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Pamela G. Bowen
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A PHENOMENOLOGICAL STUDY OF OBESITY AND ITS IMPACT ON
FUNCTIONAL STATUS, LIFE-SPACE MOBILITY, AND PHYSICAL ACTIVITY IN
SOUTHERN AFRICAN AMERICAN OLDER WOMEN

by

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A DISSERTATION

Submitted to the graduate faculty of The University of Alabama at Birmingham,
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

BIRMINGHAM, ALABAMA

2012

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FUNCTIONAL STATUS, LIFE-SPACE MOBILITY, AND PHYSICAL ACTIVITY IN
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PAMELA G. BOWEN

UAB SCHOOL OF NURSING PHD PROGRAM

ABSTRACT

The majority of work on health disparities has focused on public policy and identifying disparate conditions. Obesity is a significant public health problem that has reached epidemic proportions, considered the second leading cause of preventable death, encourages a sedentary lifestyle, and can lead to a higher prevalence of functional impairments. Moreover, obesity increases the risk that persons may develop one or more serious medical conditions, such as cardiovascular disease, hypertension, stroke, Type 2 diabetes, and osteoarthritis, especially among African Americans.

In the United States, African American women are more likely to be classified as overweight or obese. In fact, approximately 61% of African American women 65 years and older are classified as being obese in comparison to 32% of their European American counterparts of the same age group. Moreover, the decline in functional status and physical activity levels among this population further contributes to the escalating obesity crisis.

Despite published research that illustrates how physical inactivity contributes to obesity and functional decline, overweight and obese southern African American older women are still less likely to participate in regular physical activity. The purposes of this study were to examine: 1) the lived experience of overweight and obese southern African American older women and how these conditions impact functional status and life-space

mobility and 2) what factors prompt or prevent the participation of regular physical activity.

The qualitative research approach used for this study was phenomenology, which described the investigated phenomenon through the eyes of the participant. Semi-structured, audiotaped interviews were used to elicit descriptions from 10 participants. Interview data was transcribed verbatim and then coded and analyzed using Colaizzi's seven-step method.

Data analysis revealed the emergence of six meta-themes and the overarching theme among all the participants was good quality of life, which encompassed maintaining independence and mobility. Significant findings from this study were that overweight and obese southern African American older women have negative connotations for the terms "obesity" and "exercise", being independent and self-sufficient were important, and culturally appropriate neighborhood interventions that address quality of life issues were essential to encourage engagement in regular physical activity.

Keywords: obesity, physical activity, African American, older women

DEDICATION

Dedicated to all of the women who participated in this study.
You all invited me into your homes with open arms and you made me a part of your lives for a short time. With much gratitude, I will cherish the time we spent together.

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First, I would like to give reverence to God, who is the head and the ruler of my life. He has always provided my heart and mind with the following scriptures when things became difficult for me during my dissertation journey- Proverbs 3:5-6, “⁵*Trust in the LORD with all thine heart; and lean not unto thine own understanding.*”⁶ *In all thy ways acknowledge him, and he shall direct thy paths*”.

Next, I would like to express my heartfelt appreciation to all the members of my dissertation committee for their dedication and willingness to assist me whenever necessity dictated. To my committee chairperson, Dr. David Vance, “Thank you so much” for graciously assuming this role when modifications to my committee had to be made. I have gained invaluable knowledge from you that I am certain will enhance my future career as a researcher and an author. My extreme gratitude is extended to Dr. Yvonne Eaves who has served as my advisor and co-chairperson. Dr. Eaves has supported and guided me every step of this long journey and I am eternally grateful to you for sharing your time, resources, and expertise with me. I would also like to thank Dr. Andrea Cherrington who offered me encouragement and an enthusiastic willingness to share her research experiences and pearls of wisdom. I was very fortunate to meet you and benefit from your knowledge. Thank you so much Dr. Julie Locher for your eagerness and pledge to support me throughout this dissertation process. You have

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LIST OF ABBREVIATIONS

AA.....	African American
ADL	activities of daily living
BMI.....	body mass index
IADL.....	instrumental activities of daily living
EA	European American
U.S.	United States

CHAPTER 1

INTRODUCTION

This qualitative phenomenological study examines and describes the lived experience of being overweight or obese in southern African American (AA) older women. The purposes of this qualitative phenomenological study are to examine: (1) the lived experience of overweight or obese southern AA older women and how these conditions impact functional status and life-space mobility and (2) who or what prompts or prevents these women to engage or not to engage in regular physical activity. Knowledge of how being overweight or obese influences regular physical activity behaviors among overweight or obese southern AA older women is essential for the development of culturally appropriate interventions for use by healthcare professionals.

For the examination of regular physical activity, life space mobility, and functional status among overweight or obese southern AA older women, the most appropriate qualitative research paradigm to use for this study is phenomenology. Phenomenology is the process of describing and uncovering the meaning of an experience or a phenomenon as it is lived by the participant and the researcher describes his or her interpretation of the participant's lived experience (Kleiman, 2004; Van Manen, 1990). Phenomenological research examines the relationship of varied ranges of experiences related to one's own perceptions, feelings, aspirations, behaviors, and decision-making (Kruger, Ham, & Prohaska, 2009). Moreover, qualitative

phenomenology allows the researcher to obtain pure, comprehensive descriptions of a phenomenon (Sandelowski, 2000b).

Significance and Background of the Problem

Obesity

Obesity is a multifaceted, chronic condition that encompasses environmental, behavioral, psychosocial, inherited, and metabolic factors (American Obesity Association, 2005). Not only is obesity a growing health problem, it is a very complex issue to resolve. The prevalence of being overweight or obese is growing to epidemic proportions all over the world. Although obesity is a preventable condition, in the United States (U.S.) between the years of 2009-2010, approximately 35.7% of all U.S. adults were classified as being obese (Ogden, Carroll, Kit, & Flegal, 2012).

In 2005, the World Health Organization estimated that approximately 400 million adults worldwide would be classified as obese, and by 2015 the number of obese adults is estimated to surpass 700 million (World Health Organization, 2006). In addition, the World Health Organization stated that the incidence of obesity has increased by three-fold in European countries since 1980 and this has lead to a 2-8% increase in health care costs.

The obesity epidemic is so pervasive that it is even filtering to developing countries that are trying desperately to combat hunger. The International Obesity taskforce estimated that approximately 780 million people out of a total 815 million hunger stricken people in the world reside in developing countries. Countries, such as Brazil and Colombia, have approximately a 40% incidence rate of obesity, which is

equivalent to many European countries. Unfortunately, developing countries, such as sub-Saharan Africa that have a larger number of starving people, are now becoming inundated with the same obesity health crises as other nations (International Obesity Taskforce, 2002) including the U.S.

Over the past 30 years, the incidence of obesity in the U.S. has grown tremendously without regard to socio-economical status, gender, race, age or region (American Obesity Association, 2005; Paschal, Lewis, Martin, Dennis-Shipp, & Simpson, 2004; Wang, Colditz, & Kuntz, 2007). Furthermore, obesity in the U.S is annually responsible for an estimated 300,000 deaths, is considered the second leading cause of preventable deaths (American Obesity Association, 2005), and negatively influences people's health as well as add to the national health care cost in general, which is estimated to be \$100 billion (American Obesity Association, 2005; He, Sengupta, Velkoff, & DeBarros, 2005; Wang et al., 2007).

