review of the literature relevant to this study. Chapter III details the methodology used to conduct this study, including the research design, population, sample, data collection procedures, analysis, and limitations. Chapter IV presents the study findings, and Chapter V provides and interpretation of the findings, including conclusions, implications for actions, and recommendations for future study.
CHAPTER II: REVIEW OF THE LITERATURE

A combination of genetic, environmental, and social factors cause obesity (Rose, 2016). To achieve weight loss, all three factors must be understood and addressed. The high rates of obesity and the number of persons affected by the pandemic make understanding the mechanisms through which successful interventions can be achieved critical, especially given the sizable number of overweight and obese people seeking professional help in their lifetime (Cawley & Meyerhoefer, 2012; Teixeira et al., 2015). Improving the effectiveness of weight loss interventions therefore has substantial clinical and public health importance (Teixeira et al., 2015). Recent research efforts focused largely on processes, predictors, or determinants through which interventions could produce significant and long-term change, or the casual mediators for intervention effects (Anderson, Bulatao, & Cohen, 2004; Flegal, Carroll, Kit, & Ogden, 2012; Teixeira et al., 2015). For African American women, studies must also include how cultural, social, and environmental factors impact their willingness to engage in weight loss programs. For instance, evidence suggested this population engaged in lower physical activity compared to other ethnicities (Anderson et al., 2004). A critical review of previous research was necessary for this study to provide a comprehensive background examining the impact of self-concept on weight loss as perceived by African American women. It included a review of the obesity phenomena, its definition, prevalence, and classification. The risk factors for obesity among African American women was also examined. Then, the conceptual framework for the study was presented, comprising the self-concept theory. Lastly, literature on self-concept domains that could have the greatest impact on weight
loss for African American women was reviewed, which included self-concept and weight loss, self-regulation skills, and psychological skills important in weight loss.

**Obesity**

**Prevalence and Classification**

Obesity is a chronic disease characterized by an increase in body fat (Hamdy, 2017). The condition was considered a public health crisis and a pandemic both in the U.S. and across the world, especially in industrialized countries (Flegal et al., 2012). In the U.S., an estimated 79 million adults (42 million women, 37 million men) and more than 12 million adolescents and children and adolescents were considered obese (Flegal et al., 2012). The prevalence of obesity among children and adolescents tripled in the last decade, and obese children were likely to develop into obese adults (Yanovski & Yanovski, 2002).

In terms of classification, obesity is indicated when the percentage of body fat is greater than 25% for men and 33% for women (Hamdy, 2017). Multiple methods can be used in measuring body fat. Techniques used in research include magnetic resonance imaging (MRI), underwater weighing (densitometry), and multi-frequency bioelectrical impedance analysis (BIA; Dehghan, Akhtar-Danesh & Merchant, 2005). Clinical techniques to measure body fat include measuring skinfold thickness, body mass index (BMI), and waist circumference. The clinical techniques are not as effective as the research methods; however, they are effective for identifying risks. Among the clinical techniques, BMI is considered more efficient for use in adults compared to children because of the physiological changes that take place in children’s bodies as they grow. BMI also does not distinguish between fat and fat-free mass (FFM; muscle and bone),
which could affect obesity assessments for more muscular children. BIA for body fat measurement was successfully used in both population-based and clinical studies because it differentiates between FFM, fat, and total body water (TBW) in children. Waist circumference is used for both adults and children because it identified central obesity (Dehghan et al., 2005).

Obesity is commonly described using BMI, which was calculated as weight divided by height. According to the World Health Organization (WHO, 2000), a BMI between 25-29.9 is classified as overweight, 30-39.9 as obese, and above 40 as severely or morbidly obesity. Children are classified as overweight when their BMI is above the 85th percentile and obese when their BMI is above the 95th percentile (Hamdy, 2017). Based on BMI, over one-third of adults in the U.S and 17% of children and adolescents fall into the obese category (Hamdy, 2017).

Obesity is associated with many co-morbidities such as ulcers, hypertension, metabolic syndrome, Type 2 diabetes, coronary heart disease, stroke, osteoarthritis, depression, asthma, sleep abnormalities, infertility in women, and erectile dysfunction in men (Flegal et al., 2012; Hamdy, 2017). The U.S. spends an estimated $190.2 billion every year, representing 20.6% of its national health expenditures, on managing obesity (Cawley & Meyerhoefer, 2012; Hamdy, 2017). An obese person uses on average $2,741 more for medical costs annually compared to a non-obese person (Cawley & Meyerhoefer, 2012). Loss of productivity associated with obesity costs the United States an estimated $73.1 billion annually, with $121 billion spent on weight-loss products and services every year (Hamdy, 2017).
Risk Factors in Obesity

The body uses nutrients from food such as protein, carbohydrates, and fats to make energy for daily body functions. Excess energy consumed is stored for future use as fat (Harvard School of Public Health, 2017). Energy imbalance means energy input from ingested foods and drinks (caloric intake) is greater than the energy used for body activities such as breathing, digestion, regulation of body temperature, and physical activity (caloric use). Thus, obesity results when caloric intake is more than caloric use. The body stores excess calories as body fat, with body weight building up over time. However, the risk of developing obesity is not simply related to high caloric intake (Harvard School of Public Health, 2017). Rose (2015) developed a model encompassing six factors contributing to obesity: environmental, genetic, medical, endocrine, social, and neurobehavioral (Figure 1).

![Obesity is a multifactorial disease](image)

*Figure 1*. Factors associated with obesity. Source: Adapted from Rose, 2016.

Some risk factors for obesity could be changed, for instance, environmental factors and unhealthy lifestyle habits; however, other risk factors like genetics, race,
ethnicity, age, and sex could not be changed (Harvard School of Public Health, 2017). Heredity and genetic factors play a role in obesity. Studies showed being overweight and obese ran in families (Harvard School of Public Health, 2017). Factors such as maternal diabetes, high birth weight, and family history of diabetes could predispose children to obesity, and there is 40% to 80% chance of obesity in children if one or both parents were obese (Nauta, Byrne, & Wesley, 2009). Genes also interact with other factors like lack of physical activity and unhealthy diet to cause obesity (Harvard School of Public Health, 2017). For instance, the DNA of fetuses could be affected by the eating habits of their mothers, predisposing them to obesity. Pregnant mothers who smoke are also more likely to have children who become obese adults (Harvard School of Public Health, 2017). Some genetic syndromes even cause obesity, such as the Prader-Willi syndrome, Cohen syndrome, Bardet-Biedl syndrome and Alström syndrome (Department of Health and Human Services, 2017). Similarly, some endocrine disorders or tumors cause obesity because the endocrine system produces hormones important for maintaining energy balance and body regulation. For instance, in hypothyroidism, low levels of thyroid hormones are associated with decreased metabolism, which results in increased weight even when caloric intake is reduced (Department of Health and Human Services, 2017).

Unhealthy lifestyle habits such as poor eating patterns, lack of physical activity, high amounts of stress, and insufficient sleep increase the risk of being overweight or obese (Department of Health and Human Services, 2017; Harvard School of Public Health, 2017). Unhealthy eating behaviors creating a risk for obesity include eating more calories than needed, eating unhealthy foods containing too much trans and saturated fats,
and eating foods high in sugars. In the typical Western diet, meals are high in unhealthy fats, sugars, refined grains, and red meat, all of which play large roles in obesity (Harvard School of Public Health, 2017). In addition, junk food is largely available in schools, workplaces, and convenience stores, and people are influenced by food and beverage advertising on television to buy foods that put them at risk for obesity (Harvard School of Public Health, 2017).

Lack of proper information and education regarding nutrition leads to increased caloric consumption (Rose, 2016). Disorders such as binge eating, night eating syndrome, and bulimia nervosa can also lead to obesity. An estimated 2-3% of adults in the U.S. are affected by a binge eating disorder. In binge eating, the person eats large amounts of foods frequently, at least once every week, over a 3-month period. Up to 50% of severely obese patients engage in binge eating. Night eating syndrome affects about 5% of the U.S. population and involves about 25% of food consumption taking place after the evening meal. Bulimia involves recurrent binge eating and purging afterwards (Rose, 2016).

Socio-economic status is also an important factor in obesity since it determines nutritional status (Harvard School of Public Health, 2017). Low-income families have more obese children as they typically consume more fast food and lack access to healthy foods such as fruits and vegetables. Environmental factors affecting weight gain and obesity include limited access to safe places to play or exercise, easy access to fast foods, and in some cases, potential exposure to chemicals causing hormonal changes and increased body fat (Harvard School of Public Health, 2017).
Physical inactivity is an important contributor to weight gain. Inactivity is associated with television watching, computer use, video games, and other screen usage (Cawley & Meyerhoefer, 2012; Nauta et al., 2009). Studies also show an association between high BMI and insufficient sleep, indicating a relationship between sleep and the way the body processes nutrients for energy; a lack of sleep could affect the hormones associated with hunger urges (Li et al., 2010). Similarly, acute and chronic stress triggers the production of hormones like cortisol, which controls energy balances and hunger (Department of Health and Human Services, 2017; Harvard School of Public Health, 2017). Race and ethnicity represent another important factor in obesity; in American adults, the rates of obesity are highest for African Americans, followed by Hispanics and then Caucasians (Bombak, 2014; Thorpe et al., 2015). Asian adults have the lowest BMI rates (Anderson et al., 2004; Dingfelder, 2013). Sex is also a factor in obesity as men stored more unhealthy fat in their abdomen compared to women (Department of Health and Human Services, 2017; Harvard School of Public Health, 2017). Lastly, the use of medications such as antiepileptics, antipsychotics, antidepressants, and antihyperglycemics also lead to weight gain and obesity (Rose, 2016).

Treatment and Management of Obesity

Treatments for being overweight or obese include nutritional management, physical activity, behavior therapy, pharmacotherapy, staged weight management, and bariatric surgery (Bays, 2012; Ross, Kolbash, Cohen, & Skelton, 2010; Suarez & Mullins, 2008). Recommended approaches for treatment or management are based on observations of the behaviors associated with the individual’s obesity, as well as clinical experience and trials. General guidelines for obesity interventions include evaluating
changes in BMI over time, counseling, and routine risks assessment (Ross et al., 2010; Suarez & Mullins, 2008). Multidisciplinary intervention programs that include a psychologist or psychiatrist, a physician, physical therapists, and dietitians often result in long-term weight loss of between 5% and 10% depending on the patient and program (Bays, 2012). These management approaches are usually employed together, but for clarity are addressed separately in the following sections.

**Physical activity.** Physical activity is associated with reduced BMI; therefore, incorporating exercise and increasing physical activity levels is an important element in managing obesity (Dehghan et al., 2005). In tandem with nutrition and self-monitoring, the National Weight Control Registry (NWCR, as cited in Bays, 2012) noted successful weight loss maintenance included at least 60 minutes of physical activity daily, eating breakfast daily, and minimizing sedentary activities such as watching TV. Establishing a routine that increased physical activity is important in maintaining long-term weight loss (Bays, 2012).

**Nutritional management.** A healthy diet should include a variety of food in the right portions from each food group (Jensen & Ryan, 2014). The portions needed from the diverse food groups vary depending on sex, age, weight, and other considerations such as pregnancy or health conditions. Healthy eating supports all body functions, including mental processes, immune functions, reproduction, digestion, and healthy weight. Nutritional management of obesity requires an effective strategy involving dietary goals and planning activities to accomplish those goals. Dietary goals could include limiting the amount of sugar and sugary beverages consumed, limiting the number of times spent eating at fast-food restaurants, reducing portion sizes, or
increasing the intake of vegetables and fruits (Jensen & Ryan, 2014). Adopting a reduced-glycemic load diet is another strategy in the management of adolescent obesity (Dehghan et al., 2005). A low-calorie diet provides 800-1500 calories per day and a very low-calorie diet provided less than 800 calories per day (Bays, 2012).

Fresh fruit, vegetables, whole grains, lean meat, fish, eggs, poultry, and nuts eaten in proportion to calorie needs is the foundation of a healthy diet plan to help manage weight (CDC, 2016). However, a combination of caloric restriction, self-monitoring, physical activity, program adherence, and patient preference is more effective for obesity management than just focusing on a specific diet (Bays, 2012). Similarly, although increasing physical activity could contribute to weight loss, the most effective intervention is a negative caloric balance. Today, wearable technologies and apps can help patients track and assess nutrition, caloric intake, and physical activity (calories expended) to better implement a healthy lifestyle (Bays, 2012).

Behavior therapy. A variety of behavioral strategies are also used in weight management. Established counseling techniques used in the treatment of obesity were based on a behavioral change model that included stimulus control, self-monitoring, goal setting, and positive reinforcement (Suarez & Mullins, 2008). The goal of stimulus control is to reduce the environmental cues promoting unhealthy behaviors while creating an environment conducive to health and healthy behaviors. For instance, removing televisions from bedrooms and removing unhealthy foods from the home helps reduce negative behaviors. Increasing access to healthy foods such as vegetables and fruits could lead to improved health and weight outcomes (Suarez & Mullins, 2008).
Self-monitoring focuses on identifying risk behaviors and often used food and activity logs (Suarez & Mullins, 2008). Through self-monitoring, the patient and family members can identify the behaviors responsible for weight gain. Other contributors such as meal environments and level of hunger can also be evaluated through this process. The self-monitoring process is usually overseen by a professional healthcare worker or a physician (Suarez & Mullins, 2008).

Goal-setting is an effective technique used to prompt changes in behavior (Ross et al., 2010; Suarez & Mullins, 2008). Goals related to overall health, rather than focusing on weight loss, provide greater motivation and were more sustainable. The process is efficient, but goals must be realistic, measurable, maintainable, and time bound (Ross et al., 2010; Suarez & Mullins, 2008).

Additional techniques adopted to promote behavioral changes include motivational interviewing, family-centered communication, and scare tactics (Hill, Chapman & Donovan, 1998). Motivational interviewing is increasingly used in obesity treatment and uses the patient’s values to effect change in behavior (Suarez & Mullins, 2008). An encouraging, nonjudgmental, and empathic tone is adopted throughout the process. The healthcare provider engages in reflective listening as the patient is encouraged to identify his or her reasons for wanting to change behavior. Readiness to change can be assessed using numerical analogs or interviewing. The assessment helps both the patient and the health professional identify ambivalence, which was an important step in changing behavior. As in goal setting, realistic and specific goals related to overall health are selected for focus rather than setting goals that targeted weight loss specifically (Suarez & Mullins, 2008).
Family-centered communication involves engaging the entire family unit in the conversation to select behavior change goals. This ensures an intervention plan can be implemented confidently by the patients with the support of their families, enhancing the chances of success (Ross et al., 2010; Suarez & Mullins, 2008). Lastly, scare tactics are conversations about obesity emphasizing the health consequences of the condition (Hill et al., 1998). The clinician or health professional is responsible for educating affected persons regarding the risks associated with being overweight and obese. This includes providing accurate information to describe any health implications based on the person’s weight. This tactic is rarely used anymore because it tended to attract the patient’s attention in the short-term, but did not help with long-term changes. Risk-based thinking did not yield consistent responses. It is more efficient and effective to focus on outcomes such as reduced mobility, reduced athletic ability, and other immediate health experiences to motivate the patient to lose weight (Hill et al., 1998).

**Staged weight management.** The staged approach in weight management is simply a technique where the obesity intervention is divided into stages based on the BMI, age, and the weight management history of the patient (Ross et al., 2010). Interventions under this strategy are divided into four stages. The first stage is termed prevention plus, the second stage is structured weight management, the third stage involves multidisciplinary evaluation, and the fourth stage is tertiary care (Ross et al., 2010).

**Pharmacology.** Weight management pharmacotherapy is indicated or considered for patients who are overweight or obese and not successful in weight loss using nutritional management and physical activity (Bays, 2012; Després, 2012). Weight
management pharmacotherapy is used in conjunction with nutritional management, increased physical activity, and behavioral change therapies (Jensen et al., 2013). Prescription drugs for weight loss are approved for patients with a BMI of 30 and above, as well as those with a BMI of 27 or above with additional adverse conditions such as Type 2 diabetes, dyslipidemia, or hypertension (Bays, 2012; McKinney, 2013).

Many drugs are marketed for weight loss. For example, the drug Orlistat blocks intestinal lipase, an enzyme that reduces fat absorption in the gastrointestinal tract; it was approved by the FDA in 1999 (McKinney, 2013). Another drug, Phentermine, is used for 8-12 weeks as a short-term treatment for obesity. Lorcaserin was approved in 2012 by the FDA and activates specific receptors in the brain to promote satiety. A combination of Phentermine HCl and Topiramate also increases satiety. Other anti-obesity drugs included naltrexone, an opioid antagonist; bupropion, an antidepressant; and liraglutide, a metabolic hormone (McKinney, 2013).

**Surgery.** Candidates selected for bariatric surgery have a BMI greater than 40 or a BMI of 30-40 combined with significant complications such as obstructive sleep apnea, Type 2 diabetes, and hypertension (Bays, 2012; Hamdy, 2015). Bariatric surgery is usually supported by a multidisciplinary support team (Hamdy, 2015). This type of surgery leads to weight loss and improves the co-morbidities associated with chronic or severe obesity (Bays, 2012; Hamdy, 2015).