The increased prevalence of obesity among U.S. older adults is the result of an increase in the older adult population in general and an increase percentage of this population being classified as obese (Villareal, Apovian, Kushner, & Klein, 2005). In 1990, there were 9.9 million Americans who were age 60 and older and classified as obese, which represented 23.6% of the older adult population (Arterburn, Crane, & Sullivan, 2004). These same authors stated that in 2000, there was an increase to 32% or 14.6 million older adults classified as obese; unfortunately, their worse case estimate is that by 2010, the prevalence of obesity in this age group will rise even more to 39.6% and almost half of this group is expected to be older women. Furthermore, the National Center for Health Statistics stated that between the years of 2001-2004, 71.5% of women

age 65-74 and 64% of women age 75 and older were considered overweight (U.S. Department of Health and Human Services, 2007a). Not only is the prevalence of obesity increasing among older women, the number of states impacted by obesity is also increasing at alarming rates.

In 2003, obesity prevalence rates of 15 states were between 15-19%, in 31 states the rates were between 20-24%, and in 4 states, greater than 25% prevalence. Alabama was one of the four states with a prevalence rate greater than 25% (Alabama Department of Public Health, 2005). Moreover, Colorado was the only state with an obesity prevalence rate less than 20%, 32 states had rates approximately 25%, and six states had rates greater than 30%. According to the Centers for Disease Control and Prevention (2012), the *Healthy People 2010* goal to lower the obesity prevalence to 15% or less for all 50 states was not met. In fact, the 30% obesity prevalence for a number of states has increased from nine states in 2009 to 12 states in 2010. Regrettably, Alabama obesity prevalence rate was 31.4%, which qualifies this state as being one of the states with the highest prevalence for obesity (Centers for Disease Control and Prevention, 2012) and this prevalence trend is manifested when investigating each of Alabama's 67 counties.

Variation in obesity prevalence rates among Alabama's 67 counties is startling. According to the Alabama Obesity Taskforce, 16 counties have a 36.0-43.7% obesity prevalence rate; 17 counties have a 32.9-35.9% rate; the prevalence rates of 18 counties are between 30.9-32.8%, and the obesity prevalence of the final 16 counties are between 24.6-30.8% (Alabama Department of Public Health, 2007). Additionally, in 2004, Alabama participated in the CDC Behavioral Risk Factor Surveillance System in order to collect obesity data on the state. Surprisingly, the prevalence of obesity in Alabama's

largest and most populated county, Jefferson, was higher than both the state's and the national averages. In fact, Jefferson County's obesity prevalence rate was 34.1%, which is higher in comparison to Alabama's average of 32.2% and the national average of 26.7%. As the population continues to increase in age, so will the obesity prevalence trends (Newman, 2009; Villareal et al., 2005) increase in Alabama.

Aging

According to the Administration on Aging, there were 39.6 million people age 65 and older in 2009; however, this number will dramatically increase to 55 million by the year 2020, which is a 20 million increase in this population since 2000 (Administration on Aging, 2011). It is projected that in 2020, there will be 6.6 million adults 85 and older, which is a net increase of 2.4 million people since 2000. Moreover, this age group is expected to triple in number by the year 2050 (Administration on Aging, 2011). In 2009, 19.9% of older persons in the U.S. were minorities and AA accounted for 8.3% of this number (Administration on Aging, 2010b). By the year 2030, the number of people 65 and older will have increased from 35 million (in 2000) to 70 million, which is approximately 20 percent of the total American population. Similarly, in the year 2050, approximately 86.7 million people will be 65 years of age and older and 11% of these will be AAs (Administration on Aging, 2010a; He et al., 2005).

Because of the "Baby Boom" generation, there will be a proliferation of people 65 and older during the years 2010- 2030 (Administration on Aging, 2010a). The Administration on Aging projected that this population would increase to 8 million (20.1%) by 2010 and 12.9 million would account for 23.6% of the older adult population

in 2020. Not only is the population aging, women are living longer in comparison to men and among AAs in the 65+ age group, every 3 in 5 people are women (Administration on Aging, 2010b). Moreover, in 2009, there were 22.7 million older women in the U.S. compared to only 16.8 million older men; this ratio continues to increase with age (Administration on Aging, 2011). Although average life expectancy increases for people who reach age 65, 19.9 years are added to women versus only 17.2 years to males (Administration on Aging, 2011). According to the U.S. Census Bureau, 13.8% of Alabama's population were age 65 and older in comparison to 13.0% for the U.S. (U.S. Census Bureau, 2012). Moreover, the Administration on Aging projected that people 65 years and older will increase to 15.9% (approximately 739,580) by 2015 and to 21.3% (approximately 1,039,160) by 2030. When comparing national AA population numbers to Alabama's numbers, people 65 years old and older are growing. In 2008, older AAs accounted for 8.3% (3.2 million) of the U.S. population and that proportion is expected to increase to 11% (9.9 million) by 2050 (Administration on Aging, 2010a). Similarly, in 2006, there were 104,170 older AA Alabamians and 108,032 in 2008, which accounts for a 3% increase during this two year period (Alabama Center for Health Statistics, 2009). In fact, there are approximately 127,818 older AAs (19.4%) in Alabama compared to 529,974 European Americans (EA) (80.6%) (Alabama Department of Public Health, 2011).

The largest county in the state of Alabama is Jefferson County, which has a total population of 658,466 people. Of this number, 53.0% are EA and 42.0% are AA (U.S. Census Bureau, 2012). According to the U.S. Census Bureau (2012) survey of Jefferson County, there are approximately 34,227 men (5.2%) over age 65 in comparison to 52,216

(7.9%) of women in the same age category. Because of advancing age and women are living longer than men, the likelihood of older women suffering from one or more chronic illnesses, such as obesity or obesity related illness is great (Newman, 2009).

Obesity in African American Women

Obesity is a global health care issue that affects all ages of the lifespan. Roughly 69.0% of the total population is overweight or obese compared to 34.8% who are obese (National Centers for Health Statistics, 2007). Since the 1960s, the rate of obesity in the U.S. has grown tremendously from 0.8% to 4.9% (Bellar, Jarosz, & Bellar, 2008). AAs in the U.S. are more likely to be classified as obese and/or overweight and these conditions are the second leading reason of avoidable deaths (American Obesity Association, 2005). AA women are disproportionately affected by obesity (Tilghman, 2003); thus, with the projected growth of minority older adults, this trend is likely to continue (Zamboni et al., 2005).

Approximately 61% of AA women 65 years and older are classified as being obese, compared to 32% of older EA women of the same age group (National Centers for Health Statistics, 2007; Ogden, Carroll, McDowell, & Flegal, 2007). The incidence of obesity continues to rise in this population despite all of the information available to the lay public and despite media attention to the problem (Houston, Stevens, Cai, & Morey, 2005). Moreover, the decline in functional status and physical activity levels of older adults further contributes to the escalating obesity crisis (Jensen & Hsiao, 2010).

The Behavioral Risk Factor Surveillance System Alabama survey results revealed that AA women were at the greatest risk of being obese (40.7%) compared to their EA

counterparts who have a low risk (23.5%) of being obese. Because there are approximately 63,840 AA women 65 years and older in Alabama, there is a high probability that almost half of this number could be classified as obese (Alabama Center for Health Statistics, 2007). With the growing disparity of obesity among AA women, it is imperative to examine motivation of this population to adopt healthier lifestyle practices in order to reduce or eliminate the impact that obesity will continue to have on this group as they age.

Consequences of Obesity

Due to the high association between prevalence of obesity and risk factors for morbidity and mortality, reducing the incidence of obesity has become a critical health issue (Mokdad et al., 2003). Obesity has the potential to cause emotional, social, and physical health consequences (Newton, Cromwell, & Rogers, 2009). Furthermore, obesity increases the risk that persons may develop one or more serious medical conditions, such as certain types of cancers, cardiovascular disease, hypertension, deep vein thrombosis, stroke, Type 2 diabetes, osteoarthritis, liver and gallbladder diseases, or even sleep apnea (American Obesity Association, 2005; Centers for Disease Control and Prevention, 2009). According to Administration on Aging (2010), the majority of older AAs have at least one chronic illness, but usually this group suffers from multiple chronic illnesses. Because of the growing number of older adults, obesity in this population is progressively becoming recognized as a major health crisis and a strain on national health care expenditures (Newton et al., 2009).

Significant weight gain leads to a higher prevalence of functional impairments (Houston et al., 2005). Functional status refers to the ability needed to perform all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) without assistance from others (Koster et al., 2006; Moody-Ayers, Mehta, Lindquist, Sands, & Covinsky, 2005). Obesity can exacerbate the normal decline in physical mobility that can accompanies aging resulting in decreased quality of life, serious medical conditions, such as diabetes, osteoarthritis and heart disease, and increased nursing home admission rates (Kane, Ouslander, Abrass, & Resnick, 2009; Villareal et al., 2005). Obesity also promotes a sedentary lifestyle and reduces mobility, which paves the way to functional decline (Jensen, 2005).

In 2000, approximately 40 million people 65 and older were enrolled in the Medicare and Medicaid programs, which cost the federal government an astonishing \$222 billion per year (He et al., 2005). In addition to the usual health care costs that occur with aging, the total healthcare cost of caring for people who are overweight and obese is \$117 billion dollars a year. Moreover, Medicare and Medicaid pay \$1,723 and \$1,021 respectively more per obese patient compared to their normal weight counterpart (Centers for Disease Control and Prevention, 2009; U.S. Department of Health and Human Services, 2007b). Furthermore, during the years 1987-2001, obesity related illnesses resulted in a 27% increase in health care costs (Centers for Disease Control and Prevention, 2009) meaning that, the cost of caring for older adults who are obese adds an additional strain or burden to the health care system.

Several preventable factors contribute to obesity in AA women, such as insufficient physical activity, poor dietary habits, and a sedentary lifestyle (Arterburn et

al., 2004; Sherman, Gilliland, Speckman, & Freund, 2007). Although increasing physical activity is one of the *Healthy People 2020* leading health indicators, physical inactivity has become more problematic among all age, racial, and ethnic groups of the U.S. (Belza et al., 2004; Drewnowski & Evans, 2001; U.S. Department of Health and Human Services, 2010). This is especially true in the South when compared to other regions of the United States (Sanderson et al., 2003; U.S. Department of Health and Human Services, 1996). Furthermore, AA women are more likely to lead a sedentary lifestyle in comparison to their EA counterparts (Brownson et al., 2000). Over time, physical inactivity in older adults can lead to musculoskeletal problems that cause pain as well as mobility and functional impairments. Thus, ordinary physical behaviors that people generally take for granted, including common everyday activities, such as walking, climbing stairs, or just standing from a sitting position, may become difficult for the physically inactive older adult. Obesity related musculoskeletal conditions, such as osteoarthritis that commonly occur in older adults, could also threaten one's ability to function effectively and to move all of their extremities.

Obesity or being overweight negatively affects functional status or a person's ability to provide their own personal care, which include such activities as bathing, using the toilet, and getting in and out of a chair or bed (U.S. Department of Health and Human Services, 2007a). Many older adults value their independence, which they demonstrate by their ability to perform ADL; however, threats to independence occur among older adults who are obese or who suffer from obesity related illnesses. In addition, obesity affects weight-bearing joints of the body, particularly, the knees and hips, and such impairments usually lead to a decline in functional abilities (Tak, Staats, Van Hespen, &

Hopman-Rock, 2005) and consequently, increased dependence on others (Bryant, Grigsby, Swenson, Scarbro, & Baxter, 2007).

There is a voluminous body of research on obesity in persons ages 3 to 50, but research on obesity and its impact on the health of southern AA older women are limited. Moreover, research that examines the interplay of obesity, physical activity and inactivity, functional status, and life-space mobility in southern AA older women is limited. The projected increases in the minority older adult population over the next few decades and the growing epidemic of obesity among southern AA older women, in particular, is a call to action for health scholars to engage in research to examine this rising obesity disparity phenomenon. Specifically, exploratory research is needed to provide a beginning foundation to discover effective and efficient strategies to combat the growing obesity epidemic (Kumanyika et al., 2005; Yancey et al., 2006) especially among southern AA older women who are obese or overweight and to learn why they choose or do not choose to engage in physical activity, which affects their functional status and life-space mobility.

For the most part, obesity is directly related to the lack of regular physical activity (Jakicic & Otto, 2006; Newman, 2009; Wang & Beydoun, 2007), which is one of the reasons *Healthy People 2020* identified increasing physical activity as a priority (U.S. Department of Health and Human Services, 2010). A 2001 national health survey found that 56.6% of women 65 and older do not engage in regular physical activity (Kruger, Carlson, & Buchner, 2007) and of this percentage, 63.5% were AA in comparison to 45.4% of their EA counterpart.

There is substantial evidence that interventions to promote physical activity in AA older women have been unsuccessful (Belza et al., 2004; Johnson & Nies, 2005; King, Mainous, Carnemolla, & Everett, 2009); this is largely due to this population's lack of motivation to engage in regular physical activity, even when they are knowledgeable about its benefits (Belza et al., 2004; Johnson & Nies, 2005; Sanderson et al., 2003). Several researchers have identified facilitators to engage and barriers that prevent engagement in physical activity among older adults (Gallagher et al., 2010; Korkiakangas, Taanila, & Keinänen-Kiukaanniemi, 2011); however, why southern AA older women who are overweight or obese do not participate in regular physical activity remains unknown. Perhaps the scientific community does not understand what motivation means to this group, how they use motivators, or if they use something else for which we do not have a term that will give them the impetus to engage in regular physical activity. Therefore, research to investigate southern AA older women's perceptions about obesity, coupled with subjective and objective data on functional status, physical activity levels, and life-space mobility are crucial to understand how to prevent functional decline among this population.