**Policy.** The National Institute for Health is funding obesity research as part of a strategic plan of the federal government to address obesity (Trust for America’s Health & Robert Wood Johnson Foundation, 2014). The goal of the research is to discover the biological processes influencing body weight and behavior, design and test interventions
for maintaining healthy weight, and harness technology to improve the health of people. At the state and local levels, with the increasing prevalence of obesity and its co-morbidities in society, managing obesity was beginning to be viewed as more than the sole responsibility of the individual. More people are understanding the risks that obesity pose to society, the wide-ranging factors that drive the pandemic, and the role of government policy in helping people stay healthy. Due to increasing public consciousness, leaders in cities across the U.S. began promoting public policies to encourage and support both healthy eating and active living. Such policies included creating more spaces for walking, biking, and exercising, as well as more parks and recreation centers (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

Some policy efforts focused on food financing and improving access to healthy foods for lower-income residents (Trust for America’s Health & Robert Wood Johnson Foundation, 2014). Communities and local governments also worked together to promote community gardens and farmer’s markets. However, it was unclear how effective these programs were at reaching and benefitting communities such as African American women who were highly vulnerable to obesity (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

*State of Obesity* (Trust for America’s Health & Robert Wood Johnson Foundation, 2014) recommended that investments toward preventing obesity directly involve local communities and partner with African American residents and other organizations. The report recommended equity as a measure for grants to assure that disparities were effectively addressed in obesity programs. Support should also be
increased at all levels of government (federal, state, and local) to address the racial and ethnic inequities associated within obesity. Other recommendations in the report included the use of culturally sensitive communications in obesity management programs, limiting access to advertisement for unhealthy foods, promoting leadership by community members, and encouraging private sector investments in grocery stores and selling of fresh produce (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

**Obesity among African American Women**

The prevalence of obesity among African American children and adults is very high. Over 75% of African Americans are either overweight or obese compared to 67.2% of Whites (Zhang & Rodriguez-Monguio, 2012). African American adults are 1.5 times more likely to be obese than Caucasian adults (CDC, 2012). Similarly, African American children have a higher overweight and obesity rate compared with Caucasian children (CDC, 2012). From 2011 to 2012, an estimated 21% of African American girls were obese as compared to 16% of Caucasian girls (Dias & Whitaker, 2013; Ogden, Carroll, Kit, & Flegal, 2012). In the same period, 20% of African American boys were obese compared to only 13% of Caucasian boys. Over 8% of African American children were severely obese versus 4% of Caucasian children (Dias & Whitaker, 2013; Ogden et al., 2012). Almost 60% of African American women fell into the obese category compared to 32% for Caucasian women and 41% for Hispanic women (CDE, 2012). This statistic indicated that African American women have a higher risk of developing co-morbidities such as hypertension and Type 2 diabetes than their male counterparts or women from other races (Dingfelder, 2013). The obesity trend among African American women also
negatively affects life expectancy (Dingfelder, 2013). Obesity among African American women and girls is multifaceted in its causes, including factors such as poverty and nutritional access, fast food, lack of exercise, limited access to safe places, and education.

**Poverty and Nutritional Access**

Lower socioeconomic status and poverty correlate with an increase in obesity rates; this correlation occurs because calorie-dense and less nutritious foods are cheaper than healthier foods (Trust for America’s Health & Robert Wood Johnson Foundation, 2014). Over 38% of African American children below age 18 and 43% of children below age five live below the poverty line (Dingfelder, 2013; Zhang & Rodriguez-Monguio, 2012). More than 12% of African Americans live at less than 50% of the federal poverty threshold, which is considered deep poverty (Trust for America’s Health & Robert Wood Johnson Foundation, 2014). One out of every four African American families are insecure with regard to nutrition and lack consistent access to food, compared with 11% of Caucasian families (Harris, 2010). A high percentage of African Americans live in low-income neighborhoods with limited access to supermarkets and healthier food (Dingfelder, 2013).

**High Exposure to Fast Food Marketing**

The easy access and less expensive nature of fast food also greatly affects African Americans (Harris, 2010; Yancey et al., 2009). Predominantly African American neighborhoods have 13 times more billboards and assorted outdoor advertisements for foods with low nutritional value than in Caucasian neighborhoods. Therefore, African American children are bombarded with more advertisements for fast foods compared to
Caucasian children, which further exacerbates the obesity rates of African American children (Harris, 2010; Yancey et al., 2009).

**Lack of Exercise**

Both exercise and physical activity improve health and fitness. Individuals who exercise by combining cardio training and weight lifting increase their muscle mass and decrease body fat (Neferu, 2016). Lack of physical activity, specifically exercise, and poor diet contribute to the increasing rate of obesity among African American women (Neferu, 2016). The level of physical activity in African American women may be correlated to sociocultural barriers, such as a concern with hygiene (Huebschmann et al., 2016). For example, African American women take great pride in their hair, and straightening and/or braiding their hair is an expensive and time-consuming process. These styles were meant to be worn for multiple days. African American women indicated that exercise made their hair smelly and they would rather keep their hair fashionable and clean by not exercising (Huebschmann et al., 2016).

**Limited Access to Safe Places**

African Americans communities lack safe places where children can be physically active (Dingfelder, 2013). As a result, African American children are 70% less likely to be involved in physical activity programs (e.g., sports) than Caucasian children (Dias & Whitaker, 2013; Trust for America’s Health & Robert Wood Johnson Foundation, 2014). Additionally, African American neighborhoods have fewer public parks, green space, and public pools than mostly Caucasian neighborhoods (National Recreation and Park Association, 2013). Due to the threats of violence and lack of neighborhood safety, African American women limit the amount of time they let their daughters play outdoors.

**Education**

Studies found higher levels of education correlated with lower obesity rates. When the head of the household lacked a high school diploma, the family was more likely to be obese (CDC, 2012). Conversely, obesity rates dropped to 7% among females and 11% among males when the head of the household had a college education (CDC, 2012). Studies also found that women who were older than 25 and did not hold a college degree were more likely to be obese than women of the same age who held a college degree (National Center for Education Statistics, 2016; Ogden, 2015). In 2015, only 22% of African Americans held a college degree, indicating a higher risk for obesity among 80% of African Americans (Census, 2015).

**Cultural and Social Factors**

Obesity among African American women had historical roots extending back to the slavery era. The types of food introduced to slaves remain a part of many African American’s diets; such food was high in calories with the goal of keeping the slaves productive in their work (Huey, 2013). This food is high in sugar, trans fat, and fried food, all which contribute to obesity; this food is an integral part of the cultural heritage and identity of African American communities and is transferred from generation to generation, making this a health risk (Edwards, 2003). A lack of food was a constant challenge during the slavery era, so being overweight was perceived as a sign of health and beauty in the African American culture (Huey, 2013). This perception of body image of African American women is a health risk because it promotes obesity (Huey, 2013).
Stress

High levels of stress from financial, racial, housing, social, employment, and unemployment issues affect the health and eating habits of African American women and girls (Dingfelder, 2013; Trust for America’s Health & Robert Wood Johnson Foundation, 2014). The research emphasized the importance of understanding the interaction between environment, negative health behaviors, stressors, mental health disorders, and physical conditions (Jackson, Knight, & Rafferty, 2010). Jackson et al. (2010) posited that structural life inequalities could cause physical and mental health problems. Structural life inequalities in employment, income, wealth, and educational opportunities were significant and unfavorable for African Americans, although variable for other minority groups. Overeating was found to be one of the ways in which African American women coped with chronic stress (Jackson et al., 2010). Studies showed that African American women used high-calorie “comfort foods” to buffer themselves from chronic stress associated with supporting their family and racism (Dingfelder, 2013).

Other Factors

The list of additional factors contributing to obesity in African American women includes obesogenic and built environments, cultural perceptions, and intervention contexts. These contribute to behaviors such as increased incidence of eating outside the home, lower physical activity levels, and increased consumption of high-calorie foods and beverages.

Obesogenic environment. The obesogenic environment uses a socio-ecological perspective to look at how local, state, and federal laws and policies influence body weight and weight gain. For instance, at the federal level, agricultural subsidies that led
to availability of low-cost products increased consumption of less nutritious but higher-calorie foods, without a corresponding subsidy for nutritious foods such as fruits and vegetables (Dingfelder, 2013).

**Built environment.** A built environment referred to the characteristics of individual communities. Neighborhood safety, community design, and available services are a few of these characteristics. Women who do not feel safe in their neighborhoods walk less than women who live in safer neighborhoods and limit the amount of time their children spent playing outside (Dingfelder, 2013). Physical activity in children is also reduced because African American neighborhoods often have less recreational spaces than Caucasian neighborhoods (Trust for America’s Health & Robert Wood Johnson Foundation, 2014). There were also more supermarkets with a larger selection of healthy foods in Caucasian neighborhoods compared to African American neighborhoods, and fewer fast food restaurants (Dingfelder, 2013; National Recreation and Park Association, 2013). Decreased opportunity for physical activity, limited access to healthy foods, and the convenience of poor-quality foods contribute to communities with high obesity rates.

**Culture and perceptions.** The disparity in obesity rates among African American, Caucasian, and Hispanic women is not explained by levels of income or education. Even with a higher educational levels and income, African American females were still more likely to be obese compared to their Caucasian counterparts (Dingfelder, 2013). Misperceptions about determining a healthy versus unhealthy weight appear to be an important factor in obesity, especially among African American women (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).
**Intervention contexts.** The effectiveness of current intervention programs for obesity varies for African Americans. Some programs did not show any benefits from interventions (Trust for America’s Health & Robert Wood Johnson Foundation, 2014). Evidence from research suggested that success may be better achieved by including African American women in context, family, developmental considerations, and cultural tailoring. They should also be included in the theoretical frameworks for such interventions (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

**Interventions for African American Women**

Many programs provided by local, state, and federal government agencies target obesity among African American women. For example, one federal program provides nutritional assistance to help families with low-income levels to access food; over 3.9 million African American families had access to federal benefits in 2011 and 29% of Women, Infant, and Children (WIC) enrollees were African American (National Research Council, 2013; Trust for America’s Health & Robert Wood Johnson Foundation, 2014). SNAP-Ed is a partnership between U.S. Department of Agriculture (USDA) and individual states to provide education on nutritional management; the program helps to increase the consumption of nutritious foods among its participants (National Research Council, 2013; Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

At state and community levels, many interventions target African American women. For instance, the *Prime Time Sister Circles* is a 12-week program initiated by medical professionals to help women lead healthier lives in Tampa, Chicago, Orlando, Philadelphia, Maryland, and the greater Washington, D.C. area (Dingfelder, 2013). The
women meet once a week to support one another, share stress management strategies, and discuss how to take better care of their health. Similarly, *Sisters Together: Move More, Eat Better* is a national program that uses small group discussions to empower African American women to live healthier lives. *Challenge* is another government program that focuses on obesity-prevention by promoting healthy eating and physical activity in culturally sensitive ways (Dingfelder, 2013).

**Theoretical Framework: Self-Concept**

Through recorded history, people believed there was more to the human being than the physical body. Cavemen drew pictographs indicating their understanding of a spiritual or non-physical self. Greek philosophers such as Plato, Socrates, and Aristotle developed on the idea of the soul or spiritual entity as part of the human being. Years later, theologians, such as Thomas Aquinas, further expanded on this as a separation of spirit and the human body in which it resides.

Early philosopher Rene Descartes (1659) studied the mind as to how it affects people’s bodies in the sense that thoughts affected actions. Other philosophers such as Spinoza and Liebnitz expressed ideas about the mind, soul, psyche, and self without experimentation. Overall, metaphysical disorganization existed until more recent times.

**Premier Studies of Self in America**

Over the last 150 years, American psychology has become a common discipline in academics. Interest in the self and self-belief was piqued when Williams James (1896) stated “the total self of me, being as it were duplex” (p. 54). James (1896) identified the self as knower, or I, and the self as known, or me. The I, he indicated, is pure ego and the me is composed of three elements: physical, social, and spiritual.
James (1896) noted his intent was to prove that the “I” and “me” were not separate, but rather aspects of self and he provided a mathematical equation for self-esteem. His equation contended that as people achieved a goal, their self-esteem improved. On the other hand, when people did not reach their goals, self-esteem decreased (James, 1896). Although James’ theories held strong for many years, his concept of the separate “I” versus “me” came under scrutiny by Albert Bandura (1997), who argued that thoughts and retrospect of such thoughts were of one action.

Cooley (1902) built upon the work on James and stated that self-esteem was formed by developed self-beliefs, a theory referred to as the looking-glass self. Appraisal by others helped form self-perceptions. Cooley (1902) argued children’s self-perception was formed by siblings, parents, teachers, and significant others. He also asserted self-identity was shaped during the formative years of people’s lives based on how others perceived them (Cooley, 1902). From the early works on self-concept and self-perception by James and Cooley, other theories were formed based on various schools of psychology.

**Influence of Popular Psychoanalysts**

Sigmund Freud was one of the most influential psychologists in the early 20th century. His idea of the id, ego, and superego influenced Americans across the country. Freud’s definition of the constant balance of thought stemmed from the id, ego, and superego reconciling with each other (Freud, 1923). Other psychoanalysts, such as Vygotsky (1925) and Mead (1934) countered that sense of self was developed more by environment and social experiences, or personality. Lewin (1935) stated that sense of self drives personality, giving much weight to the notion of self-actualization.
Self-Actualization

Abraham Maslow (1954) spearheaded the behavioristic approach to self-actualization in the mid-20th century. He developed a theory on the hierarchy of needs, with self-actualization being the highest point on the pyramid. Maslow (1954) stated the importance of self-actualization led to self-fulfillment, inner peace, and contentment. Many behaviorists conceded to Maslow’s interpretation of self-actualization (Diggory, 1966). However, another major force in the self-actualization movement was Carl Roger (1961), who stated personality was a concept self-developed by interpersonal relationships and social experiences. Roger’s (1961) approach to psychotherapy revolved around the client’s perceptions because of his or her experiences and found such revelations essential to behavioral adjustment.

Self-Efficacy

Albert Bandura (1997), educated as a behaviorist, was uncomfortable with the idea that behavior was not thought provoked. Bandura believed that self-doubt led to inactivity; if people lacked the knowledge or experience, they often believed it was impossible to acquire the new knowledge or skill. Bandura (1997) argued that people are proactive and self-regulating, versus reactionary or controlled by environment and/or biology as stated by William James. Bandura’s (1997) theory noted self-efficacy affects choices and decisions that people make in many ways, indicating people tended to stay with what was comfortable and rarely ventured into something that appeared too challenging. Thus, self-efficacy directly related to confidence levels. Bandura (1997) stated self-efficacy beliefs could affect emotions. For example, low self-efficacy could make one believe something was more challenging. Thus, self-efficacy could serve as a
form of self-prophecy as people limited themselves based on what they thought they could or could not achieve.

**Self-Concept**

Self-concept is a broad term encompassing self-perceptions, self-esteem, and self-worth. Self-perceptions within an individual are situational and vary greatly. For example, people may perceive they are good at their jobs, but not good at parenting or another skill. Self-esteem refers to the confidence one has in his or her abilities. Self-worth is the value people place on their lives, which is based on a collection of self-perceptions and the number of positive versus negative perceptions. Thus, self-concept is how someone perceives themselves based on their self-perceptions, self-esteem, and self-worth.

Stangor and Lange (1994) defined self-concept as how a person views him or herself physically and mentally, including personality traits, values, goals, and physical characteristics. They classified self-concept into three broad categories. The first related to physical existence and traits, such as being tall or blond. The second aspect of self-concept was the personality traits or adjectives one attached when talking about him or herself, such as intelligent or determined. The third aspect of self-concept was externally reflected in the social aspect of self; the other members of the group or the sense of group membership largely dictated the social aspect of a person’s self-concept (Stangor & Lange, 1994).

Linville’s (1985) theory of schemas took a more holistic approach to self-concept and asserted self-concept was formed based on individual’s own personal traits and attributes. Thus, self-concept was considered highly individualistic, varying from person
to person, without specific categories or domains. Linville (1985) believed the self-schemas reflected the types of roles people had in their lives (e.g., student, parent, friend, sibling) and people conceptualized themselves based on broad experiences within their various roles.

In contrast to Linville’s holistic approach, Shavelson and Bolus (1982) indicated self-concept theory was multidimensional. They categorized self-concept into two broad classes: (1) academic self-concept and (2) non-academic self-concept. Academic self-concept focuses on intelligence and achievement in learning environments whereas non-academic self-concept class is segmented into emotional, physical, and social domains, with physical self-concept further divided into physical aptitude and physical appearance (Shavelson & Bolus, 1982). Building off the work of Shavelson and Bolus and others, Herdman (2011) classified self-concept as having six distinct patterns: social self, personal identity, physical self, self-esteem, threats to self-concept, and history of related physical or psychological problems.

*Synthesis of Research on Self-Concept* (Beane, Lipka, & Ludwig, 1980) posited that self-esteem decisions may be based on values and differing values affect self-perceptions. This aspect of self-concept is particularly important when working with someone whose values differ from another. As such, motivations and strategies to improve self-concept could be highly independent because they would need to be based on the individual’s values.

Bracken (1992) formed his description of self-concept through the study of all psychanalytic practices before him and by utilizing the studies of individuals such as Bandura, Meade, Freud, James, Maslow, and Herzberg. Bracken identified six domains
of self-concept: academic, affect, competence, family, physical, and social. Self-concept, and specifically Bracken’s (1992) theory, served as the conceptual framework for this study.

**Conceptual Framework: Self-Concept**

Bracken (1992) described the self as a pattern of behaviors unique to the individual that characterized the individual; these behaviors were used to describe the individual. The self was a cognitive representation and a complex structure that assisted in organization of relevant self-knowledge (Rosas, Pimenta, Maroco, & Leal, 2017). Baumeister (2010) described three aspects of the self as (1) awareness and knowledge of oneself (the overturn of consciousness toward itself), (2) interpersonal relationships (since the self-emerged in reciprocal relations with others among various functions), and (3) decision-making and self-control. Furthermore, Oyserman, Elmore, and Smith (2012) defined self as comprising a thinking agent (I) and the object of contemplation (me).