Statement of Problem

Although obesity is a significant public health problem that has nationally reached epidemic proportions, there is paucity in the literature, which has studied the vulnerable group of southern AA older women who are obese or overweight. The current research illustrates that the population is aging and there is a growing incidence of obesity among all people, especially AA women. Regardless of all the media and educational attention,

the problem of obesity has continued to rise nationally, which negatively affects the quality of life of the older adult population. In fact, older AA women disproportionately suffer from obesity, a lack of regular physical activity, and a decline in functional status when compared to their male and EA counterparts. Furthermore, there is little information to explain why this phenomenon is occurring among southern AA older women.

Statement of Purpose

Even though many studies that have explored obesity among people ages 3 to 50, very few focuses primarily on older obese AA women. The purposes of this study are to describe and explore the lived experiences of being overweight or obese and its impact on functional status and mobility in southern AA older women and who or what prevents these women to engage or not to engage in regular physical activity. This effort will provide an improved understanding of the obesity phenomenon among this population. Moreover, with the rising obesity epidemic and the increasing awareness of obesity related illnesses, knowledge alone is not enough to motivate behavior change (Folta et al., 2008). For this reason, along with quality of life issues that arise with advancing age, it is crucial to know what motivates southern AA women who are obese or overweight to adopt regular physical activity (Folta et al., 2008; Moons, 2004; Moons, Budts, & De Geest, 2006; Sandelowski, 2000a). Therefore, in order to reduce this growing disparity among southern AA older women, it is necessary to understand this population's perceptions of their weight status and factors that would influence them to participate in regular physical activity.

Study Aims and Research Questions

The specific aims of this project are to:

1. Describe the lived experiences of overweight and obese southern AA older women.
2. Investigate the perceived impact of being overweight or obese on functional status and life-space mobility.
3. Identify what influences overweight and obese southern AA older women to engage or not to engage in regular physical activity.
4. Determine the emic or participant perspective on what overweight or obese southern AA older women label as the “phenomenon” that “motivates” or prompts them to engage in regular physical activity and their emic views on the benefits obtained.

Specific Research Questions:

1. What is the lived experience of being overweight or obese for southern AA older women?
2. What are southern AA older women’s perceptions of overweight, obesity, and physical activity?
3. How has being overweight or obese impacted functional status and life-space mobility in southern AA older women?
4. What factors, events, situations, or persons influence overweight or obese southern AA older women to engage or not to engage in regular physical activity?
5. What “emic” term(s) do overweight or obese southern AA older women use to describe the concept “motivation” concerning intent to participate in regular physical activity?

Definition of Terms

The definitions used in the study are as follows:

Older women. Older females who are age 65 years and older (Administration on Aging, 2010a).

Overweight. Overweight status is defined as a body mass index (BMI) of 24.5-29.9 kg/m² (National Heart Lung and Blood Institute, 2011)

Obesity. Obesity is defined as a BMI of 30 kg/m² or greater; BMI is a weight-to-height ratio and is considered the gold standard measurement (National Heart Lung and Blood Institute, 2011).

Motivation. Motivation is the extremely valued force, diligence, and desire to move behavior towards a specific goal (Ryan & Deci, 2000).

Functional status. Functional status is based on a dependency continuum, in which the person's ability to complete a task is reliant on the amount of human assistance required to perform that task (Kane et al., 2009).

Life-space mobility. Life-space mobility is a measure of the frequency and independence of community-dwelling older adults' ability to move or travel in five concentric distances ranging from their home sleeping area to regions outside the U.S. (Baker, Bodner, & Allman, 2003; Peel et al., 2005).

Physical Activity. Physical Activity is any movement made by the skeletal muscles of the body that can result in energy expenditure, which can be classified as either occupational, household, or other activities (Caspersen, Powell, & Christenson, 1985).

Summary

In summary, obesity is a universal health care issue. Even though obesity is a preventable health condition, the incidence of obesity and obesity related illnesses will continue to increase to epidemic proportions among minority populations and this condition will further manifest itself in older adults. This phenomenological study proposes to answer the questions related to how obesity affects the functional status and life-space mobility of southern AA older women and to understand why this population choose or do not choose to participate in regular physical activity. Information from this study would facilitate in the development of culturally appropriate and sensitive strategies to reduce this growing health crisis among this population, which would aid in eliminating or decreasing this major health disparity.

Chapter 1 provides a synopsis of four components. Primarily, this chapter opens with providing the background and the significance of this study, which provides the rationale and the focus of this study. The problem statement and the purpose statement offers pertinent details that are specific to the obesity phenomenon and its impact on southern AA women's life space mobility and functional status as well as the how and the rationale for conducting this project. Thirdly, there is a description of the study's specific aims and research questions, which have directly resulted from the purpose of this study. Finally, chapter 1 provides definitions in order to avert potential misunderstandings of key terms and concepts in used in this study.

Chapter 2 discusses two main elements of the study. The chapter begins with an analytical and critical synthesis of the literature related to the key concepts of motivation,

physical activity, physical activity in older adults, physical activity in older AA women, functional status, and life-space mobility. Next is a discussion of the philosophical framework and underpinnings of this dissertation as it relates to the literature.

Chapter 3 contains this project's research methodology and design. First, this chapter provides a description and rationale for the use of qualitative phenomenology as the chosen research tradition for this study. Subsequently there is a discussion of the study's research design, procedures, sample, recruitment, and setting. Following this is data generation and collection, coding and data analysis. In addition, ethical considerations of the study and issues related to evaluating trustworthiness concludes this chapter.

Chapter 4 includes the interpretation and synthesis of the results and findings of this project. Chapter 5 discusses the six meta-themes that evolved from the data analysis as well as conclusions and implications from this study. Recommendations for practice and future research are also provided.

CHAPTER 2

REVIEW OF THE LITERATURE

In the U.S., southern AA older women are more likely to be classified as obese or overweight and these disease classifications are considered the second leading basis of avoidable death. Moreover, the incidence of obesity continues to rise despite all of the information available to the lay public and despite media attention to the problem. Not only is the general population becoming more obese and older (Houston et al., 2005), but the functional status and physical activity levels of older adults are declining, which further contributes to the obesity crises (Jensen & Hsiao, 2010). Therefore, the purposes of this qualitative phenomenological study are to examine: (1) the lived experience of being overweight or obese among southern AA older women and how these conditions impact functional status and life-space mobility and (2) who or what prompts or prevents these women to engage or not to engage in regular physical activity. Specifically, the intention of this chapter is to review the current literature related to this study. This chapter has four major components: the literature review, the philosophical framework and underpinnings, gaps in the literature, and the summary. The literature review will encompass information on motivation, physical activity in older AA women, functional status, and life space mobility.

Motivation

Motivation comes from the root word *motive*, which is Latin for motion. This term represents concepts, such as desire, excitement and drive, which all suggest movement to act or to initiate some activity (Furchtgott, 1999). Motivation usually refers to a human characteristic that encompasses initiation, persistence, purpose, and the behaviors toward achieving a valuable goal (Loeb, 2004; Ryan & Deci, 2000). Moreover, motivation, more than just a stagnant component of one's personality, consists of modifiable factors that influence a person to adopt or decline health-promoting behaviors (Phillips, Schneider, & Mercer, 2004). According to Phillips et al. (2004), motivation is the perception that people have to be successful at achieving an important goal regardless of the perceived cost or the desire to remain the same. Obviously, if any one of these elements of motivation is changed or distorted in any way, motivation will be altered (Geelen & Soons, 1996).