An individual’s self-concept describes the way he or she perceives him or herself; self-concept is affected by beliefs about one’s own personality traits, values, goals, physical characteristic, and existence (Stangor & Lange, 1994). Self-concept is a collection of mental notions that reside in the object of contemplation and determine who the individual is and what he or she will become (Oyserman et al., 2012). As the person interacts with the environment, beliefs and self-concepts are produced that, in turn, reinforce or discourage the appraisals of significant persons in the individual’s life and the results of his or her own behavior (Schunk & Pajares, 2009).

Hattie (1992) defined self-concept as both a structure and a process, meaning it is a set of beliefs guiding people’s behavior and actions, and it mediates or regulates
behavior in different social settings. Supporting this view, Shavelson and Bolus (1982) noted the structure of self-concept organizes one’s process of information, assists the categorization of knowledge, and allows communication between those diverse categories. Evaluative judgments regarding the individual’s attributes are thus distributed across specific domains or schemas (Harter, 2008).

**Domains of Self-Concept**

Bracken (1992) defined self-concept as a “multidimensional and context-dependent learned behavioral pattern that reflected an individual’s evaluation of past behaviors and experiences, influences an individual’s current behaviors, and predicts an individual’s future behaviors” (p. 10). Bracken’s (1992) widely accepted description of self-concept involves six domains: affect, academic, competence, family, physical, and social. Bracken’s (1992) Multidimensional Self Concept Scale (MSCS) is used to assess self-concept and comprises of 150 self-report items using a Likert scale; each of the six domains of self-concept was represented by a 25-item sub-scale. The MSCS was validated through research and considered accurate (Waugh, 2000).

**Affect self-concept domain.** The affect domain of self-concept describes self-evaluation, awareness, and acceptance of the individual’s affective state, as well as the conditions contributing to the different affective states experienced (Bracken, 1992). For instance, some people are easily angered, saddened, embarrassed, or made anxious. Their ability or inability to cope with such negative emotions impacts how well they maintain a positive self-concept (Bracken, 1992).

**Academic self-concept domain.** Academic self-concept describes how an individual feels about himself or herself in an academic setting or regarding academic
progress (Bracken, 1992). Academic self-concept is influenced by many factors, such as successes and failures in school as a whole or in individual areas like math or reading; how easy or difficult it is to acquire information; overall cognitive or intellectual abilities, especially when compared to that of other students; relationships with peers and adults in the school setting (such as lunchroom, classroom, and playground); and acceptance of the individual’s contributions by others within the school setting (Bracken, 1992).

**Competence self-concept domain.** The ability of the individual to meet his or her basic needs is competence self-concept (Bracken, 1992). People who possess the verbal, social, intellectual, financial, physical, and other means to meet their needs are likely to develop a positive sense of competence compared to others who struggle to meet the same needs (Bracken, 1992).

**Family self-concept domain.** Family self-concept is determined by how people feel about themselves within their families or as members of their family (Bracken, 1992). This self-concept domain depends on many factors such as family size; parenting style (e.g., permissive, authoritarian, abusive, neglectful); and the mental and physical health of individuals in the family. Family self-concept also depends on internal or personal characteristics such as the individual’s social standing, artistic ability, academic successes and failures, temperament, and mental and physical health (Bracken, 1992).

**Physical self-concept domain.** Physical self-concept describes how individuals feel about their physical qualities (Bracken, 1992). This domain includes feelings about physical appearance such as hair, size, attractiveness, or skin color; feelings about health and any physical limitations such as health conditions and disabilities; and feelings about prowess such as agility, stamina, and athletic ability (Bracken, 1992).
Social self-concept. Social self-concept refers to how the individual feels about his or her social abilities – the ability to interact and mingle with other people, participate in social life, and be accepted in social settings (Bracken, 1992). Just like the other domains of self-concept, there are subareas in social self-concept the individual could learn or acquire. For instance, successes and failures in same-sex peer relations, opposite-sex adult relations, and opposite-sex peer relations could influence future behaviors. Social interactions and the associated interpersonal relations are important for healthy mental states (Bracken, 1992).

Global Self-Concept and Hybrid Self-Concept

Bracken (1992) described self-concept as having a hierarchical structure. The top of the hierarchy is global self-concept, the sum of the interaction of all domains, and the six domains constituted the secondary levels of self-concept. As depicted in Figure 2, these secondary levels of self-concept are considered independent, but at the same time overlap and influence each other (Bracken, 1992).

![Figure 2. Domains of self-concept presented as a hierarchical model. Source: Bracken, 1992.](image-url)
A hybrid sub-domain is formed when two or more domains overlap (Bracken, 1992). For example, physical self-concept could overlap with competence to form athletic ability or influence physical competence. Family self-concept could overlap with social self-concept as family socioeconomic status, religious, and political affiliations could influence the level of social acceptance the children experienced. Global self-concept thus describes the merging of all these domains and their effects on self-concept (Bracken, Bunch, Keith, & Keith, 2000).

**Self-Concept Acquisition**

Bracken’s (1992) model of self-concept used behavioral learning theory in explaining how self-concepts were acquired, including the function of both direct and indirect interactions with factors in the environment. People receive positive or negative feedback about their attributes and behavior either directly through personal experiences (personal perspective) or indirectly from other people (other perspective). Feedback is received and evaluated based on four standards – the absolute, the comparative, ipsative, and the ideal (Bracken, 1992). Figure 3 provides a graphic depiction of how the four standards interact and feed into global self-concept.
Figure 3. Model of acquisition of self-concept. Source: Bracken, 1992.

The absolute standard is a fair and objective personal evaluation based on outcomes that could be observed directly by the individual and/or others (Bracken, 1992). The comparative standard for evaluation applies when the behavior or characteristics of the individual is contrasted with other people. The comparative standard can also be evaluated personally or by others. Ipsative standards are evaluations in one area compared to other areas (e.g., across domains). Lastly, ideal standards were used when the perfect level of accomplishment represent the standard of comparison. Such goals are not always realistic, but could serve as healthy motivators for self-improvement (Bracken, 1992).

This concept is important because it relates to how African American women acquire self-concept regarding their health. When self-concept is closely aligned with the physical reality, then congruence exists and self-alignment with reality is present
(Rogers, 1951). However, in the case of African American women, their bodies are perceived in a different way from established health and societal norms (Fletcher, 2014). It would be hard to point to one specific factor influencing this incongruence; rather it is a mixture of factors such as culture, historical heritage, social reality, and level of education influencing the current global self-concept of African American women (Fletcher, 2014).

**Body Image**

Although body image is a commonly used term, it is important to understand the clinical definition and its use on African American women’s self-concepts and the impact on weight loss. Cash (2011) described body image as a multidimensional psychological construct representing the subjective perceptions, attitudes, behaviors, and beliefs an individual had regarding his or her body. Cash (2011) further identified two core axes in body image: the attitudinal axis, which included evaluative and investment components, and a self-concept axis. The evaluative component in the attitudinal axis looked at the level of satisfaction people had with their appearance and beliefs about discrepancies between their appearance and their self-ideals (Cash, 2011; Rosas et al., 2017). On the other hand, the investment factor looked at the degree of emotional, behavioral, and cognitive importance the individual assigned to the self-evaluation of the body (Cash, 2011; Rosas et al., 2017).

These two attributes of body image evaluation and investment were constructs in cognitive, emotional, and behavioral processes. They were also influenced by contexts and events (Cash, 2011). People made body image investments based on the specific self-schemas they develop regarding their appearance (Cash, 2011; Rosas et al., 2017).
As self-schemas developed from the interaction of multiple domains, contextual experiences also influenced how people evaluated information about their body (Cash, 2011). As a result, understanding appearance-related self-schemas was important when trying to understand and evaluate body image experiences (Rosas et al., 2017).

Bracken (1992) held that self-concept was synonymous and indistinguishable from self-image and self-esteem in practical every day functioning. However, Baumeister (2010) believed several dimensions that constituted self-image depended upon one’s thoughts at various times. As a result, Baumeister (2010) described spontaneous self-image as a specific domain present in the individual at a particular moment. Spontaneous self-image undergoes change whereas other, deeper aspects of self-image such as self-esteem and body image tended to resist variations (Baumeister, 2010).

To summarize the definition of body image, Alipoor, Goodarzi, Nezhad, and Zaheri (2009) defined body image as a psychological construct comprising the individual’s self-concept, perception of his or her body and appearance, and perceived feelings regarding the person’s body. This definition supported the importance of exploring the self-concept of people who experienced weight loss (Alipoor et al., 2009; Rosas et al., 2017); how the physical self-concept affected weight loss (Binkley, Fry, & Brown, 2009); and the need to explore how self-concept could impact weight loss behaviors (Rosas et al., 2017).

In the United States, both males and females faced unrealistic body standards that damaged people’s self-image. Exaggerated body image goals such as being slim and fit caused women to aim for extreme thinness whereas men were influenced to carry out
extreme investment for muscularity (Murnen, 2011; Rosas et al., 2017). Studies found negative investment in body image affected gender differently; women had a higher concern about the size of their body whereas men were more concerned with both body fat and muscularity (Pritchard, 2014).

Throughout the research on obesity, overweight and obese people showed dissatisfaction with their appearance and their bodies; obese people also reported dissatisfaction with specific body traits in addition to dissatisfaction with size and weight (Rosas et al., 2017; Sarwer, Dilks, & Spitzer, 2011). Sarwer et al. (2011) noted health improvement and the reduction of risks for health-related problems did not constitute the main motivation reported for weight loss. Rather, most individuals reported improving their physical appearance as their main motivation (Sarwer et al., 2011).

**Weight Loss and Weight Control**

**Self-concept and Weight Loss**

Weight loss is defined as a decrease of the body mass caused by the loss of body fluid, fat, and muscles, which results when the body burns more calories than it consumes (Stuhldreher et al., 2016). To maintain a healthy weight, a typical individual could consume roughly 2,000 to 2,500 kilocalories per day (Rolfes et al., 2014). Any excess calories turn into fat and weight gain whereas to lose weight, a daily deficit of 500 kilocalories was needed. A healthy weight loss is attained through diet and exercise (Rolfes et al., 2014). Weight loss involved several changes linked to the individual’s psychosocial, psychological, and physical features (Sarwer et al., 2011). Therefore, it is important to understand how self-concepts influence weight loss to achieve successful weight loss in the African American context, as these elements (psychosocial,
psychological, and physical) are all represented in Bracken’s self-concept domains (Rosas et al., 2017).

Recent studies in the U.S. showed the increasing prevalence of obesity despite the national public health directives in place to reduce the rate of obesity and the dominant cultural ideals favoring slim and fit physiques (Chang & Christakis, 2003). This disjuncture between the continuing weight gain in the population and the medical and cultural injunctions regarding the importance of weight loss reflect the challenges of successful weight loss and healthy weight maintenance, and possibly, a variation in standards for evaluating beauty or the body. For some people, the disjuncture could be based on how their self-concept regarding appropriate weight differs from the normative cultural and public health standards (Chang & Christakis, 2003). This view is supported by previous studies indicating self-perceived weight status did not adequately represent an individual’s actual body size (Chang & Christakis, 2003; Rand & Kuldau, 1990).

Studies found a strong association between weight control behavior and self-perceived weight status. For instance, studies on weight control behavior in the U.S. also showed many people who were clinically normal weight were attempting to lose or desired to lose weight (Levy & Heaton, 1993). In contrast, a notable proportion of overweight people did not attempt to lose weight or desire to do so (Chang & Christakis, 2003). This behavior highlights the importance of self-concept in promoting engagement in weight loss activities. Therefore, self-perceived weight appropriateness is important when designing and implementing clinical and public health initiatives. However, as further noted by Chang and Christakis (2003), self-evaluation of weight status is likely influenced by social patterns and not a simple individual and autonomous response.
Attitudes toward body size and the preference for certain levels of weight are heavily influenced by local cultural and social factors important to the individual (Levy & Heaton, 1993; Rand & Kuldau, 1990). Thus, perceptions regarding weight appropriateness vary among subgroups in a population (Chang & Christakis, 2003; Levy & Heaton, 1993). This factor was clearly seen in the African American culture where being overweight is a sign of beauty and contributes to a positive self-concept (Levy & Heaton, 1993; Zhang & Rodriguez-Monguio, 2012).

A study implemented by Chang and Christakis (2003) examined how socio-demographic factors influence how Americans perceive their weight appropriateness. They found perception of weight appropriateness was important in eating habits and weight loss behaviors, and was influenced by factors other than the actual weight of the individual. Objective, medical weight standards were established as the control element in this experiment. Based on comparisons to these established standards, the study revealed that 29.8% of men and 27.5% of women classified their own weight status incorrectly. An alarming, 32.8% of overweight men thought they were underweight or about the right weight. In comparison, 38.3% of women with normal weight thought they were overweight. Multivariate regression analysis showed several factors were independently associated with self-evaluation of weight status when controlling for BMI: race, age, gender, marital status, education, and income. Based on these findings, the authors concluded that self-perceived appropriateness of weight varied in predictable ways among sub-groups in the population and probably reflected differences in normative evaluation of body weight standards (Chang and Christakis, 2003). The findings from this study clearly support the view that social patterns play a large role in
the discrepancy between clinical recommendations on weight and the actual weight control behaviors seen in society (Chang and Christakis, 2003; Waugh, 2000).

Because different domains in life are affected when an individual’s health is threatened, the study of self-concept is important in physical health. Rojas, Brante, Miranda, & Perez-luco (2011) examined the self-concept of patients with morbid obesity who had bariatric surgery. The authors found that participants reported an increase in feelings of attractiveness and satisfaction. The patients also felt more accepted, agile, and secure (Rojas et al., 2011). Similarly, investigating the association between physical self-concept and weight, Binkley et al. (2009) found that men and women who perceived themselves to be at a normal weight had a higher score on physical self-concept compared to those who perceived themselves to be overweight or obese. This would imply that such positive self-concept could constitute a motivator for undergoing weight loss treatment. This thinking is further supported by Sarwer et al. (2011) in that health improvement and the reduction of health risks did not constitute the main motivation reported for weight loss; rather, improving physical appearance was the main motivation for losing weight.

African American women had higher risks for obesity compared to Caucasian women and tended to weigh more compared to Caucasian women (Huey, 2013; Pan et al., 2009). Despite this fact, studies found African American women were more satisfied with the size of their bodies compared to Caucasian women (Croll, Neumark-Sztainer, Story, & Ireland, 2002; Huey, 2013). African American women also attributed fewer negative qualities to being overweight and were less likely to engage in eating disorder behaviors in a bid to lose weight compared to Caucasian women. Studies suggested
African Americans were also less susceptible to body dissatisfaction issues compared to Caucasians because they adhered to a cultural ideal promoting the heavier body type while discouraging stringent weight goals (Croll et al., 2002; Huey, 2013). Being overweight was also supported by the cultural standard that African American men preferred heavier female body weight compared to Caucasian men (Huey, 2013). However, some scholars held that ethnicity did not significantly influence the preference for body shape and tolerance for obesity (Cachelin, Rebeck, Chung, & Pelavo, 2002). These views and research findings further emphasized the need to design obesity interventions that account for the influence of self-concept because self-concept varied across different sub-groups irrespective of the prevailing societal standards.

**Weight Loss and Self-Regulation Mediators**

The goal of obesity management is weight loss and mitigation of associated co-morbidities (Teixeira et al., 2015). Currently, comprehensive lifestyle interventions that involve behavior modification are the first step recommended in obesity management (Teixeira et al., 2015). Pharmacological and surgical treatments have moderate success, but come with associated safety and efficacy concerns, especially in the long-term. As a result, they are recommended as second-line treatments and only for severe and chronic obesity and serious co-morbidities (Low, Bouldin, Sumrall, Loustalot, & Land, 2006; National Institutes of Health, 2000). Public health interventions involve actions such as taxing sugary drinks, which had the potential to achieve a high, long-term impact depending on the level of political and public support (Wadden, Brownell, & Foster, 2002). Therefore cognitive-behavioral treatments are the first line of intervention for obesity (Jensen et al., 2013; Teixeira et al., 2015).
Behavioral treatments typically include psychoeducation for nutrition and physical activity, behavioral skills for self-regulation such as stimulus control and self-monitoring, and cognitive strategies like thought restructuring (Butryn, Webb, & Wadden, 2011; Teixeira et al., 2015). When well executed, these behavioral treatments body weight between 7 and 10% and decrease accompanying risk factors for diabetes and heart disease (Butryn et al., 2011).

Clinical trials evaluate the effectiveness of programs aimed at changing lifestyle behavior reveal mixed results, and even when effective, the interventions largely result in small improvements in negative behaviors (Bandura, 2005; Teixeira et al., 2015). Standard behavioral treatments tend to yield low adherence rates with regard to calorie and physical activity prescriptions, and more success is achieved when individuals are in a controlled environment where adherence to prescriptions is guaranteed (Hall, 2010). At the same time, weight loss accomplished through treatment programs are not maintained in the long-term (Bandura, 2005). Significant amounts of weight are regained within a year of treatment, and substantial weight regain occurs within five years (Jeffery, Wing, Sherwood, & Tate, 2003; Teixeira et al., 2015; Wadden & Butryn, 2003). Individuals who attempt to lose weight without participating in any intervention programs commonly report they discontinued such efforts because of frustration due to the slow rate of weight loss (Smith, Burke, & Wing, 2000). Additionally, less than 20% of adults report success at maintaining long-term weight loss or a 10% reduction in weight for one year (Forman & Butryn, 2015).

Although available interventions yield limited results in reversing the obesity pandemic, focusing on behavior change at the individual level remains a key research
subject in obesity (Teixeira et al., 2015). Valid rationales exist for the focus on behavior change at the individual level as a key intervention goal (Maes & Karoly, 2005). First, interventions focused on behavior have broad consequences for the person’s health beyond weight loss alone. Second, successful self-regulation of behavior makes for sustainable weight loss outcomes and lasting health improvements. Such self-regulation skills or abilities can be transferred to other areas of life and improve the person’s quality of life. Third, although some interventions were not as effective when used on their own, in combination with other strategies, they could contribute to the overall effectiveness of intervention (Maes & Karoly, 2005). This is particularly evident when individual and environmental level approaches to weight loss management are used in conjunction (Lakerveld et al., 2012).

Lifestyle interventions for the treatment of overweight and obesity usually focus on making changes in diet and physical activity through strategies such as enhancing patient motivation, setting goals, establishing accurate and realistic beliefs and expectations, and providing guidance for a range of self-regulation skills (Huey, 2013; Sniehotta, Scholz, & Schwarzer, 2005; Teixeira et al., 2005). To accomplish this goal, many health behavior change theories were employed to identify the determinants of behavior such as social cognitive theories, theories on motivation, health action process theories, and control theory (Teixeira et al., 2015). All these theories looked at the regulation of behavior through intrapersonal factors or self-regulation factors (Teixeira et al., 2015). Success and failure regarding self-regulation of health behaviors is determined by multiple behavioral and psychological factors (Bond & Bunce, 2003). Teixeira et al. (2015) implemented a systematic review on self-regulation in successful
behavior change in adult obesity interventions. The goal of the review was to identify the “most consistent self-regulation mediators for medium-term as well as long-term weight control, dietary intake, and physical activity in both clinical and community interventions that targeted behavior change in overweight/obese adults” (p. 1). The authors found intrinsic motivation, self-monitoring, self-efficacy, and a positive body image acted as mediators and were for beneficial weight loss. Additionally, flexible eating and positive body image could also improve outcomes for weight loss (Teixeira et al., 2015).

It could be assumed these self-regulation mediators (high intrinsic motivation, self-regulation skills, and self-efficacy), would lead to positive outcomes for weight loss. Thus, it was important to see the extent to which self-regulation plays a role in weight status and consequently weight loss for African American women.

**Psychological Skills for Weight Control**

The difficulty in maintaining adherence to prescriptions regarding behavioral change often results from an inability to exert self-control over biological responses to internal and environmental cues (Schulz et al., 2006; Teixeira et al., 2015; Wansink, 2006). This makes self-concept domains important in addressing weight loss. Psychological skills were further differentiated by clarity and committing to goals, metacognitive awareness, and tolerance for experiential distress or pleasure reduction.

**Values clarity and committing to goals.** Both innate tendencies and pressure from the external environment hold the capacity to lower motivation to engage in appropriate weight control behaviors. In most cases, an individual will not put forth the effort except when clear goals between the choices exist within an articulated, deeply-held values system (Eccles & Wigfield, 2000; Forman & Butryn, 2015). For instance, a
commitment to wake up early and exercise must be based on a clear goal (Deci & Ryan, 2000; Forman & Butryn, 2015).

Several studies showed intrinsic motivation and a commitment to change were linked to weight loss outcomes. For example, self-motivation was a strong predictor for adherence to physical activity prescriptions (Deci & Ryan; Forman & Butryn, 2015). Forman and Butryn (2015) also showed the intensity of participation in exercise was closer to a targeted rate when the participants were presented with values they rated highly compared to participation based on values not meaningful to them. These findings are supported by the self-determination theory that lasting behavioral change is achieved when the values for change are internalized and responsibility is accepted for autonomous behavior regulation (Deci & Ryan, 2000; Forman & Butryn, 2015).

Practical application of this skill is consistent with the principles of intrinsic motivation theory (Deci & Ryan, 2000). Using treatment approaches that emphasize acceptance involve participants choosing goals emanating from their personal life values. A structured process is used to identify relevant life values and develop connections to these values. Participants learn skills to help them be aware of their behavior choices moment-by-moment and in their long-term goals (Deci & Ryan, 2000). In such programs, commitment is emphasized as being key to achieving change (Forman & Butryn, 2015).

**Metacognitive awareness.** Research in both social and cognitive psychology revealed that implicit and spontaneous cognitive processes contribute to behaviors, including eating and physical activity behaviors (Forman & Butryn, 2015). Specific stimuli can trigger certain implicit processes. For instance, the sight of tasty food could
activate hedonistic motivations and cues, and television could trigger implicit processes leading to sedentary behavior (Wadden et al., 2002; World Health Organization, 2010). Furthermore, such implicit processes tend to favor hedonistic comfort and pleasure instead of long-term health objectives (Forman & Butryn, 2015; Mai et al., 2011). Thus, the ability to adhere to dietary and physical activity goals demands self-regulation skills to maintain continued awareness of current behavior, and how the behavior compares with the goal or relevant standard (Forman & Butryn, 2015). Conversely, a lack of awareness in behavior and the consequences of behavior results in mindless decisions and uncontrolled actions (Wansink, 2006). Metacognitive awareness is therefore important for healthy decision-making (Forman & Butryn, 2015).

In terms of practical application, mindfulness-based interventions are effective in helping people become more attuned to satiety and hunger cues. Evidence also suggested such strategies are more successful in binge eating interventions than for weight loss goals (Telch, Agras, & Linehan, 2001). Interventions are also more effective when they incorporate training to help the individuals increase their awareness of perceptual, affective, and cognitive experiences in decision-making about eating and physical activity (Forman & Butryn, 2015). Both metaphors and experiential exercises could be used in training people to become more aware and present-centered. Such awareness would in turn reduce the chances of engaging in mindless eating and unhelpful behaviors. In Forman and Butryn’s (2015) study, the participants were required to monitor how their body reacted and felt before exercise or eating, during exercise or eating, and after exercise or eating. This technique helped in the development and exploration of cognitive and affective responses (Forman & Butryn, 2015). This type of training helped
participants be consistent in making mindful or deliberate behavioral choices regarding
the types of food they bought and ate, what time they ate, when they exercised and were
physically active, and what they wanted in their personal environment (Forman &
Butryn, 2015; Lillis & Kendra, 2014; Telch et al., 2001). Skills gained through such
training interrupts automatic and unconscious influences leading to overeating or
sedentary behavior (Forman & Butryn, 2015).

**Tolerance for Experiential Distress or Pleasure Reduction**

Individuals experience certain internal experiences as aversive, such as troubling
thoughts, urges, cravings, anxiety, and sadness (Forman & Butryn, 2015). People,
however, vary in their ability to accept or tolerate unpleasant experiences versus the need
to diminish them. Experiences can be diminished psychologically through distraction or
suppression, or diminished behaviorally through performing an action to change the
experience. The extent to which a person accepts or strives to avoid aversive experiences
is a predictor for health and psychological outcomes associated with that experience.
People attempting to refrain from binge eating experience cravings and urges to eat. If an
individual has a higher tolerance of the distress, he or she will be less likely to consume
food in a bid to reduce this distress. Similarly, in physical activity programs, unpleasant
experiences related to the activity such as anxiety, fatigue, sweating, and boredom could
occur. Low tolerance for such experiences diminishes compliance with physical activity
goals and reduced motivation (Forman & Butryn, 2015).

Another aspect of intolerance is the inability to cope with negative effects. For
example, intolerance for anxiety or sadness is associated with emotional eating (Forman
& Butryn, 2015). Successful self-control involves the ability to tolerate distress as well
as the ability to tolerate reduced pleasure. Making health decisions about obesity would involve trade-offs relating to pleasure and distress. It was important to make the right decision and tolerate the reduced pleasure or even distress that could be involved until the health goal was achieved (Forman & Butryn, 2015).

Practical applications of this skill in intervention programs for weight loss involve helping clients understand that eating is easily used as a coping mechanism in the obesogenic environment of today (Lillis & Kendra, 2014). The participants must learn to engage in desired behaviors for weight loss while tolerating adverse states related to eating and physical activity (Forman & Butryn, 2015). Experimental exercises such as walking could allow participants to distance themselves from aversive thoughts and feelings and reduce the likelihood of acting on such thoughts. However, attempts to suppress or ignore these thoughts and urges did not contribute to long-term weight loss. The ability to adhere to health behaviors and tolerate unpleasant experiences in the long-term is critical to the success of such programs (Forman & Butryn, 2015).

**Summary**

This literature review provided a comprehensive background to examine the impact of self-concept on weight loss as perceived by African American women. The prevalence of obesity among African American children and adults remains high, with almost 60% of African American women falling into the obese category (CDC, 2016). Obesity among African American women and girls is associated with many factors including low socioeconomic status and high poverty, high exposure to fast food marketing, lack of exercise, limited access to safe places, lack of education on health and weight, cultural and social factors, and stress. Other factors important in the high
prevalence of obesity among African American women included their external environment, culture, and perceptions, as well as intervention contexts.

This study was based on Bracken’s (1992) model of self-concept, which involves six different domains: academic, affect, competence, family, physical, and social. This concept was important in the current study because it provided insight about how African American women acquired self-concepts regarding their health. Understanding appearance-related self-schemas was important when trying to understand and evaluate body image experiences. For this context, it was also important to understand the psychosocial, psychological, and physical elements represented in self-concept domains for African American women as it related to weight loss. The literature states higher intrinsic motivation, self-regulation skills, and self-efficacy were key regulation skills necessary to lose weight. Psychological skills for weight control included value clarity, committing to goals, metacognitive awareness, and tolerance for experiential distress or reduced pleasure. The next chapter discusses in detail the methodology applied in conducting this study examining the self-concept of African American women in the context of obesity reduction.
CHAPTER III: METHODOLOGY

Chapter III presents the methodology used in this study, which explored the impact of self-concept on the weight loss of African American women. This chapter begins with a reiteration of the purpose statement and research questions. This is followed by a description of the research design, population, sample, instruments, data collection process, and data collection techniques. This chapter concludes with an overview of the research limitations and a summary.

Research methodology was described as a system of methods or processes used to come to a specific conclusion (Creswell, 2009). The components involved in methodology include the research design, types of data, population, sample, purpose statement, and finally, research questions (Creswell, 2009). This chapter distinguishes between various research methods and explains the procedures employed in this study. It also defines the population, sample, instruments used to gather data, and data analysis used in this study. This chapter also provides a discussion of the research limitations and concludes with an overall summary.

Purpose Statement

The purpose of this mixed-methods study was to understand and describe the impact of Bracken’s (1992) six domains of self-concept (academic, affect, competence, family, physical, social), on weight loss as perceived by African American women.

Research Questions

This study focused on the impact of self-concept as it pertained to weight loss for African American women utilizing the six domains of self-concept developed by Bracken
(social, competence, affect, physical, academic, family). The specific research questions guiding this study were:

1. How does the affective/emotional aspect of self-concept impact weight loss and fitness as perceived by African American women?
2. How does the academic aspect of self-concept impact weight loss and fitness as perceived by African American women?
3. How does the competence aspect of self-concept impact weight loss and fitness as perceived by African American women?
4. How does the family aspect of self-concept impact weight loss and fitness as perceived by African American women?
5. How does the physical aspect of self-concept impact weight loss and fitness as perceived by African American women?
6. How does the social aspect of self-concept impact weight loss and fitness as perceived by African American women?
7. What elements of Bracken’s six domains of self-concept do African American women perceive as having the greatest impact on weight loss and fitness?

**Research Design**

This study used a mixed-methods approach integrating both quantitative and qualitative research approaches. More specifically, a sequential explanatory methods approach was used to understand and describe which of Bracken’s (1992) six elements of self-concept were perceived to have the greatest impact on weight loss among African American women. McMillan and Schumacher (2010) noted “mixed-methods are useful
in identifying issues, factors, and relevant questions that can become the focus of a quantitative study” (p. 395).

Roberts (2010) stated, “Qualitative and quantitative approaches in a single study complement each other by providing results with greater breadth and depth. Combining what with a possible why adds power and richness to your explanation of the data” (p. 145). Furthermore, using a mixed-method approach is “an intuitive way of doing research that is constantly being displayed through our everyday lives” (Creswell & Plano Clark, 2011, p. 1). Mixed-method research focuses on collecting and analyzing data using both quantitative and qualitative research methods, including questionnaires and interviews that offer a fixed choice of closed-ended questions, and surveys and interviews with open-ended questions. The general premise of mixed-method research was that it used both quantitative and qualitative approaches, in combination, which thereby provided a more detailed understanding of the research topic than a qualitative or quantitative review could provide alone (Creswell, 2003; Creswell & Plano Clark, 2011; Roberts, 2010).

The quantitative portion of the study was conducted via an electronic survey containing closed-ended questions. The quantitative survey assessed the level of agreement women had regarding the impact of self-concept on weight loss. The qualitative portion of this mixed-method study was conducted via face-to-face interviews with African American women participating in a weight loss program. Upon completion of both the quantitative and qualitative measures, the data were interpreted to ensure the strength and consistency of the data.
Sequential Explanatory Mixed-Methods

A mixed-methods sequential explanatory approach was appropriate for this study because it provided quantitative data regarding self-perceptions supported by in-depth interviews that explored the personal experiences of African American women. According to McMillan and Schumacher (2010), this method “provides for a more comprehensive picture of what is being studied, emphasizing quantitative outcomes as well as the process that influenced the outcomes” (p. 401). Patten (2012) stated that quantitative researchers can select larger participant populations because questionnaires are easy to administer to many individuals at the same time and the researcher can statistically analyze on the results. Quantitative data can be collected in a short amount of time and can easily be reduced to a statistical analysis. McMillan and Schumacher (2010) noted this method uses two consecutive data collection procedures: a quantitative phase followed by a qualitative phase. For this study, greater significance was placed on the quantitative data because more people completed the quantitative survey than participated in the qualitative interviews. Figure 4 depicts a visual demonstration of the sequential explanatory research design used for this study, with capital letters signifying the priority decision on the quantitative data collection.

Figure 4. Sequential explanatory mixed-methods research design.
Quantitative Research Phase

Quantitative research provides greater breadth because more people typically complete the surveys than could participate in qualitative data collection (Patton, 2015). For the quantitative phase of this study, an online survey was administered to assess the perceptions of African-American women regarding how self-concept impacted weight loss and fitness.

Qualitative Research Phase

A qualitative approach enables a detailed and in-depth understanding of the research questions without being constrained by predetermined categories (McMillan & Schumacher, 2010). Creswell and Plano Clark (2011) explained “qualitative understanding arises out of studying a few individuals and exploring their perspectives in great depth” (p. 8). In a mixed-methods sequential explanatory design, the qualitative data are collected to better understand and explain findings from the quantitative data. Applying mixed-methods also allows for triangulation of the data, increasing the confidence in the findings (McMillan & Schumacher, 2012). For this study, interviews were conducted with 10 African American women who completed the survey in the quantitative phase of the study.

Population and Sample

Population

Population is defined as all the subjects with the same characteristics that the researcher was interested in studying and drawing conclusions (Creswell, 2009). A population in research is a group (e.g., people, objects, events) that conform to a specific set of criteria to which the researcher intended to generalize findings (McMillan &
Schumacher, 2010). The population for this study was overweight African American women.

Per the 2016 US Census, the population of the United State was 323,127,513, of which 13.3% were African American (U.S. Census Bureau, 2016). Of the approximately 42,000,000 African Americans, nearly 47% are considered obese, with obesity rates of 37% for males and 56% for females (CDC, 2016). This population would be too large to study accurately; therefore, this mixed-method study focused on a smaller target population. A target population refers to a representative subset of the population for which research findings are meant to be generalized (McMillan & Schumacher, 2010). California has the fifth highest population of African Americans compared to the other states, and the Los Angeles area has the greatest number of African Americans in California (Census Bureau, 2015). Thus, the target population for this study was African American women living in the greater Los Angeles area of southern California. Approximately 500,000 African American women over the age of 18 reside in the greater Los Angeles area (U.S. Census Bureau, 2016).

**Sample**

The sample is a group of participants in a study selected from the population from which the researcher intends to generalize. According to McMillan and Schumacher (2010), sampling is selecting a “group of individuals from whom data are collected” (p. 129). Similarly, Patton (2015) and Creswell (2003) defined a sample as a subset of the target population representing the whole population. Although sampling is often random; the sample population for this study was criterion-based. The study used purposeful sampling for the both the quantitative and qualitative approaches. According to
McMillan and Schumacher (2010), purposeful sampling is when the researcher “selects a sample that is representative of the population or that includes subjects with needed characteristics” (p. 138).

In addition to purposeful sampling, convenience sampling was also utilized. Due to limitations on time, cost, and accessibility, convenience sampling was also used for proximity and accessibility. The greater Los Angeles area was selected to align the research focus on the research problem and the ability to interview a select group of African American women. “Site selection, in which a site is selected to locate people involved in a particular event is preferred when the research focus is on complex micro processes” (McMillan & Schumacher, 2010, p. 326).

This study focused on self-concept with regard to weight loss and fitness for African American women. It was necessary to obtain a sample of African American women who had participated in a weight loss or fitness program; thus, purposeful sampling was used. The criteria for participation in this study were:

- Female
- African American
- Over the age of 18
- Resides in the greater Los Angeles area
- Participated in a weight loss and/or a fitness program within the past 16 months

Due to limitations on time, cost, and accessibility, convenience sampling was used for proximity to the researcher and accessibility. A convenience sample was deemed the best method because it was “widely used in both quantitative and qualitative
studies...due to practical constraints, efficiency, and accessibility” (McMillan & Schumacher, 2010, p. 137). Furthermore, a convenience sample benefitted this study due to the breadth of the population and the need to elicit volunteers (Creswell, 2009). Similarly, a convenience sampling method offered ease for selecting participants based on their availability (Patton, 2015). Additionally, snowball sampling was used by asking the initial cohort of participants to invite other African American women they knew to participate in the study.