Not only does motivation to adopt and maintain healthy lifestyle behaviors among some older adults appear to be absent (Furchtgott, 1999), this population is usually neglected from studies because researchers inaccurately assume that the older population do not want to make health behavior changes (Newsom, Kaplan, Huguet, & McFarland, 2004). For example, Newsom et al. (2004) surveyed approximately 17,354 Canadians 60 years of age and older in order to examine their self-reported changes in health behaviors, their motivation to make healthy changes, and their perceived barriers to make health changes. The researchers found that approximately 63.2% of the participants did not attempt to improve their lifestyle behaviors, such as eating healthy, maintaining a healthy weight, during the previous year; 66.7% did not believe that there was room for health

improvements; and approximately 50% of the participants stated that they did not have any will power to make health behavior changes. Although the sample of the study consisted of female and male older Canadian adults, there were no indications of race or ethnicity. Therefore, the results may not be generalizable in the U.S., especially in Alabama. This study suggests that research which targets motivation in the southern AA older adult population, especially AA women, would be beneficial to add to medical health knowledge.

Loeb (2004) examined motivation to adopt health-promoting behaviors, its influence on self-rated health, along with psychosocial aspects of health in men ages 55 and older. Loeb used a correlational descriptive design to survey 135 community-dwelling men to investigate health motivation using the Health Self-Determination Index and found that this sample exhibited more intrinsic motivation in regards to their health. The results revealed that encouraging self-motivation among older men would produce increased health awareness and overall good health. The outcome of this study most likely would be different if women had been included because Ratner, Bottorff, Johnson, and Hayduk (1994) suggest that women and men think and reflect differently about their health.

In contrast, Satia, Walsh, and Pruthi (2009) examined factors that influenced the promotion of health behavior changes between AA and EA men between the ages of 45-70 diagnosed with prostate cancer for approximately one year. They found these men were more likely to be motivated to adopt healthy lifestyle changes with external motivators, such as family support (Satia, Walsh, & Pruthi, 2009). Because this study targeted men with a history of prostate cancer, this may have yielded different results if

older women diagnosed with obesity were included to examine whether intrinsic or extrinsic motivation was present.

Young et al. (2001) examined motivation among 34 AA women ages 50 and older by exploring successful and unsuccessful maintenance of weight loss and participation in regular physical activity. They found that intrinsic and extrinsic factors, such as health concerns, maintaining weight, and the support of others, motivated women who exercised. Conversely, non-exercisers indicated that intrinsic and extrinsic factors would motivate them to initiate and maintain healthier lifestyle behaviors e.g., exercise and weight loss; however, the researchers noted that the women's perceptions and attitudes towards their ability to achieve and maintain success were not completely positive. The sample was more likely to state that they felt tired, lacked motivation, or felt deprived of "bad food," such as fried foods and sweets (Young, Gittelsohn, Charleston, Felix-Aaron, & Appel, 2001). In contrast, another study examined motivation of older adults to start and maintain regular exercise (Phillips et al., 2004). Phillips et al. found that older adults have many barriers, such as fear of falling, illnesses, and limited funds or exercise partners, that decrease motivation to establish a regular exercise routine. Moreover, it is imperative for healthcare providers to encourage older adults to engage in regular exercise in order to improve quality of life.

Although motivation is a construct that is deeply rooted within the field of psychology, it empirically explains differences in peoples' behaviors (Ferguson, 2000). However, the role of motivation to adopt healthier lifestyles in older adults is understudied (Loeb, 2004; Miller & Iris, 2002; Satia & Galanko, 2007; Young et al., 2001), especially among AA. Not only is it essential to understand the role of motivation among

older AA women, but the type of motivation is also important. Furchtgott (1999) argues that some older adults do not desire to achieve or maintain health promotion behaviors because of lifelong habits that are difficult to change. There is growing evidence that older adults can successfully adopt healthier lifestyle behaviors, such as participating in regular physical activity with the right motivation (Dacey, Baltzell, & Zaichkowsky, 2008; Newsom et al., 2004); therefore, it is important to discern what motivates this population to engage in regular physical activity.

Physical Activity

Physical activity is one of the *Healthy People 2010* leading health indicators (U.S. Department of Health and Human Services, 2000) and it is defined as any movement made by the skeletal muscles of the body that can result in energy expenditure, which can be classified as either occupational, household, or leisure-time physical activities, such as sports (Caspersen et al., 1985; Office of Disease Prevention and Health Promotion, 2011). According to the U.S. Department of Health and Human Services, participating in regular physical activity, at any amount appropriate to one's level of fitness, increases a person's health benefit outcomes (Office of Disease Prevention and Health Promotion, 2011). Moreover, physical activity is a lifestyle choice that can have an important and profound effect on one's overall health. Although numerous studies have documented the positive health benefits that accompany the participation in regular physical activity across the lifespan (Blair, LaMonte, & Nichaman, 2004; Bopp et al., 2007; Mathews et al., 2010; Young & Cochrane, 2004), older adults, especially older AA women, are more

likely to remain inactive (Kruger et al., 2007; Tortolero, Mâsse, Fulton, Torres, & Kohl, 1999).

Physical Activity in Older Adults

One of the most important steps that a person 65 years and older could do to improve and maintain his or her overall health is to participate in regular physical activity (Mathews et al., 2010; U.S. Department of Health and Human Services, 2008).

Participating in regular physical activity increases the probability of meeting the *Healthy People 2010* objective related to decreasing health disparities (Bopp et al., 2007).

Although numerous health benefits of physical activity for older adults are well documented, such as it reduces the risk of falls, dying from heart disease, and developing hypertension, diabetes, and colon cancer, regular physical activity is an underused health promotion activity (Phillips et al., 2004; U.S. Department of Health and Human Services, 2008). Furthermore, regular physical activity in the older adult can promote feelings of well-being, improve stamina, and maintain healthy bones and joints (Centers for Disease Control and Prevention, 1999). Conversely, physical inactivity continues to be an urgent public health concern (Haskell et al., 2007) despite the federal government's recommendation that older adults should participate in moderate physical activity for at least 30 minutes a day on most days of the week (Centers for Disease Control and Prevention, 1999; U.S. Department of Health and Human Services, 2008).

In 2001, Kruger, Carlson, and Buchner (2007) found that older adults did not reach any of the five *Healthy People 2010* physical activity objectives. Furthermore, only 8.2% of older adults participated in aerobic and muscle strengthening activities that

are federally recommended for this population. The number of U.S. older adults is growing and because AA older adults tend to be more sedentary, it is not only important to identify and address why this group does not engage in regular physical activity (Belza et al., 2004); but researchers also need to know how this population perceive and describe regular physical activity (Tudor-Locke et al., 2003). This knowledge is essential because older adults may not consider certain activities, such as walking the dog, yard work, housework, or bowling, as physical activity (Arcury et al., 2006; Tortolero et al., 1999). This information would be beneficial to older adults overall health if they would engage in these activities on most days of the week.