For the quantitative phase, survey data were collected from an original sample of 66 African American women over age 18 residing in the greater Los Angeles area. The researcher used his personal network to recruit participants to the study. As owner of the Warrior Fitness and Wellness Camp, he had access to African American women participating in a weight loss or fitness program. Further, the initial study volunteers were encouraged to share the survey link with other African American women they knew who also participated in a weight loss or fitness program.

For the qualitative study phase, interviewees were drawn from the survey participants. At the end of the survey, participants were asked if they would be interested in being interviewed as part of the study. Among those who agreed to participate in a follow-up interview, the researcher randomly drew names until 10 volunteers were identified and were interviewed.

**Researcher as an Instrument of the Study**

In qualitative research, the researcher is considered the instrument of data collection (Patton, 2015). As such, Pezalla, Pettigrew, and Miller-Day (2012) noted the personality and interviewing skills of the researcher influence the data collection process,
introducing potential bias. Therefore, qualitative studies could include biases based on
the researcher’s background and own experiences. For this study, the researcher of this
study was born in the Congo, where obesity was held to a different connotation than in
the U.S. In the Congo, obesity was a sign of wealth and opportunity because it
demonstrated a consistent availability of resources. Beginning in 2000, the researcher
served 12 years in the United States Marine Corps. During this time, he headed the
fitness division of basic training. Infantry men and women could not perform their duties
correctly or efficiently if they were overweight. The researcher's duty was to correct this
shortcoming and prepare individuals for combat. This background provided the
researcher with helpful information and insight about varying viewpoints on obesity and
fitness. In 2006, while still on active duty, the researcher started the Warrior Fitness
Camp fitness facility located in Santa Clarita, CA. The majority of the clientele were and
remain female. With over 20 years of experience in the fitness world, the researcher
trained thousands of people both privately and as members of the Warrior Fitness and
Wellness Camp.

**Instrumentation**

Instrumentation refers to how a study was conducted and implemented in terms of
data collection (Roberts, 2010). Instruments consisted of “questionnaires, interview
schedules, observation forms,” and the like (Roberts, 2010, p. 151). Additionally, these
instruments must be carefully evaluated in the context of the study for usefulness,
population, setting, and appropriateness to the research questions (Creswell, 2014). For
the quantitative phase of the study, an online survey was administered and for the
qualitative phase, interviews were conducted.
Quantitative Survey

“Quantitative measurement uses some type of instrument or device to obtain numerical indices that correspond to characteristics of the subjects” (McMillan & Schumacher, 2010, p. 173). Instruments are often in the form of surveys, pencil-and-paper tests, and questionnaires. Instruments used to collect data must be reliable and provide a range of responses in a numerical analysis that can then be analyzed for a summary of results.

A closed-ended quantitative survey, titled Self-Concept and Weight Loss (Appendix A), was developed based on a review of the literature and study of Bracken’s (1992) six domains of self-concept. The survey consisted of 32 questions with a response scale of 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree. The first six items asked demographics questions and the remaining items focused on questions aligned with each domain of self-concept, with four items each for affect, academic, competence, family, physical, and social domains, and two questions about which had the greatest impact on weight loss (Appendix A). Prior to completing the survey, participants were made aware of their rights as research participants and consented to participating in the study (Appendix B).

Qualitative Interviews

Qualitative research has five common methods for collecting data: “interviews, observations, questionnaires, document reviews, and audiovisual materials” (McMillan & Schumacher, 2010, p. 343). For this study, interviews were conducted in a face-to-face modality by the researcher asking open-ended questions. The qualitative interview began with a brief overview of the study. The researcher discussed the Research Participants
Bill of Rights and obtained the participant’s signature on the informed consent form and the audio recording release form (Appendix B). The signed forms were collected and the researcher proceeded with the interview.

For the qualitative phase of the study, 10 participants were randomly selected to participate in follow-up interviews. Patton (2015) stated that researchers should know what they want to find out when the question is answered, noting “questions should be open-ended so people can respond in their own words” (Patton, 2015, p. 446). As such, a semi-structured interview protocol (Appendix C) was used that consisted of six open-ended questions, one for each of Bracken’s (1992) six domains of self-concept. The intent of the interviews was to gather in-depth, qualitative data about the development and influence of self-concept on their weight and health.

Validity and Reliability

Validity

Validity refers to the precision of the findings from the viewpoint of “the researcher, participant, or the readers of an account” and “addresses trustworthiness, authenticity, and credibility” (Creswell, 2009, p. 201). Validation of findings in research occurs when findings accurately represent the phenomenon and “the degree to which the scientific explanations of phenomena match reality” (McMillan & Schumacher, 2010, p. 104). To ensure the validity and reliability of this study, the researcher employed a variety of sources from which he mined data; quantitative online surveys as well as qualitative face-to-face interviews were employed to triangulate the data.

To increase the validity of the findings, the online survey was drafted based on Bracken’s (1992) six domains of self-concept and it was reviewed by an experienced
researcher for face and content validity. For the qualitative interviews, only those participants who had previously completed the online survey were selected for confidential face-to-face interviews. To increase the validity of the questions, the interview protocol was reviewed by an expert panel consisting of three individuals. One had expertise with the study populations and ensured the questions were culturally sensitive. The second had content expertise in self-concept and ensured the questions would illicit responses to address the research questions. The third panel member had expertise in research and ensure the questions did not introduce bias or lead the participants toward a particular response. To increase the accuracy of the data, the interviews were transcribed and the transcriptions were emailed to the respective participants to review and provide additional feedback as needed. Table 1 presents the alignment between the research questions, survey questions, and interview questions.

Table 1

**Alignment of Survey and Interview Questions to the Research Questions**

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Survey Question(s)</th>
<th>Interview Question(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does the affect aspect of self-concept impact weight loss as perceived by African American women?</td>
<td>11, 12, 13, 14, 31</td>
<td>3</td>
</tr>
<tr>
<td>2. How does the academic aspect of self-concept impact weight loss as perceived by African American women?</td>
<td>19, 20, 21, 22, 31</td>
<td>5</td>
</tr>
<tr>
<td>3. How does the competence aspect of self-concept impact weight loss as perceived by African American women?</td>
<td>15, 16, 17, 18, 31</td>
<td>4</td>
</tr>
<tr>
<td>4. How does the family aspect of self-concept impact weight loss as perceived by African American women?</td>
<td>23, 24, 25, 26, 31</td>
<td>6</td>
</tr>
<tr>
<td>5. How does the physical aspect of self-concept impact weight loss as perceived by African American women?</td>
<td>27, 28, 29, 30, 31</td>
<td>2</td>
</tr>
<tr>
<td>6. How does the social aspect of self-concept impact weight loss as perceived by African American women?</td>
<td>7, 8, 9, 10, 31</td>
<td>1</td>
</tr>
<tr>
<td>7. What elements of Bracken’s six domains of self-concept do African American women perceive as having the greatest impact on weight loss?</td>
<td>31, 32</td>
<td>7</td>
</tr>
</tbody>
</table>
Reliability

Roberts (2010) defined reliability as “the degree to which your instrument consistently measures something from one time to another” (p. 151). For the interviews, the researcher asked primarily open-ended questions. To increase the reliability of the coded data, the research applied intercoder reliability to “check the consistency between raters” (Roberts, 2010, p. 152). Intercoder reliability, although not directly ensuring validity, was an essential element of content examination and the interpretation of the data (Lombard, Snyder-Duch, & Bracken, 2004). To perform the intercoder reliability, the researcher worked with an expert in qualitative research. The expert possessed a doctorate degree and had nearly 20 years of research experience. The researcher provided the data to the expert, who selected 20% of the data to double-code. Upon completion, the researcher and expert met to compare notes and discuss any discrepancies. Per Lombard et al. (2004), intercoder agreement of 80% or more was considered acceptable and 90% or greater was considered ideal. The researcher and expert agreed on 92% of the codes, indicating a high level of consistency.

Field Testing

Prior to data collection, the survey instrument and interview protocol were field tested to ensure the questions were clear and could be answered by the intended population. The researcher administered the survey and conducted interviews with two individuals who met the study criteria, but were not part of the study. Upon completion of the survey and interviews, the respondents were asked about the questions and the interview process, providing feedback to improve the questions and interviewing technique. Additionally, during one of the pilot interviews, an experienced researcher
observed the process and provided suggestions on how to improve the process. These data were used to finalize the interview script and revised questions as needed. Additionally, this process helped ensure the questions were asked consistently and the researcher did not present potential bias during the interviews.

Confidentiality

Protecting the confidentiality of this study’s participants was ensured by prohibiting the disclosure or release of confidential or personally identifiable information or data related to research participants. All data were kept in files only accessible to the researcher, and were destroyed upon completion of the study. Participants were asked to sign an informed consent form informing them of the physical demands of the research and the extent to which they were being studied. Verbal and written consent was provided prior to any data collection.

Data Collection Procedures

According to Ivankova, Creswell, and Stick, (2006), in a sequential explanatory mixed-methods approach, the researcher begins data collection with quantitative approaches or numeric data, such as through a survey. Following the established sequence, the next step was to collect and analyze the qualitative, or narrative, data. This information was used to “help explain or elaborate on the quantitative results obtained in the first phase” (Ivankova et al., 2006, p. 5). Data were from two distinct phrases, the quantitative phase using an online survey followed by the qualitative phase conducting one-on-one, semi-structured interviews. Prior to any data collection taking place, the researcher obtained approval from the Brandman University Institutional Review Board (BUIRB) to conduct the study.
For the quantitative portion of the study, participants were asked to complete an online survey (Appendix A). SurveyMonkey was used to administer the survey. African American women participating in a weight loss and fitness program at Warrior Fitness and Wellness camp were sent an email invitation requesting their participation in the study. The email invitation included a link to the survey, as well as the informed consent form and participant’s bill of rights (Appendix B). These women served as the initial sample and were then asked to forward the email link to other women they knew who met the study criteria. A total of 66 women completed the survey.

For the qualitative phase of the study, 10 of the survey participants who indicated a willingness to be interviewed were randomly selected to participate in interviews. The researcher contacted participants by phone and invited them to participate in the interviews, and continued to contact people until 10 interviews were scheduled. Interviews were conducted at a time and location convenient to the participant, and lasted approximately 30 minutes. Prior to the start of each interview, the research reiterated the purpose of the study and participants were asked to sign the informed consent form (Appendix B). With permission of the participants, the interviews were audio recorded and transcribed; transcriptions were sent to the participants to check the accuracy and completeness of the information. Once the participant approved the transcript, it was uploaded and prepared for data analysis.

**Data Analysis**

The data were analyzed separately, beginning with the quantitative survey, and followed by qualitative interviews, according to the two-phase approach. This approach allowed the qualitative questions to be based on the quantitative survey responses to gain
a deeper understanding and explanation of the quantitative data. The qualitative data were analyzed via the constant comparative method to generate themes from the face-to-face interviews. According to Creswell (2014) the comparative method included “open-coding, axial coding, and selective coding” (p. 162), and it “eliminates researcher bias from the responses” (p. 224).

**Phase I – Quantitative Research**

The quantitative data were obtained through an online survey administered through Survey Monkey. The survey instrument included four items for each of Bracken’s (1992) six domains of self-concept. Each domain had its own set of items and a mean score across the four items was computed to create an overall mean. Thus, an overall mean was calculated for each self-concept domain: academic, affect, competence, family, physical, and social. Several domains included negatively worded items, which were re-coded prior to calculating the overall mean.

Once the overall means were computed, descriptive statistics (e.g., mean, standard deviation, percentage) were then used to answer the related research question. “Descriptive statistics are used to transform a set of numbers of observations into indices that describe or characterize the data” (McMillan & Schumacher, 2010, p. 149). Descriptive statistics summarize the data and provide a general picture about the data. A 4-point response scale ranging from 1 = *Strongly Disagree* to 4 = *Strongly Agree* was used. As such, mean ratings above 2.5 indicated agreement and ratings above 3.5 indicated strong agreement. In contrast, ratings below 2.5 indicated disagreement, and below 1.5 indicating strong disagreement. Participant responses were used to generate additional questions for the qualitative phase of the study.
Phase II – Qualitative Research

Creswell (2014) defined coding as the process of organizing data by “bracketing chunks into categories” (p. 198). To begin the process, the researcher read through each transcript to gain a fuller understanding of the types of responses generated. The research read through the transcripts again, this time deriving potential themes and categories from the data. On the third read through, the data were coded based on the themes generated from the prior reads. Intercoder reliability is a term used when a third-party evaluator reads and compares the data and reaches the same conclusions and consistencies in coding the characteristics as the researcher (Patton, 2015). For this study, a second researcher was selected to check the coding to ensure accuracy of the themes. The codes were then reviewed to identify which were most common across the participants and to establish themes aligned to the research questions. This method of coding established various themes in the research as the codes in the study were based on emerging data. Furthermore, the codes were helpful in answering the research questions as they held to the experiences of participants in the weight loss and fitness program.

Limitations

Roberts (2010) described limitations as aspects of the study that could negatively impact the results or the ability to generalize the findings. Obvious limitations of this specific study were both the sample size and the response rate to the survey. It was difficult to find volunteers for this study as the participants needed to be both African-American and female. In the Santa Clarita Valley, African Americans represented less than 4% of the population, whereas Caucasians composed 76.6% (U.S. Census Bureau, 2015). Furthermore, the researcher himself was an immigrant from the Congo and not a
member of any African American community locally, making cultural differences a factor as well. The researcher owned and operated the Warrior Fitness and Wellness Camp, opening the study to possible bias.

Summary

In summation, the goal of this mixed-methods sequential explanatory study was to understand and describe the impact of self-concept on weight loss as perceived by African American women. This study focused on identifying the specific elements of self-concept as it related to weight loss. This study used both qualitative and quantitative methods that closely adhered to Bracken’s (1992) six domains of self-concept, which were used to identify how African American women conceptualized themselves and in return how this perception influenced weight loss. For the qualitative part of the study, the researcher conducted face-to-face interviews with a convenience sample of 10 participants who were asked open-ended questions. Given the researcher’s extensive background in weight loss and fitness training, careful attention was given to all aspect of the study to avoid bias. Finally, an external reviewer was utilized to ensure reliability and validity.
CHAPTER IV: RESEARCH, DATA COLLECTION, AND FINDINGS

This study used a mixed-methods approach designed to examine obesity and weight loss perceptions among African American women through the lens of Bracken’s (1992) domains of self-concept. Prior studies examined associations between factors, domains, and physical activity; however, the studies were limited in the context of gender and age demographics, motivational readiness, perception of environment, and physical activity to pursue weight loss with body composition as a mediator (Hucles & Davis, 2010; Mama et al., 2015). The current study collected closed-end survey questions as well as face-to-face interviews. The survey data were analyzed through descriptive statistics using SPSS. This section presents the statistical analysis for the survey data, and the frequency of codes and outcomes from the interview data. The outcomes are presented in line with the presentation of research questions, beginning with self-perceptions of weight and affect/emotional aspects of weight loss and closing with the elements of Bracken’s (1992) six domains of self-concept.

Purpose Statement

The purpose of this mixed-method study was to understand and describe the impact of Bracken’s (1992) six domains of self-concept on weight loss as perceived by African American women.

Research Questions

This study focused on the impact of self-concept as it pertained to weight loss for African American women utilizing the six domains of self-concept developed by Bracken (academic, affect, competence, family, physical, social). The specific research questions guiding this study were:
1. How does the affective/emotional aspect of self-concept impact weight loss and fitness as perceived by African American women?

2. How does the academic aspect of self-concept impact weight loss and fitness as perceived by African American women?

3. How does the competence aspect of self-concept impact weight loss and fitness as perceived by African American women?

4. How does the family aspect of self-concept impact weight loss and fitness as perceived by African American women?

5. How does the physical aspect of self-concept impact weight loss and fitness as perceived by African American women?

6. How does the social aspect of self-concept impact weight loss and fitness as perceived by African American women?

7. What elements of Bracken’s six domains of self-concept do African American women perceive as having the greatest impact on weight loss and fitness?

**Research Methods and Data Collection Procedures**

This study employed a sequential mixed-methods exploratory design. A web-based survey was administered, followed by in-person interviews. Data were collected from African American women who participated in a fitness and weight loss challenge. The survey consisted of 32 questions, 24 related to Bracken’s six domains of self-concept (four per domain), and several demographic questions. The interviews consisted of seven open-ended questions. For the quantitative phase, the survey was originally sent out to the researcher’s network, and those participants were asked to forward the survey to additional women who met the study criteria. The survey also asked respondents if they
would be interested in participating in a follow-up interview. The researcher randomly selected 10 volunteers to be interviewed.

**Population**

The population was comprised of African American females age above the age of 18 who reside in the greater Los Angeles area. The target population was African American women over 18 who participated in either a physical fitness or weight loss program within the past 16 months.

**Sample**

The participants were selected by convenience sampling and snowball sampling based upon geographic location and associations. The initial participants were from the researcher’s personal network and they were encouraged to invite other African American women to participate in the study. Further, the sample was generated with consideration to proximity to the researcher. For the quantitative phase, the sample consisted of 66 participants. For the qualitative phase, the sample consisted of 10 participants.