Dacey et al (2008) examined physical activity in older adults and factors that would persuade this population to engage in physical activity. There were 645 adults in the study and the participants were primarily white, married females, who self-rated their health as excellent. These researchers found that increased intrinsic and extrinsic motivational facilitators, such as enjoyment, health, and fitness positively correlated with increased physical activity. Although age and gender of this study are comparable to the dissertation's targeted population, only 5% were minorities (Dacey et al., 2008). Moreover, this study further demonstrates the importance of analyzing the role of motivational facilitators to adopt healthier lifestyle behaviors, such as physical activity among older AA women.

Dunn (2008) explored the perceptions of 14 postmenopausal AA women with a BMI greater than 25kg/m^2 in order to determine what deters or encourages participation in regular physical activity. Dunn found that participants who did not adhere to regular physical activity identified family commitments, time constraints, lack of partners, and

health problems barriers whereas the women that adhered to regular physical activity did so because it promotes good health, enjoyment, a time of meditation, and a positive self-body image. Although the findings of this study are consistent with other research (Bopp et al., 2007), the oldest participant of this study was 66 years old, which excludes needed data from AA women who are 70 years of age or older. Because physical activity typically decreases with age and AA women are more likely to be sedentary, it is imperative to describe and explore the role of physical activity among southern AA older women (Bopp et al., 2007; Dunn, 2008; U.S. Department of Health and Human Services, 2008).

Physical Activity in Older AA Women

Schoenborn and Heyman (2009) examined the health characteristics of 66,076 older adults in four age groups: 55-64 years, 65-74 years, 75-84 years, and 85 years between the years of 2004-2007. When Schoenborn and Heyman specifically explored the 65 and older participants, they found that only 42.9% of all women in the sample participated in regular physical activity compared to 51.4% of men in the same age category. Not only does physical activity vary by age and gender, AAs were less likely to participate in regular physical activity. Only 33.7% of AAs 65 years of age and older participate in regular physical activity compared to 48.4% of their EA counterpart (Schoenborn & Heyman, 2009). Although the findings in this report are consistent with other studies, research on southern AAs age 65 and older are limited in regards to physical activity participation (Dutton, Martin, Welsch, & Brantley, 2007; King et al., 2005; Wilbur et al., 2008).

In another study, Kruger, Carlson, and Buchner (2007) investigated the level of physical activity participation among 11,969 survey participants, age 50 and over, to learn whether they were meeting the *Healthy People 2010* physical activity recommendations. Approximately 44% of the sample was ≥ 65 years old, 46.5% were women, 24.1% had a BMI ≥ 30.0 kg/m², and 10.1% of the sample were AA compared to 79.7% EAs. The results of this study illustrated that 63.5% of older AA women were more likely to be sedentary when compared to 45.4% of their EA counterparts. In addition, only 6.8% of AA women participated in regular vigorous-intensity aerobic activity in contrast to 14.9% of EA (Kruger et al., 2007). Limitations to this study include the possibility of respondents overestimating their physical activity level, becoming confused over the physical activity terminology and meaning, and no use of a commercial instrument, such as a pedometer to measure physical activity. Despite the limitations, particular interests in this research include the use of national data to conduct this study and the comparison of physical activity recommendations based on the *Healthy People 2010* objectives among older Americans.

Kirchhoff, Elliott, Schlichting, and Chin (2008) examined 19 Midwestern AA women ages 27-77 from South side Chicago who were classified as physical activity maintainers n=10 or physical activity relapsers n=9. The researchers described the maintainers as people who participate in regular physical activity at least 30 minutes a day, five or more days a week and relapsers were people who revert to an inactive physical status. To qualify for the study, the participants' had to have at least one diabetes risk factor, such as a BMI ≥ 25 , first degree family member diagnosed with diabetes, a history of gestational diabetes, an impaired glucose intolerance test, and a

current or past history of physical activity maintenance. Both the maintainers and the relapsers identified comparable benefits from exercise, such as weight loss, improved appearance, and health problem prevention. On the other hand, both groups similarly described work responsibilities and inclement weather as barriers to regular exercise. Interestingly, 67% of the relapsers were employed and the maintainers were more likely to be single and have a lower BMI, which suggest a negative correlation between work/spouse time commitments and the amount of time to engage in regular physical activity. In other words, as time commitments increased, duration of regular physical activity engagement decreased. Despite the limitations of the study, which included wide age ranges, urban Midwestern location, self-selection of participants, and self-report of health and physical status, this study offers suggestions on how to motivate “high risk” AA women to engage in regular exercise (Kirchhoff, Elliott, Schlichting, & Chin, 2008). This study also supports the need for additional examination and descriptions of physical activity levels among older adults in other regions of the U.S., such as in the South.

Bopp, Wilcox, Laken, and McClorin (2009) examined physical activity participation among 571 AAs who were affiliated with African Methodist Episcopal congregations in South Carolina. Thirty-two percent of the participants were age 50-64, 14.6% were 65 years and older, and 35.7% and 39.3% were classified as overweight or obese, respectively. In addition, women represented 71% of the sample and Bopp et al. found that 18% of the participants were physically inactive and 24% were physically active based on the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System physical activity module; this resulted in 54% being classified as unsatisfactorily active. Not surprisingly, the findings of this investigation are similar to

other studies (Dunn, 2008), which further demonstrate that most AA women continue under active lifestyles. Consequently, social support, culturally sensitive materials, and peer role modeling were identified as facilitators for encouraging regular physical activity. Although the findings of this study contribute to the literature, additional research that examines the role and perception of regular physical activity among southern AA older women is essential for healthy aging and overall functional health status (Mathews et al., 2010).

Functional Status in Older Adults

With advancing age, the likelihood of developing functional impairments increases (Administration on Aging, 2010a). Functional status is measured by the person's ability to independently perform activities of daily living (Kane et al., 2009). According to the Administration on Aging (2010), in 2007, 25% of community-dwelling older adults 65 years and over reported having difficulty completing one or more ADL and approximately 15% stated that they have problems with IADL. Similarly, when examining activities, such as walking, sitting, bending, shopping, and socializing, women were more likely to have difficulty with performing these activities than men, with these findings being extremely evident among people 65 and older and AAs. Therefore, the groups who are more at risk for developing an impaired functional status include older women (15.0% for women compared to 11.0% for men), and AAs (18.7%), and Hispanics (18.0%) as compared to their EA (12.9%) counterparts (Dunlop et al., 2005). Furthermore, these discrepancies show that minorities are less likely to engage in routine

physical activities and they are more likely to have conditions that are more chronic and interfere with functional status.

Because functional status usually declines with aging and the presence of one or more chronic illnesses, McDonald, Zauszniewski, and Bekhet (2010) examined the correlation between functional status, chronic illnesses (number and types), and acceptance of the chronic illnesses among 62 older adults in northeast Ohio with only 26% classified as AA. The participants who were recruited live in a retirement community, their ages ranged 62 to 92 years old, and 82% were women. The researchers found that functional status decreased with increased numbers of chronic illnesses and participants had increased difficulty accepting chronic illnesses as a natural part of life that occurs with aging, which is associated with substandard functional status. Although AAs perceived their level of functioning higher than the EA participants, only 16 participants were AA and their mean age was 76 compared to their EA counterpart whose mean age was 84. This positive perception of their functioning level could be unique only to this group of AAs because they have similar factors to the EA in their community in relation to resources and support (McDonald, Zauszniewski, Harvey, & Bekhet, 2010) and therefore, these results cannot be generalized to all older adults, especially AAs residing in retirement communities. Another study confirms that older adults with positive perceptions and stronger beliefs about their general physical condition usually exhibit a better functional health status, with fewer limitations in performing daily tasks (McAuley et al., 2006). Although positive perceptions of abilities and history of chronic illnesses influences the functional status of older adults, obesity plays a major role.

Impact of Obesity on Functional Status

Obesity and lack of regular physical activity exert a detrimental effect on older adults' existing functional abilities. Both women and AAs experience more declines in functional status than other groups. Specifically, older women have a 15% risk of developing alterations in functional status compared to an 11% risk in older men. Furthermore, AAs who do not participate in regular physical activity have an 18.7% risk of developing functional status decline compared to a 12.9% risk in EAs (Dunlop et al., 2005).

Obesity profoundly affects and exacerbates functional status in the older adult population (Villareal et al., 2005) and this alteration in functional ability results in abandonment of societal activities (e.g. outdoor or sport activities), an increased dependency on others, and a decrease in the ability to burn calories. Jensen (2005) found that there are strong links that exist between obesity and functional status, particularly among older women. Moreover, older women in comparison to men are more likely to have a higher BMI, increase body fat, self-report functional impairments, live longer, and experience more functional limitations, which are considered potential reasons for the gender inconsistencies. Obesity usually leads to functional decline, destructive joint disease, a sedentary lifestyle, decreased mobility, and heart disease, which all contribute to functional decline of the older adult (Jensen, 2005). In other words, the greater the BMI, the more likely the person's health declines.

Not only does obesity exacerbates functional decline in older adults, it also affects the weight bearing joints of the body that impairs mobility. Obesity, particularly a high BMI, is associated with an increased prevalence for age-related osteoarthritis

predominately of the knee joints in older adults (Newman, 2009; Villareal et al., 2005), which is one of the leading causes of immobility (Kane et al., 2009). Osteoarthritis often leads to decreased or altered mobility, muscle atrophy, and poor balance (Sutbeyaz, Sezer, Koseoglu, Ibrahimoglu, & Tekin, 2007). Because osteoarthritis is the most common joint disorder and its occurrence is projected to rise to more than 20% in persons 65 years and older by the year 2030 (Centers for Disease Control and Prevention, 2003), efforts directed toward preventing and treating obesity in older adults may help to decrease the negative impact that this chronic condition has on mobility (Kane et al., 2009). In other words, older adults who have declines in mobility and functional status usually develop these impairments as a result of being overweight or obese for years (Lang, Llewellyn, Alexander, & Melzer, 2008; Villareal et al., 2005), but how severe the impact of obesity is on overall functional status and mobility can be determined by using a Life-Space Assessment scale.

Life Space Mobility

Mobility is profoundly altered or diminished in obese older adults in comparison to their normal weight counterparts (Imai et al., 2008; Kane et al., 2009). When assessing the mobility status of community-dwelling older adults, the use of the University of Alabama Study of Aging Life-Space Assessment scale is an essential tool because it measures the participant's past four weeks of movement, frequency of the movement, and any assistance required to perform the movement (Baker et al., 2003). Baker et al investigated the validity and the reliability of the Life-Space Assessment scale on participants who were age 65 and older by determining the scale's ability to assess

changes in life-space mobility at 2-weeks from the baseline assessment and then at 6-months from the initial interview. The sample consistent of 306 participants (54% were women and 43% were AA). These researchers were interested in measuring older adult's general overall health, changes in health status, personal mobility, and any coping mechanisms used to maintain mobility. They validated that the Life-Space Assessment scale does measure mobility and general health.

The Life-Space Assessment scale evaluates community-dwelling older adults' personal mobility within their homes and beyond. By measuring older adults travel distance, independence, and frequency of movement (Baker et al., 2003), this study will use this scale to measure mobility of southern AA older adults who are overweight or obese and determine whether these participants use assistance or not to perform daily activities (Baker et al., 2003).

Although Life-Space Assessment mobility among older adults have been associated with different variables, such as oral health-related quality of life (Makhija et al., 2011), trajectories after hospital discharge (Brown et al., 2009), unintentional weight loss (Ritchie et al., 2008), a similar study used the University of Alabama Study of Aging Life-Space Assessment to explain and describe the associations between Life-Space Assessment and daily function measures, physical performance, cognitive status, depressive symptoms and sociodemographic variables (Peel et al., 2005) among 998 participants aged 65 and older. The participants were recruited from five counties in central Alabama, with 50% (500) of the sample being AA and 50% (499) classified as women. These researchers found that the Life-Space Assessment scale is fundamental in

documenting the mobility status of community- dwelling older adults as well as barriers and changes to mobility and physical performance (Peel et al., 2005).

Philosophical Framework and Underpinnings

Phenomenology

The qualitative research approach that will be utilized for this study is phenomenology. According to Moran (2000), phenomenology is a “radical, anti-traditional style of philosophizing, which emphasizes the attempt to get to the truth of matters, to describe phenomena, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experience” (p.4). Each individual has a unique perspective and perception of a lived experience. Phenomenology attempts to describe the investigated phenomenon through the eyes of the participant.

The Paradigm

Phenomenology is grounded in the philosophy of Edmund Husserl and Martin Heidegger. Husserl defined phenomenology as the study of a person’s actual life experiences or it is an attempt to gain understanding of what humans experience and presume as they go through life on a daily basis (Lavery, 2003). Through phenomenology, a person can revisit or reexamine things in life that were once taken for granted such as physical activity and obesity and then look for new meaning. Husserl also believed that “bracketing” was an important part of phenomenology. Bracketing occurs when researchers suspend their own judgments about a phenomenon and set away

any existing hypotheses about an everyday experience in order to focus on how that phenomenon or the interpretation of the experience was formed by a participant (Schwandt, 2007). Husserl believed that in order for a researcher to be able to understand a phenomenon completely, that person must not have any personal biases and attempt to look at the phenomenon, as it actually is (Lavery).

In a similar manner, Heidegger defined phenomenology as the study of lived human experiences with a focus on clearly identifying details and factors that occurred in life but that are often overlooked (Lavery, 2003). In other words, things that may appear unimportant initially are examined in an effort to provide meaning and understanding. Heidegger also believed that through phenomenology, a person's awareness and perceptions of the world and what is reality are derived from the person's past personal experiences. Heidegger believes that regardless of what people encounter in the world, they must use their own historical background as a reference point in order to be able to interpret life and develop an understanding or meaning of the experience (Lavery, 2003).

Although both of these philosophers' positions on phenomenology have good aspects that could be used for this study, the philosophical underpinnings that appear to be most evident for examining the lived experiences of southern AA older women and their physical activity choices would be Husserl's phenomenology. With the Husserlian phenomenological approach, the participant must describe the lived experience of being obese through conscious awareness and the researcher must learn to bracket out or set aside any particular beliefs about obesity and healthy physical activity patterns in order to experience what the participant has experienced in an impartial manner (Lavery, 2003).