**Demographic Data**

The study delimitations set certain demographic variables. All participants needed to be female, African American, and over the age of 18. Age has a significant impact on self-perception and self-esteem, particularly among women (Bleidorn et al., 2015; Huang, 2010;). The mean age of the sample was 42 years, with a standard deviation of 10 years. The ages were grouped into five categories: 18 to 25; 26 to 35; 36 to 45; 46 to 55; and 55 and over. As can be seen in Table 2, 91% of participants were older than 35.
Table 2

Participant Age Ranges

<table>
<thead>
<tr>
<th>Age Range</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 to 25</td>
<td>4</td>
<td>6.1</td>
</tr>
<tr>
<td>26 to 35</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>36 to 45</td>
<td>24</td>
<td>36.4</td>
</tr>
<tr>
<td>46 to 55</td>
<td>21</td>
<td>31.8</td>
</tr>
<tr>
<td>55 and Over</td>
<td>15</td>
<td>22.7</td>
</tr>
</tbody>
</table>

*Note.* n = 66

Survey participants were also asked how they perceived their weight. More than one-third (34.8%) perceived themselves to be slightly overweight, and no women thought they were underweight. The data in Table 3 indicated that 71.2% of the women in this study perceived themselves as overweight. This showed a slight under-estimation compared to CDC (2012) report showing 4 out of 5 African American women were overweight.

Table 3

Participant Self-Perceptions of Weight

<table>
<thead>
<tr>
<th>Perception</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Average Weight</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td>Slightly Overweight</td>
<td>23</td>
<td>34.8</td>
</tr>
<tr>
<td>Moderately Overweight</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td>Highly Overweight</td>
<td>5</td>
<td>7.6</td>
</tr>
</tbody>
</table>

*Note.* n = 66

Presentation and Analysis of Data

This study examined the weight loss perceptions by adult, African American women using Bracken’s (1992) six domains of self-concept. The findings are presented
based on each of the research questions, with the quantitative data presented first followed by the qualitative data.

Findings for Research Question 1

Research Question 1 was: *How does the affect/emotional aspect of self-concept impact weight loss and fitness as perceived by African American women?*

Three items for the affect/emotional domain were negatively worded and re-coded for the overall mean. The overall mean for items related to the affect domain was 3.03 on a 4-point scale ranging from *Strongly Disagree* to *Strongly Agree*, indicating some agreement that weight affected the affect/emotional domain of self-concept (Table 4).

Table 4

*Ratings for Items on the Affect/Emotional Domain of Self-Concept*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am shy because of my weight*</td>
<td>1.36</td>
<td>.60</td>
</tr>
<tr>
<td>I am an emotional eater*</td>
<td>2.38</td>
<td>.95</td>
</tr>
<tr>
<td>I am embarrassed because of my weight*</td>
<td>1.73</td>
<td>.76</td>
</tr>
<tr>
<td>I am happy with myself just as I am</td>
<td>2.59</td>
<td>.73</td>
</tr>
<tr>
<td>Overall affect mean</td>
<td>3.03</td>
<td>.55</td>
</tr>
</tbody>
</table>

*Note.* n = 64; *denotes negatively worded item that was re-coded for the overall mean; 3 of the 4 items were negatively worded resulting in a mean that appears higher than the individual items means.

The qualitative data provided more context explaining some of the quantitative results. Half of the women interviewed indicated their weight negatively affected their emotions. For example, one participant shared,

*I think that weight and emotions go hand in hand, unfortunately. I say when you weigh more, your emotions are out of check, and it’s harder to not react in an emotional situation. When you feel better about your*
weight, I think your emotions are more calm, and you can react in situations a little bit better (participant #1).

In contrast, two other participants reported that emotions did not directly affect their weight. Participant #2 stated, “If you perceive yourself as being overweight, a lot of times it’s emotional eating.” Three participants reported their weight did not affect their emotions; they noted they were confident regardless of their weight, such as participant #3, who shared, “I don’t feel like my weight affects my emotions because I’m pretty secure in who I am, so I don’t feel emotional about my weight. I don’t feel embarrassed about my weight.” The frequency of codes related to weight and the affect/emotional domain are presented in Table 5.

Table 5

<table>
<thead>
<tr>
<th>How Weight Affects the Affective/Emotional Domain of Self-Concept</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Negatively Affects Emotions</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Weight Does not Affect Emotions</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Emotions Directly Affect Weight</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

Note. n = 10

The findings for Research Question 1 indicated that overall, African American women were not embarrassed by their bodies and were happy just as they were. This finding was consistent with a study conducted by Huey (2013) who found African American women were more satisfied with their bodies than women of other racial and ethnic backgrounds.

Findings for Research Question 2

Research Question 2 was: How does the academic aspect of self-concept impact weight loss and fitness as perceived by African American women?
Two items for the academic domain were negatively worded and re-coded for the overall mean. The predominate theme stemming from Research Question 2 was that participants did well in school and did not associate weight status with their ability to learn. As shown in Table 6, the participants agreed they did well in school ($M = 3.43$), and strongly disagreed their weight affected their ability to learn ($M = 1.41$). Other than this survey, no other research could be found refuting or supporting the effects of obesity on learning in the adult.

Table 6

*Ratings for Items on the Academic Domain of Self-Concept*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did well in school</td>
<td>3.43</td>
<td>.59</td>
</tr>
<tr>
<td>Learning new things is easy for me</td>
<td>3.23</td>
<td>.66</td>
</tr>
<tr>
<td>My weight affects my ability to learn*</td>
<td>1.41</td>
<td>.58</td>
</tr>
<tr>
<td>I have poor study habits*</td>
<td>1.95</td>
<td>.84</td>
</tr>
<tr>
<td>Overall academic mean</td>
<td>3.32</td>
<td>.49</td>
</tr>
</tbody>
</table>

*Note. n = 63; *denotes negatively worded item that was re-coded for the overall mean.*

The qualitative data also indicated that weight did not affect the participants’ perceptions of academic self-concept. Seven of the 10 (70%) women interviewed indicated weight had no connection to academics. For example, one participant noted, “I don’t think it’s affecting me academically at all because I’m still able to do whatever I want to, when it comes to being able to learn.” Participant #3 shared this sentiment, noting,

"It has not affected me academically. I have a Master’s Degree. I have three degrees, and I’ve taken advanced leadership training at work. I’m a certified Green Belt and Six Sigma, and I’m working on my Black Belt. It has not affected me academically."
In contrast, two women indicated academics affected their weight in that they gained weight while attending classes. Participant #4 shared, “I worked during the day. I had vending machine dinners. It’s a really good excuse to just be too busy for the gym when you’re in school.” Participant #5 reported her weight affected her professional options, saying,

I actually have a passion for health and fitness and just awareness, especially among African Americans. Often, I feel like I can’t be in that profession though because I don’t fit the appearance. I’m overweight so how I tell someone else you need to eat right; you need to get fit. It affects me academically because I probably would’ve pursued a profession more in psychical fitness or health awareness, or weight loss journeys, or just feeling good about yourself if I thought my packaging matched what I felt in the inside.

Table 7 provides a summary of the frequency of codes for the interview questions about weight and the academic domain of self-concept.

Table 7

<table>
<thead>
<tr>
<th>How Weight Affects the Academic Domain of Self-Concept</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight has no Connection to Academic</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>School Added to Weight</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Weight Limited Professions</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>

Note. n = 10

Findings for Research Question 3

Research Question 3 was: *How does the competence aspect of self-concept impact weight loss and fitness as perceived by African American women?*
All the questions on the survey for the competence/health domain were positively worded. The responses for the self-perceptions of competence and health were more evenly distributed than the academic domain, with lower standard deviations. In contrast to the distribution, the prevailing theme in the qualitative data was a desire to become more competent.

The highest mean for items related to competence, 3.47, was for the item that participants could take care of themselves. The item with the lowest mean and the highest standard deviation related to self-confidence, showing more mixed-responses, related to participant perceptions of being self-confident (Table 8). This finding aligned with and supported studies that found self-concept was relative to social and cultural norms familiar to the individual (Levy & Heaton, 1993; Rand & Kulda, 1990).

Table 8

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can take care of myself</td>
<td>3.47</td>
<td>.62</td>
</tr>
<tr>
<td>I succeed at most things</td>
<td>3.25</td>
<td>.59</td>
</tr>
<tr>
<td>I could lose weight if I really tried</td>
<td>3.37</td>
<td>.60</td>
</tr>
<tr>
<td>I am very self-confident</td>
<td>3.16</td>
<td>.72</td>
</tr>
<tr>
<td>Overall competence mean</td>
<td>3.30</td>
<td>.48</td>
</tr>
</tbody>
</table>

During the interviews, participant responses varied and fit into multiple codes. Six (60%) of the participants reported a desire to be healthier and feel more competent, although their motivation to do so varied. Several participants noted they just wanted to look good, whereas others referenced health, participant #6 noted fear of health-related diseases. She commented,
It’s not really the perception of my body, it’s the perception of diabetes, and weight in my family, that makes me want to care for my health more, because I know that I don’t want to have diabetes, be overweight, and be 50 years old, 60 years old, and not be able to do all the things, physically, that I was able to do before. I’m trying to do things now when I’m younger. I have to say that the care for my body is more about prevention, and not really the perception of my body.

Half the women also noted some connection to family for wanting to be healthier and more competent. This was typically because they wanted to be healthy for their families or set good examples, such as participant #6 who shared, “I try to eat healthy, mainly because my kids are young and I need to be here for them.” Table 9 presents the frequency and percentage of the coded qualitative data.

Table 9

<table>
<thead>
<tr>
<th>How Weight Affects the Competence/Health Domain of Self-Concept</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire to be more Competent/Healthy</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Family Connection to Competence/Health</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Perception of Weight Matched Perception of Health</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Feel Competent/Healthy Regardless of Weight</td>
<td>3</td>
<td>30</td>
</tr>
</tbody>
</table>

Note. n = 10

Findings for Research Question 4

Research Question 4 was: How does the family aspect of self-concept impact weight loss and fitness as perceived by African American women?

One item for the family domain was negatively worded and re-coded for the overall mean. The predominate theme was that respondents believed their family members accepted their current weight and failed to treat them any differently because of
their weight. The highest mean, 3.51, was for the item that their families loved them just as they are, and the participants strongly disagreed their weight affected their families in a negative way (Table 10). This finding confirmed the findings of Fletcher (2014) who indicated African American women were embraced by several factors for which culture and societal norms prevailed, such as family connectedness.

Table 10

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>My home is warm and happy</td>
<td>3.30</td>
<td>.71</td>
</tr>
<tr>
<td>My family loves me just the way I am</td>
<td>3.51</td>
<td>.67</td>
</tr>
<tr>
<td>My weight affects my family in a negative way*</td>
<td>1.37</td>
<td>.60</td>
</tr>
<tr>
<td>My family would support me if I wanted to lose weight</td>
<td>3.46</td>
<td>.62</td>
</tr>
<tr>
<td>Overall family mean</td>
<td>3.47</td>
<td>.46</td>
</tr>
</tbody>
</table>

*Note. n = 62; *denotes negatively worded item that was re-coded for the overall mean.

Qualitative data related to family and weight showed more mixed responses as participants could expand upon their responses. Four (40%) respondents indicated their weight affected their families in a positive manner. Based on her recent weight loss, participant #7 noted she was now a role model for her family and said, “My weight affects my family a positive way because at least I’m being an example today. I’m doing something positive. Otherwise, if I wasn’t, we’d all be fat together.” Participant #8 shared this sentiment, who commented,

I think, as far as my son, I probably didn’t model great eating habits for him. I kept unhealthy options in the cabinets and the refrigerator for him. Now that I’m trying to eat healthier, and going to the gym, now I have rice cakes in the house, and I have lower fat options as far as popsicles. He’s not on a diet, but he’s trying that stuff out because it’s available. I have a
lot more fruit. I keep bananas in the house, and so I think my eating choices, and the way I perceive my weight and my weight loss goals, affect how my family eats because I’m the head of the household.

Three participants indicated their weight did not affect their family. Participant #9 said her family always supported her and did not think she needed to participate in a weight loss challenge, noting,

Everyone always tells me, “Oh, you look good” even when I’m on this journey, they tell me, “why do you need to lose weight? You look good. You’re just thick. You’re just curvy,” so, it was actually one of those things where my family supported my physical appearance, versus them making me feel like I needed to lose weight.

As can be seen in Table 11, three additional participants indicated that family affected their weight, such as participant #10 who said, “It affects your family. My husband doesn’t want to eat healthy so I have to do two separate things.” Two additional participants reported their weight affected their family in a negative way. For example, participant #8 shared,

Before I was on a weight loss journey, I do believe it affected them. They were concerned because I, at one time, weighed more than I had ever weighed before in my life. I think it was more of a concern for them on me being healthy. Now that I am working on that, it affects them also because they’re proud of me, and they see it, and they understand, so they also want to be physically fit as well, or to get physically fit.
These findings were also consistent with Fletcher (2014) who indicated the support of an African American woman by her family was significantly influential and the family was influenced by culture and societal norms.

Table 11

*How Weight Affects the Family Domain of Self-Concept*

<table>
<thead>
<tr>
<th>Weight Affects Family in a Positive Way</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Affects Family in a Negative Way</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Weight Does Not Affect the Family Domain</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Family Affects Weight</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Weight Affects Family in a Negative Way</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

*Note.* n = 10

**Findings for Research Question 5**

Research Question 5: *How does the physical aspect of self-concept impact weight loss and fitness as perceived by African American women?*

The survey responses for the physical domain of self-concept had some of the lowest means for individual items. In general, the women were less comfortable with their bodies and less physically active. Fletcher (2014) found African American women expressed a desire to exercise, but the effects of it (e.g., sweat, smell) were a greater determinate and the benefits, so they avoided exercise. Another study supported the finding that African American women acknowledged weight was an issue, but were comfortable and confident with their bodies as self-concept stemmed from the unhealthy belief that more weight equaled more beauty (Huey, 2013).

The findings in this study indicated that African American women were somewhat uncomfortable with their bodies, but agreed they were attractive and that physical fitness was, in some way, important to them (Table 12).
Table 12

*Ratings for Items on the Physical Domain of Self-Concept*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am comfortable with my body</td>
<td>2.78</td>
<td>.78</td>
</tr>
<tr>
<td>I am attractive</td>
<td>3.16</td>
<td>.67</td>
</tr>
<tr>
<td>I am physically active</td>
<td>2.95</td>
<td>.90</td>
</tr>
<tr>
<td>Physical fitness is important to me</td>
<td>3.31</td>
<td>.61</td>
</tr>
<tr>
<td>Overall physical mean</td>
<td>3.05</td>
<td>.53</td>
</tr>
</tbody>
</table>

The quantitative findings aligned with the qualitative data. Six of the women (60%) reported their weight affected their self-perceptions of their appearance. They reported their weight directly affected how they felt about their bodies, noting when they weighed less, they were more comfortable with their bodies. Participant #4 commented,

> I care about my appearance a lot. I’m always looking at how I can improve my appearance by losing weight, by staying in the gym, watching what I eat. It definitely affects your appearance. Weight affects your appearance. Weight affects how you fit in your clothes. You’re going to be aware of how you fit in your favorite pair of jeans, or if you can’t fit them anymore, you’re going to be like, “oh, I need to lose weight.” It definitely affects how I look at myself when it comes to my appearance, especially when you’re getting dressed. That’s when you notice it the most.

These overweight women also believed they were attractive and half reported being confident regardless of their weight. Participant #1 stated, “For a woman of my age, I actually look pretty damn good for an old girl of 63.” Participant #2 shared,
I don’t feel bad about how I look. I know that I can drop 20. In all honesty, I can drop 20 and look my best. I know what I look like 20 pounds less, but I think that for my age, and where I am in my life, I’m fine. I think I’m doing better than most.

Table 13 provides a summary of the frequency of codes associated with weight and the physical domain of self-concept.

Table 13

<table>
<thead>
<tr>
<th>How Weight Affects the Physical Domain of Self-Concept</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Affects Self-Perception</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Still Confident Regardless of Weight</td>
<td>5</td>
<td>50</td>
</tr>
</tbody>
</table>

*Note. n = 10*

**Findings for Research Question 6**

Research Question 6 was: *How does the social aspect of self-concept impact weight loss and fitness as perceived by African American women?*

Two of the survey items on the social domain were negatively worded and recoded for the overall mean. The means for the individual items showed the participants’ weight did not affect their ability to socialize and have fun, although all the standard deviations were larger than a half point, indicating some variance. As can be seen from Table 14, the participants strongly disagreed that their weight affected their ability to meet new people and socialize.
Table 14

*Ratings for Items on the Social Domain of Self-Concept*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am fun to be with</td>
<td>3.41</td>
<td>.80</td>
</tr>
<tr>
<td>I have lots of friends</td>
<td>3.08</td>
<td>.76</td>
</tr>
<tr>
<td>My weight affects my ability to meet new people*</td>
<td>1.39</td>
<td>.63</td>
</tr>
<tr>
<td>My weight affects my ability to socialize*</td>
<td>1.41</td>
<td>.71</td>
</tr>
<tr>
<td>Overall social mean</td>
<td>3.43</td>
<td>.46</td>
</tr>
</tbody>
</table>

*Note. n = 63; *denotes negatively worded item that was re-coded for the overall mean.*

The qualitative data aligned with the quantitative findings in that African American women were able to socialize with others regardless of their weight. Four (40%) of the participants indicated their weight did not affect their social self-concept and 40% reported that when they were feeling good, their weight did not matter. Consistent with previous findings, the women were confident regardless of their weight. As participant #3 said, “It really doesn’t affect me. As far as interacting, or being in a social setting, I don’t feel intimidated or anything by my weight.” Several women indicated they could overcome negative self-perceptions about their bodies by looking and feeling good in other areas. For example, participant #4 shared, My weight affects my ability to interact with others in a social setting by my level of comfort. If I feel like if I look good, and I feel good, then I’m more open to new relationships, and meeting people, and starting conversations, and things like that.

Participant #6 commented,

Everything has to do with how I am feeling at the moment. I will tell you that I am subconscious when I don’t feel like I look good. You can be bigger than the average person, or not have the cutest body in the room,
but if what I’m wearing, or my hair is up looking good, then it has
everything to do with that, not necessarily my weight.

Three of the participants also discussed clothing and how their weight affected
their attire. For example, participant #5 noted, “If I’m in my good weight, I’ll wear stuff
that’s more fitting, I’m going to show. If I have gained a few pounds, I’m not going to
wear clothes that’s going to show my curves, or my stomach.” Participant #7 reported
clothing was one of the most important factors related to weight and the social domain,
saying,

I think weight affects my ability to interact in social settings just by being
able to fit in to attire that’s required. If it’s a formal setting, being able to
wear, like if you’re in a wedding, the same dress as the rest of the
bridesmaids. A lot times, they want to go strapless, and that’s difficult if
you’re heavier. It also depends on chairs and aisles when it goes to
restaurants. If the tables are really close together, and you’re a little a
wider on the bottom, it’s uncomfortable to move around, and it can be
embarrassing if you knock stuff over. I definitely knock things over with
my butt. That’s how it can affect your ability to interact with others.

This was consistent with studies by Fletcher (2013) and Huey (2013) that
found African American women are comfortable in social settings no matter
their weight. Table 15 provides a summary of the qualitative data for Research
Question 6.
Table 15

_How Weight Affects the Social Domain of Self-Concept_

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Does Not Affect Social Self-Concept</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>When Feeling Good, Weight Does Not Matter</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Weight Affects Clothing Options</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Affect Varies on the Situation</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

*Note.* n = 10

**Findings for Research Question 7**

Research Question 7: _What elements of Bracken’s six domains of self-concept do African American women perceive as having the greatest impact on weight loss and fitness?_

The survey included separate questions asking about each domain overall. The first question asked participants to rate the extent to which each domain affected their ability to lose weight, using a 4-point scale ranging from 1 = *Not at All* to 4 = *To a Great Extent*. Overall, participant ratings were low, indicating they did not believe these domains affected their ability to lose weight. The domain with the highest mean, 2.11, was for the affect/emotional domain, in which 34.9% of the women indicated the domain moderately or greatly affected their ability to lose weight (Table 16).
Table 16

Extent to which Each Domain Affected Participants’ Ability to Lose Weight

<table>
<thead>
<tr>
<th>Domain</th>
<th>n</th>
<th>% indicating Moderate or To a Great Extent</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Reasons</td>
<td>4</td>
<td>6.4</td>
<td>1.25</td>
</tr>
<tr>
<td>Affect/Emotional Reasons</td>
<td>22</td>
<td>34.9</td>
<td>2.11</td>
</tr>
<tr>
<td>Competence Reasons</td>
<td>7</td>
<td>11.1</td>
<td>1.49</td>
</tr>
<tr>
<td>Family Reasons</td>
<td>7</td>
<td>11.1</td>
<td>1.48</td>
</tr>
<tr>
<td>Physical Reasons</td>
<td>13</td>
<td>20.7</td>
<td>1.75</td>
</tr>
<tr>
<td>Social Reasons</td>
<td>9</td>
<td>9.6</td>
<td>1.44</td>
</tr>
</tbody>
</table>

Note. n = 62

Participants were also asked which domain had the single greatest impact on their inability to lose weight. Participants responses were somewhat mixed, with four domains all within 10 percentage points of each other. With 25.8%, slightly more participants indicated the competence domain had the greatest impact on their inability to lose weight. This was closely followed by the physical domain, affect/emotional domain, and family domain. Few participants indicated the social or academic domains affected their ability to lose weight (Table 17).

Table 17

Single Domain with the Greatest Impact on Participants’ Inability to Lose Weight

<table>
<thead>
<tr>
<th>Domain</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Reasons</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Affect/Emotional Reasons</td>
<td>13</td>
<td>21.0</td>
</tr>
<tr>
<td>Competence Reasons</td>
<td>16</td>
<td>25.8</td>
</tr>
<tr>
<td>Family Reasons</td>
<td>11</td>
<td>17.7</td>
</tr>
<tr>
<td>Physical Reasons</td>
<td>14</td>
<td>22.6</td>
</tr>
<tr>
<td>Social Reasons</td>
<td>6</td>
<td>9.7</td>
</tr>
</tbody>
</table>

Note. n = 62

Findings among those who were interviewed were also mixed. In contrast to the quantitative data in which competence was selected by 25.8% of participants as having
the greatest impact on weight loss, the physical domain was cited most often among the interview participants. Selecting the physical domain was driven by the desire to look better. For example, participant #8 shared, “For me, physical has the greatest impact on weight loss, because of course, physically, I want to look better.” Participant #9 commented,

I look at myself more than anybody else. I want to look good. I know the world, and how the world thinks, and the world is very prejudice against people who are overweight. Because I’m a big girl, meaning tall, I can carry more weight, but that’s always my first priority. To make sure I’m not all over the place…Appearance is number one because of the world we live in, the prejudice. Men don’t want you when you are overweight. You don’t have the best choice of everything. You don’t look good in pictures. Work is prejudice. It can stop you from getting a promotion. The thought of what you won’t have if you don’t keep your appearance up.

The family and social domains were both cited by two people as the domain having the greatest impact on their ability to lose weight. Those selecting the family domain talked about how their family motivated and encourage them, and how they wanted to “keep up” with their children. Those selecting the social domain focused on feeling comfortable in social situations and being motivated by people in similar situations working to lose weight, such as participant #10 who explained,

I think social, for me, has the greatest impact on weight loss. I am around other people that are super skinny, and have been skinny their whole life.
I meet people who are struggling with me, and are motivated with me, and are encouraging me because they have life going on too, and they find a way to make weight loss a priority. I think social is the most important.

As can be seen from Table 18, only one participant reported the emotional domain had the greatest impact on weight loss. Participant #4 mentioned emotional lows based on prior failed attempts and emotional highs as she successfully lost weight. Similar to the survey findings, no interviewees selected the academic domain as impacting weight loss.

Table 18

| Single Domain with the Greatest Impact on Weight Loss among Interview Participants |
|----------------------------------|-----|-----|
|                                  | n   | %   |
| Academic Reasons                | 0   | 0   |
| Affect/Emotional Reasons        | 1   | 10  |
| Competence Reasons              | 0   | 0   |
| Family Reasons                  | 2   | 20  |
| Physical Reasons                | 5   | 50  |
| Social Reasons                  | 2   | 20  |

Note. n = 10

Summary

This study examined weight loss among African American women through the lens of Bracken’s (1992) six domains of self-concept (academic, affect/emotional, competence, family, physical, and social). Chapter IV presented the data and analysis from the quantitative survey and the qualitative interviews. The qualitative data helped provide context and offer additional insights into the quantitative data. The extent to which each domain affected the participants’ ability to lose weight was mixed, although there was general consensus that the academic domain had little impact on weight and
weight loss compared to the other domains. Chapter V provides additional discussion about the findings, and includes implications for action, recommendations for further research, and concluding remarks.
CHAPTER V: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The primary aim of this study was to increase understanding and awareness of the impact of self-concept on weight loss as perceived by African American women. The method consisted of identification of specific elements of self-concept associated with weight loss based upon Bracken’s (1992) six domains of self-concept. The research design captured authentic conceptualizations of weight and self-perception among African American women by mixing both quantitative and qualitative methods.

This chapter begins with a reiteration of the purpose and research questions. A discussion of the major findings and unexpected findings follow this. Next, conclusions and implications for action are presented, along with recommendations for further research. The chapter ends with concluding remarks from the researcher.

Purpose Statement

The purpose of this mixed-methods study was to understand and describe the impact of Bracken’s (1992) six domains of self-concept (academic, affect, competence, family, physical, social), on weight loss as perceived by African American women.

Research Questions

This study focused on the impact of self-concept as it pertained to weight loss for African American women utilizing the six domains of self-concept developed by Bracken (social, competence, affect, physical, academic, family). The specific research questions guiding this study were:

1. How does the affective/emotional aspect of self-concept impact weight loss and fitness as perceived by African American women?
2. How does the academic aspect of self-concept impact weight loss and fitness as perceived by African American women?

3. How does the competence aspect of self-concept impact weight loss and fitness as perceived by African American women?

4. How does the family aspect of self-concept impact weight loss and fitness as perceived by African American women?

5. How does the physical aspect of self-concept impact weight loss and fitness as perceived by African American women?

6. How does the social aspect of self-concept impact weight loss and fitness as perceived by African American women?

7. What elements of Bracken’s six domains of self-concept do African American women perceive as having the greatest impact on weight loss and fitness?

Major Findings

Major Finding 1 – African American women believed their weight directly affected their emotions.

Study participants suggested a connection between weight and the affect/emotional domain, although the direction of that relationship was mixed. Some women believed their weight directly affected their emotions, whereas others believed their emotions affected their weight.

Major Finding 2 – African American women were not embarrassed by their bodies and were happy just as they were.

Consistent in both the survey and interview findings was that African American women were not embarrassed by their bodies and were happy just as they were. This was
consistent with Huey (2013) who found African American women tended to be happier with their bodies than Caucasian women.

**Major Finding 3 – The academic domain of self-concept was not associated with weight.**

The survey and interview results showed the academic domain of self-concept was not associated with weight. Survey participants reported they performed well in school and their weight did not affect their ability to learn. Additionally, 70% of those interviewed reported weight had no connection to their academics and 20% noted the only link was that they gained weight while going to school.

**Major Finding 4 – Participants rated themselves highly in terms of competence/health.**

Survey participants rated themselves highly on the competence/health domain. They indicated they could take care of themselves, could lose weight if they really tried, and were very self-confident. A high level of self-confidence was also found among the interviewees, but they also reported a desire to be more competent and improve their health. This aligned with a study that indicated African American women, however confident, were not connecting obesity with health issues (Duncan et al., 2011).

**Major Finding 5 – African American women were loved by their families regardless of their weight.**

The family domain of self-concept had some of the highest ratings of the survey as participants indicated their families loved them just as they were and that their families would support them if they wanted to lose weight. This aligned with the interview findings in which 40% indicated their weight affected their family in a positive way. The
condition of the family perception regarding weight and acceptance was reflected in a study that confirmed there was a disconnect among African American women when assessing obesity as a health concern (Trust for America’s Health & Robert Wood Johnson Foundation, 2014).

**Major Finding 6 – Physical fitness was important to African American women, but other priorities took precedence over health and fitness.**

Although the survey participants generally agreed physical fitness was important to them, they had lower ratings for being comfortable with their bodies and being physically active. The data showed a slightly negative connection between weight and the physical domain. Similarly, the interview participants indicated their weight affected their self-perception, but they were confident in themselves regardless of their weight. A similar study revealed that confidence and comfort among African Americans declined when addressing exercise due to sociocultural barriers related to hygiene and personal style, such as the negative effect sweat has on hair care (Huebschmann et al., 2016).

**Major Finding 7 – Weight did not affect African American women’s ability to socialize and interact with others.**

The data showed weight did not affect social self-confidence as participants reported they were still able to meet new people and socialize. This was confirmed by the qualitative data that showed weight was less important and could be compensated for by looking good in other areas. Although specific social settings were not examined in this study, Cash (2011) and Rosas et al. (2017) noted self-confidence in social settings mirrored the environment, so people were more comfortable with like-people in a comfortable, culturally relatable surrounding.
Major Finding 8 – Multiple self-concept domains affect African American women’s ability to lose weight.

This findings from this question confirmed the limited connection between weight and the academic and social domains of self-concept. On the other end of the spectrum, the physical, competence, and affect/emotional domains were most connected to participant’s inability to lose weight. Another study confirmed that African American history, culture, and social dynamics instilled a genetic disposition particular to women, noting high-stress treatment and connection to unhealthy comfort foods (Dingfelder, 2013).

Unexpected Findings

The unexpected finding in this study was that the social domain was not overwhelmingly associated with weight loss. Other studies found the stigma associated with obesity created an additional challenge to weight management programs in the context of the pervasiveness of social condemnation justified by accusations of laziness, gluttony, and a lack of self-control (Brewis, Hruschka, & Wutich, 2011; Puhl, Himmelstein, Gorin, & Suh, 2017). Among those interviewed for this study, only a small percentage of the participants asserted their weight affected their ability to meet to people and to socialize. However, none of the women interviewed owned that they themselves were overweight. These women indicated they were confident in their weight, especially when they felt good about themselves in other areas.
Conclusions

Conclusion 1: Overweight African American women will do as well academically as non-overweight women.

Based on the findings of this research, weight and weight loss among African American women was least affected by the academic domain. Participants indicated their grades and ability to perform well in school was not affected by body image issues or obesity. There is no indication that obesity affected the ability to succeed and thrive in an academic setting. Of all the domains, the academic domain appeared least related to weight and weight loss.

Conclusion 2: African American women will not lose weight due to social pressures because they are already comfortable with their bodies.

Based on the finding of this research, African American women’s self-concept was not hindered by their social environment. Most of the participants in this study did not express concern about perceived body image in a social setting. The study was general in nature did not include types of social settings. This research could be more conclusive with a variety of social settings proposed to each participant, such as a setting that could be perceived as unfamiliar and uncomfortable.

Conclusion 3: Family will support African American women regardless of their weight, and family support will affect an African American woman’s decision to lose weight.

Based on the findings of this research, there was equal concern of self-concept regarding perceptions of the family and effects on competency. The majority felt supported by their family in their current condition of obesity but, also, stated they would
be equally supported in their decision to lose weight if they desired to do so. The women in this study, overall, felt their level of competency was not affected by their weight. This research indicated the level of family acceptance in the African American woman’s life was dynamic. This was representative of the African American family that tended to support their loved ones unconditionally.

**Conclusion 4:** African American women need fitness facilities that meet their specific needs regarding physical fitness and health.

The findings of this research indicated many African American women did not see that physical activity (or lack thereof) was affecting of their self-concept. Physical activity was not a priority for most of the participants; however, some expressed a desire to be more active but feel hindered by cultural/social constructs. This research concluded that African American women need an environment knowledgeable to their specific needs and concerns regarding exercise; more specifically, fitness facilities are needed in which the African American woman feels she belongs much in the same way they belong in their church.

**Conclusion 5:** African American women who led emotional unbalanced lives are less likely to live a healthy lifestyle.

Based on the findings of this research, it was concluded that many African American women believed their emotions influenced their state of unhealthiness, and in particular, stress in their daily lives. Studies and research support this finding and indicated that African American women, more than any other racial or ethnic group, had specific burdens carried over from generation to generation. Therefore, it was in their best interest to pursue some type of mental health or behavioral therapy to understand
what triggered their emotions, preferably with an African American therapist with intimate knowledge of the connection between history, culture, and obesity.

Implications for Action

In the African American community, culture and cultural acceptance became a primary focus in the minds of women. Overweight women did not think of their health over their cultural norms. As evidenced in the research, many African American women accepted their bodies were overweight and remained comfortable with no social/environmental pressure to change. It was evident that education about health, history, and the future of the population was lacking. To eradicate the poor current and future state of health among the African American population, specific actions need to be taken.

Action 1 – Awareness and Knowledge

Target education in the African American community – Education must be delivered in three specific areas:

- The history of the African American community in America. Acknowledge the effects of the African American plight, starting with slavery, and moving through Jim Crow, civil rights, equality, and today, and the impact on psychological and physical health. The culture of the community is such that the connection to its origins was lost; ripped from families and communities, packed like cattle on slave ships, stripped of all identity, and sold/maintained like property. Many African Americans cannot connect to their ancestry beyond 200 years; what they have is a name that associates them with White slave owners. The connection to their culture and their history is vital to
understanding their cultural values and the general state of their health resulting from them. Offer parenting classes focused on the long-term health and fitness of children.

- Understand the composition of sugar and fat, and how over the years, generation to generation, the cycle created by sugar and fat consumption changed the molecular and biochemical structure in the woman’s body. Sugar and fat in the African America diet began during slavery when they were fed high caloric foods with large amounts of carbohydrates. This food composition was meant to keep their bodies performing at maximum capacity in the plantations fields. With the shift from slavery to Jim Crow, accessibility to healthier food choices was denied and the foods they prepared were a result of what they knew. The generation of people released from slavery only knew what had been put before them as slaves, so their eating habits remained the same. The foods they ate became part of their American culture (Edwards, 2003). Little attention was paid to the healthiness of the diet when much of the population was just struggling to stay alive. Today, family gatherings still entail large meals steeped in high caloric, unhealthy foods based on tradition and origin.

- Understand the culture in respect to attraction. The African American population linked personal attraction with curvy women who were viewed as healthy, wealthy, and beautiful. This influenced pop culture that sings about an attraction to big bottom girls and thick women. This directly relates to the self-esteem of African American women because if they are not overweight or
curvy, they are not desirable. Educating the population about health versus cultural attraction and acceptance is one of the most important aspects of the health epidemic.

**Action 2 – Culture and Community**

Target African American communities for support.

- Create a global movement for the Black community, especially Black women. Black women, yes, you matter! Using hashtags and slogans historically sends a compelling message and a unifying call to action. By using “Black women, yes, you matter,” every Black woman can know they are acknowledging for their struggles and they can succeed with a healthy lifestyle.

- Churches in African American communities are a major influence on this largely spiritual population. Clergy should be asked to promote the health and welfare of the Black women and its vital importance.

- Businesses visited by the African American women should post flyers for the “Black women, yes, you matter” movement with information about the health and welfare of the Black woman.

- Highlight parental responsibility and encourage parents to maintain and reinforce the importance of forming healthy habits.

- Promote individual responsibility. It is up to the individual to make the decision to move forward with healthy habits, but within a community of support. It takes 21 days to change a bad habit. For an individual to succeed, they need to find support, develop fitness routines, educate themselves about obesity and plant-based food, and surround themselves with healthy foods.
African Americans are challenged by healthy food habits because of the unavailability of healthy food choices. But, preparing foods at home is a healthy habit! Before fast food and processed foods were available on every corner, families prepared foods at home using fresh meats, vegetables, and fruits. Now the fast food trend must be reversed, or altered, to offer a healthy plant-based menu. Another option is install drive through healthy pick up food options using a phone app for convenience.

- Provide easy access to healthy recipes. In today’s quick-paced world, people often turn to options that are quick and convenient, such as fast food. A website needs to be developed that offers healthy recipes that can be prepared quickly.

**Action 3 – Intervention and Prevention**

Target government agencies to regulate foods and fitness. Government agencies can be motivated by the voice of the people. Voting initiatives and petitions are two ways of angling into a government agency. Within cities and towns, there are council meetings in which people can speak directly to their elected local officials with an outline of the problem and ideas for solutions. Although big problems underlay big government, local government is much more accessible and less cumbersome to work with, and with one town in agreement others may follow.

- Part of the mission of the U.S. Food and Drug Administration (FDA) is to protect public health by ensuring the safety of the American food supply. The people must demand the FDA and other agencies restrict, remove, and redefine the healthy diet. All animal products, processed foods, and portion
sizes need reevaluation and correction. For example, the size of a small drink in the U.S. is the equivalent of a large drink in Europe. The FDA has the authority to regulate the ingredients and the size of foods distributed and should do more to promote a healthy lifestyle for the American people.

The U.S. Department of Agriculture (USDA) oversees school lunches. The current standards for school lunches are unacceptable. Children need healthy plant-based foods available in their schools. The people need to demand the USDA to do better and remove processed foods and sugary drinks from schools. The school lunch program proposed by former first lady, Michelle Obama, was suggested and, soon, rejected by schools. The schools complained about meal preparations and time restraints and the healthy alternative lunch went by the wayside without any repercussions from government. The incentives were not lucrative enough to the schools when the alternative, healthy program was introduced and the children, reportedly, rejected the food (where presented). Children do not know, in detail, what dangers lurk in their pudding, juice and hamburger. The decision to serve healthy food in schools should never be swayed by a child’s opinion.

- The U.S. Department of Education, which establishes public school guidelines, needs to add mandates for nutrition and physical education courses. Although California has mandated minutes of required physical education every two weeks, this is not the case in most states. Courses must be taught by teachers who specialized in subject areas. The goal is to get
children healthy so future generations will be healthy. A child is never too young to learn about healthy foods and the benefits of exercise.

- The Federal Trade Commission must be tasked with regulating what and how foods are advertised to the population. In Norway, it is illegal to market unhealthy foods and drinks to children under 13. In Denmark, products with a high content of sugar, fat, and salt, cannot be directed toward children 14 and under. In Cranberra, Australia, advertising junk food, alcohol, and gambling was banned on buses since 2015. In Latvia, the sale of energy drinks to anyone under 18 is prohibited, as is advertising before, during, and after television shows aimed at those under 18. Americans can do better. The FTC is the agency that should be tasked with raising nutritional awareness. By creating a campaign, much like breast cancer awareness, that reaches a mass audience annually. Sugar awareness month, or no sugar month, needs to be an effort with maximum push. Call on advertisers and companies to call sugar, sugar and not energy. Energy drinks found in most retail stores use the word ‘energy’ to disguise what it really is, sugar. This campaign, by repetition, will stimulate a wide audience to assimilate words used to their actual meaning. As in all awareness campaigns the information needs to transcend schools, as well. By starting the campaign locally –perhaps, in the gym, first, the word begins to spread and the motion can be brought to local council followed by cities, states, and country.
**Action 4 – Nutrition**

Introduce plant-based nutrition. Plant-based nutrition was researched and presented in many forms around the world, but in the United States, the USDA, still presents the American people with food options that include animals and animal byproducts. The first food pyramid was developed and published in Sweden in 1974. The United States first developed and published its food pyramid in 1992, and it was updated in 2005 and then replaced with My Plate in 2011. The food recommendations of the USDA include animal products in addition to plant-based options. The USDA, being a government agency, should be held accountable and through petitions, social media, and local government, include a greater focus on plant-based systems.

**Action 5 – Cultural Responsibility**

Pop culture responsibility.

- Obtain support from the music and other industries to reach out to Black women via social media, television, and radio to promote health and wellness in a manner that incorporates the information in Actions 1 through 4. The power and influence of celebrity is massive, for good and bad. For example, Oprah Winfrey historically influenced purchases, lifestyles, and education standards. Currently, Oprah owns 10% of Weight Watchers and, although the program does not address Black women, specifically, if Oprah made the connection between obesity, systematic racism, and the burden on Black women’s health, she could positively affect millions through Weight Watchers (change menus and target Black women). Partnering with all social media
platforms to engage in healthy eating and lifestyles would reach the target audience—the men and women producing the next generation.

**Recommendations for Further Research**

Based on the findings from this study and its limitations, the following areas are recommended for further research:

1. The quantitative portion of this study only included 66 women and the qualitative portion only included 10 women, so it is recommended that a mixed-method study be conducted that expands the sample of African American women to areas throughout California.

2. The participants reported they were comfortable opening up to the researcher because of his race. Therefore, it is recommended that additional qualitative research be conducted by other researchers of African descent.

3. Participants noted the social and family domains were influential in terms of getting support and motivation, as well as being held accountable. Therefore, it is recommended additional qualitative and quantitative research further examine the social and family domains to better understand how they affect weight loss.

4. This study found a connection between emotions and weight, but the direction of the relationship was unclear. Additional qualitative research should further examine the role of emotions and weight among African American women combining history and culture of the African American people.
5. This study found no connection between African American women and learning abilities. Further quantitative research is needed to examine the effects of obesity on learning among African American women.

**Concluding Remarks and Reflections**

Despite the advancement of medical technology, the state of obese and overweight African American women continues to produce new, potentially negative outcomes in other areas of health. African American women diagnosed with Type-2 diabetes are at increased risk of an estrogen receptor-negative (ER) breast cancer diagnosis and worsening of systemic lupus erythematosus, as well as other health issues of fatigue, depression, and chronic pain (Healio, 2017). Whether the African American adult female is aware or chooses to acknowledge an overweight or obese status according to her BMI, the prevalence of the problem remains the same.

The outcomes of obesity and overweight are preventable. Aggressive weight loss programs aim to rectify the health problem after the fact. The aim of health and wellness programs and educational tracts must focus upon the prevention of overweight and obesity prior to treatments for women who are presently obese or overweight. Bracken’s (1992) six domain model directs the research beyond the biological factors to address socioeconomic and psychological that may stem from childhood or upbringing.

Black lives matter! Black health matters! Let’s fight obesity!

**Personal Statement**

As a young boy growing in the Congo I was told that my life would never be beyond what I could see. I grew up witnessing diseases, violence, and war. This was a common daily way of life. I did not know the meaning of freedom, including freedom to
be healthy, educated, or hope for a better life. Being overweight in Africa was a sign of wealth. We were told diabetes was the disease of the rich man, even though 2 of the 3 women that raised me died from diabetes— and we were poor! We thought dying overweight was some type of fulfillment in life. We love our women curvy. Curvy was as a sign of health, wealth, and beauty. Everything changed when I came to America. As a fitness enthusiast, I used to discriminate against overweight people, including African American people, not knowing the true story of why they had become overweight in the first place. I thought it was their own fault and they could stop eating and exercise more to stop their suffering. I was naïve, until I started to dig deep inside the history of obesity among African American woman. To understand about the disease of obesity, I needed to travel hundreds of years back in time—understanding that when the African slave was fed high-caloric, high-carbohydrate, high-sugar food for the purpose of working in the plantation fields, without acknowledging this food had consequences to health passed on from generation to generation. Today, over 100 African American women die every day from diseases related to what was given to them years ago. Now, as I acknowledge the history of African American people, I would love to say I am sorry for discriminating against my own people without acknowledging how much they suffered and paved the way for an African boy from the Congo to be successful. This doctoral journey taught me about empathy, compassion, and the importance of acknowledgment. Not to judge people without knowing where they came from. To be aware that words can make and destroy other people. And I had to take into consideration that every life matters and yes, Black woman, your life matters.
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APPENDICES

APPENDIX A – SURVEY

Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by Women

Welcome and Consent Information

Thank you for agreeing to participate in this study. The purpose of this study is to examine Bracken’s elements of self-concept, which includes social, competence, affect, physical, academic, and family, and how they affect weight loss in African American women. The information you give, along with others completing this survey, hopefully will provide a clear picture of the perceptions of African American women with regard to self-concept and weight loss. The survey should take less than 10 minutes to complete. Your responses will be confidential and all the data will be reported without reference to any individual(s).

I agree to voluntarily participate in the study. I have read the informed consent below and participant bill of rights. All my questions were answered to my satisfaction. I understand that I can skip any questions or stop taking the survey at any time without consequences.

☐ Yes
☐ No
RESEARCH TITLE: Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by African American Women

INSTITUTION: BRANDMAN UNIVERSITY 16355 LAGUNA CANYON ROAD IRVINE, CA 92618

RESPONSIBLE INVESTIGATOR: Tchicaya Msiyamou

PURPOSE OF STUDY:
The purpose of this mixed-method study was to understand and describe the impact of Bracken's (1992) six domains of self-concept on weight loss as perceived by African American women.

By participating in this study, I agree to participate to complete the survey. The survey should take 10-15 minutes to complete and my responses will be recorded.

I understand that:

a) There are minimal risks associated with participating in this research. I understand that the investigator will protect my confidentiality by keeping the identifying codes and research materials in a locked safe that is available only to the researcher. I understand that my responses will not be used by the researcher beyond the use as stated in initial scope of this research.

b) The possible benefit of this study to me is that my input may help add to the research self-concept and weight loss in African American women. The findings will be available to me at the conclusion of the study and I may be provided the results of the available data and summary and recommendations. I understand that I will not be compensated for my participation.

c) Any questions I have concerning my participation in this study will be answered by Tchicaya Msiyamou. He can be reached by e-mail at tmsiayam@brandman.edu or by phone at (818) 440-0822.

d) My participation in this research study is voluntary. I may decide not to participate in the study and I can withdraw at any time. I can also decide not to answer particular questions on the survey. I understand that I may refuse to participate or may withdraw from this study at any time without any negative consequences. Also, the investigator may stop the study at any time.

e) No information that identifies me will be released without my separate consent and all identifiable information will be protected to the limits allowed by law. If the study design or the use of the data is to be changed, I will be so informed and my consent re-obtained. I understand that if I have any questions, comments, or concerns about the study or informed consent process, I may write or call the Office of the Executive Vice Chancellor of Academic Affairs, Brandman University, at 16355 Laguna Canyon Road, Irvine, CA 92618, (949) 341-2430 office or email him at larick@brandman.edu.

f) I acknowledge that I have received a copy of this form and the Participant’s Bill of Rights. I have read the above and understand it and hereby consent to the procedure(s) set forth.
Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by Women

Demographics. Please complete this section so we might better understand survey participants.

My age range is:
- 18-25
- 26-35
- 36-45
- 46-55
- 55 or over

* My ethnicity is:
- African American
- Hispanic
- Asian
- Multi-racial
- Caucasian
- Other (please specify)________

I consider myself to be:
- Underweight
- Average weight
- Slightly overweight
- Moderately overweight
- Highly overweight

The foods I eat are:
- Mostly unhealthy
- Somewhat unhealthy
- Somewhat healthy
- Mostly healthy

In terms of weight, I should:
- Put on more weight (too skinny)
- Maintain my current weight (just right)
- Lose a few pounds (a little chubby)
- Lose a lot of weight

I have tried to lose weight or improve my fitness through diet and exercise.
- Yes
- No
Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by Women

The following statements are characteristics about your beliefs, personal identity, and social identity. On a scale from 1 (strongly disagree) to 4 (strongly agree), please rate each statement below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am fun to be with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a lot of friends</td>
<td></td>
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<tr>
<td>My weight affects my ability to meet new people</td>
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<tr>
<td>My weight affects my ability to socialize</td>
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</tr>
<tr>
<td>I am shy because of my weight</td>
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<tr>
<td>I am an emotional eater</td>
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<td></td>
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<tr>
<td>I am embarrassed because of my weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am happy with myself just as I am</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can take care of myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I succeed at most things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could lose weight if I really tried</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I am very self-confident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I did well in school</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning new things is easy for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My weight affects my ability to learn</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>I have poor study habits</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>My home is warm and happy</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>My family loves me just the way I am</td>
<td></td>
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<td></td>
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<tr>
<td>My weight affects my family in a negative way</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------</td>
<td>---------</td>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>My family would support me if I wanted to lose weight</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>I am comfortable with my body</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>I am attractive</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>I am physically active</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Physical fitness is important to me</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

To what extent have the following impacted your ability to lose weight and lead a healthy lifestyle?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>To great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective/emotional reasons</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Academic reasons</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Family reasons</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Social reasons</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Physical reasons</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Personal competence/abilities</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

Which of the following has had the greatest impact on your ability to lose weight and lead a healthy lifestyle? (select only one)

- 〇 Affective/emotional reasons
- 〇 Academic reasons
- 〇 Family reasons
- 〇 Social reasons
- 〇 Physical reasons
- 〇 Personal competence/abilities
Optional Questions. The following questions are for background information to assess survey results.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How tall are you?</td>
<td></td>
</tr>
<tr>
<td>How much do you weigh?</td>
<td></td>
</tr>
<tr>
<td>I would be interested in participating in a follow-up interview.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

If you are interested in participating in a follow-up interview, please provide your name, email address, and phone number.

<table>
<thead>
<tr>
<th>Information</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name</td>
<td></td>
</tr>
<tr>
<td>Preferred Email Address</td>
<td></td>
</tr>
<tr>
<td>Preferred Phone Number</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B – INFORMED CONSENT

INFORMATION ABOUT: Understanding and Describing the Impact of Self-Concept on Weight Loss as Perceived by African American Women

BRANDMAN UNIVERSITY
16355 LAGUNA CANYON ROAD IRVINE, CA 92618

RESPONSIBLE INVESTIGATOR: Tchicaya Missamou

PURPOSE OF STUDY: The purpose of this mixed-method study was to understand and describe the impact of Bracken’s (1992) six domains of self-concept on weight loss as perceived by African American women.

By participating in this study, I agree to participate in a private one-on-one interview. The one-on-one interview will last between 20–30 minutes and will be conducted in person and audio recorded.

I understand that:

________________________ a) There are minimal risks associated with participating in this research. I understand that the investigator will protect my confidentiality by keeping the identifying codes and research materials in a locked safe that is available only to the researcher. I understand the audio recordings WILL NOT be used by the researcher beyond the use as stated in initial scope of this research.

________________________ b) The possible benefit of this study to me is that my input may help add to the research self-concept and weight loss in African American women. The findings will be available to me at the conclusion of the study and I may be provided the results of the available data and summary and recommendations. I understand that I will not be compensated for my participation.

________________________ c) Any questions I have concerning my participation in this study will be answered by Tchicaya Missamou. He can be reached by e-mail at REDACTED or by phone at REDACTED.

________________________ d) My participation in this research study is voluntary. I may decide to not participate in the study and I can withdraw at any time. I can also decide not to answer particular questions during the interview if I so choose. I understand that I may refuse to participate or may withdraw from this study at any time without any negative consequences. Also, the investigator may stop the study at any time.

________________________ e) No information that identifies me will be released without my separate consent and all identifiable information will be protected to the limits allowed by law. If the study design or the use of the data is to be changed, I will be so informed and my consent re-obtained. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may write or call the Office

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of the Executive Vice Chancellor of Academic Affairs, Brandman University, at
16355 Laguna Canyon Road, Irvine, CA 92618, (949) 341-7641.

f) I acknowledge that I have received a copy of this form and the
Participant’s Bill of Rights. I have read the above and understand it and hereby consent
to the procedure(s) set forth.

Participant Signature   Date

Researcher Signature, Tchicaya Missamou   Date
APPENDIX C – INTERVIEW PROTOCOL

Introduction

My name is Tchicaya and I’m a doctoral candidate at Brandman University in the area of Organizational Leadership. I’m conducting research to how self-concept affects weight loss in African American women. Specifically, I am looking at Bracken’s elements of self-concept, which includes social, competence, affect, physical, academic, and family.

I am conducting approximately 15 interviews with women like yourself. The information you give, along with the others, hopefully will provide a clear picture of the perceptions of African American women with regard to self-concept and weight loss.

Informed Consent (required for Dissertation Research)

I would like to remind you any information that is obtained in connection to this study will remain confidential. All of the data will be reported without reference to any individual(s) or any institution(s). After I record and transcribe the data, I will send it to you via email so you can make sure that I accurately captured your thoughts and ideas.

Did you receive the Informed Consent and Brandman Bill of Rights I sent you via email? Do you have any questions or need clarification about either document?

We have scheduled an hour for the interview. At any point during the interview you may ask that I skip a particular question or stop the interview altogether. For ease of our discussion and accuracy I will record our conversation as indicated in the Informed Consent.

Do you have any questions before we begin? Okay, let’s get started, and thanks so much for your time.

Interview Questions

1. In what ways does your weight affect your ability to relate to or interact with others in a social setting? Can you tell me more or give me an example?
2. How does your perception of your body affect your ability to care for your health?
3. How does your perception of your weight affect your awareness of your emotions?
4. How do you feel that your weight affects how you feel about your appearance?
5. In what ways has your weight affected you academically?
6. How has your weight affected your family?
7. Which of these factors (social, physical, emotional, appearance, academics, or family) has the greatest impact on weight loss and why?

Conclusion of Interview

Those are all the questions I have for you. I will send you a copy of the transcription once it is ready. Please review it for accuracy and let me know if you want to revise to add to any response. Thank you for your time today; it is greatly appreciated.