By using phenomenological research methods, there is an increased opportunity for using a combination of strategies to collect data as well as to allow the researcher to have more flexibility to change the steps of the analysis process if unexpected findings occur that would interfere with understanding the initial phenomenon of interest (Munhall, 2007). This research approach allows the participant to have a voice regarding the phenomenon of interest. In other words, the findings or outcomes of this type of research are not converted into scientific language; however, it is described from the participant's point of view in their own words (Van Manen, 1990).

The phenomenological approach allows the researcher the ability and flexibility to formulate major themes from the participant's descriptions or narratives regarding the phenomenon of interest (Sanders, 2003). In this study, the researcher examined major themes regarding the lived experiences of being obese. From this methodology, the information obtained regarding the lived experiences of being obese may assist the healthcare community with increased understanding of how to treat and care for southern AA older women who are overweight or obese in a culturally sensitive manner.

Philosophical Foundation

According to Munhall (2007), the philosophical underpinnings of phenomenology must be understood by the researcher in order for a phenomenological study to obtain meaningful data. Phenomenological philosophy is based on assumptions of worldviews and it involves explaining, describing, and analyzing data in an effort to understand the truth and meanings of lived experiences. The philosophical foundation for this study is to understand the lived experiences of southern AA older women who are overweight or

obese. Until healthcare providers are able to understand the meaning of living as a southern AA older woman with an elevated BMI, then effective strategies to intervene in this growing obesity epidemic will not come to fruition because “we all wish to be understood” (Munhall, 2007, p. 205).

Assumptions

According to Marshall and Rossman (2006), phenomenology is based on the assumption that the essence of a phenomenon that has been lived and shared by several people can be described. Phenomenologists believe that there is no single reality or unified philosophical standpoint for all people (Schwandt, 2007). Everyone is different and what is significant and meaningful for one person is not the same for another person with the same circumstances. The healthcare community many times erroneously assumes that their values regarding healthy lifestyles are, or should be, the same for all people - this is not always the case (Ory, Kinney, Hawkins, Sanner, & Mockenhaupt, 2003). For example, Ory et al. stated that even with increased awareness of the benefits of regular physical activity for all patients, some healthcare professionals do not promote physical activity among older adults. Therefore, the input from southern AA older women who are overweight or obese is needed in order to gain essential knowledge for the healthcare community, which will aid in providing individualize care and interventions for older adults.

Because the targeted population for this study is southern AA older women, some healthcare providers believe that it is not worth the time or effort to gain in-depth, rich data regarding what would motivate this population to adopt regular physical activity behaviors (G. Childs, personal communication July 14, 2008). The assumption is that

these people are “set in their ways and are likely to die soon so why bother”. As previously mentioned, people are living longer and therefore, it is the responsibility of the healthcare community to ensure that this population has the chance to achieve and maintain a good quality of life. By learning what would encourage or motivate southern AA older women who are overweight/obese to engage in regular physical activity, the incidence of obesity, which decreases quality of life, could be decreased or eliminated. Just because a person is an older adult, healthcare providers should not assume that the person does not want the opportunity to improve their overall health status (Hirvensalo, Heikkinen, Lintunen, & Rantanen, 2005; Ory et al., 2003).

Gaps in the Literature

Obesity and its impact on functional status, mobility, and physical activity in southern AA older women has been understudied (Auslander, Haire-Joshu, Houston, Rhee, & Williams, 2002; Conn, Tripp-Reimer, & Maas, 2003; Drayton-Brooks & White, 2004; King et al., 2009; Tilghman, 2003). There is limited information available about strategies that enhance or preserve functional ability in light of advancing age. Much of the scientific literature describes how the aging process leads to increased risk of developing at least one disability; however, there is limited information regarding preventive strategies against functional disability (Bryant et al., 2007; Tak et al., 2005), especially among sedentary AA older adults. Dunlop et al. (2005) confirmed that a lack of regular physical activity could be a risk factor for a decline in functional status and the knowledge gained would lead to the development of intervention programs aimed at maintaining and improving the functional status of older people affected with at least one

mobility limitation. Another shortcoming in the literature is related to motivation. Dunlop et al. (2005) found that a lack of regular physical activity, albeit a modifiable risks, was a risk factor for functional decline among older adults. The element that is missing is how to motivate a person with or without at least one problem with mobility to participate in regular physical activity.

Summary

Motivation is essential for a person to adopt healthy behaviors. Although it has been well documented in the literature that adopting healthy lifestyle behaviors, such as regular physical activity, can greatly improve quality of life of all age groups, healthy lifestyle adherence has been on the decline for the past 18 years (King et al., 2009). Furthermore, AAs, especially the older adult, are underrepresented in many of the studies that examined the association between obesity, functional status, physical activity, and mobility in the Southern region of the U.S.

Because the targeted population for this study is southern AA older women, some healthcare providers believe that it is not worth the time or effort to gain in-depth, rich data regarding the perceptions this population to adopt a healthy lifestyle that includes regular physical activity (Hirvensalo et al., 2005; Ory et al., 2003). The assumption is that this group is unwilling or unable to make changes. People are living longer and therefore, it is the responsibility of the healthcare community to ensure that this population has the chance to maintain a good quality of life. By learning what would motivate or encourage southern AA older women to engage in regular physical activity,

the incidence of obesity, which decreases quality of life, could be decreased or eliminated. Phenomenology is essential in obtaining this information.

The use of a phenomenological approach should provide an in-depth understanding about the perceptions that southern AA older women have regarding their weight status and what factors motivate them to adopt and maintain healthier lifestyles that include regular physical activity. This knowledge is needed in order to develop potential interventions aimed at motivating southern AA older women to achieve and maintain a healthy BMI, thereby decreasing the prevalence of overweight and obesity in this group and the accompanying health risk factors.

CHAPTER III

METHODS

This chapter will first discuss phenomenology and its underlying assumptions. Next, the distinguishing features of phenomenology as a philosophy and as a research method will be discussed. Finally, the research design will be articulated, describing step-by-step the sample and sampling technique, data collection and analysis, methods for maintaining credibility, and human subjects protection

Phenomenology

Phenomenology is a qualitative research method defined as the study of lived experience (Marshall & Rossman, 2006). Phenomenology allows the researcher to understand the uniqueness of other individuals and their perceptions of a particular phenomenon or experience. Such understanding of lived experiences would be difficult without understanding the meanings or values (e.g., the essence of experiences) individuals give to the phenomenon or experience under study (Munhall, 2012). This study sought to obtain in-depth knowledge about the meaning of the lived experience of physical activity among overweight or obese southern AA older women.

Philosophical Phenomenology

Phenomenology is a philosophy as well as a research method. The philosophy of phenomenology began in Germany during the early 1900s, and it is well-known

throughout modern philosophy (Dowling, 2007). The term phenomenon (or *phaenesthai*) is Greek for, “to flare up, to show itself, to appear” (Moustakes, 1994 as cited in Dowling, 2007, p.132).

Phenomenology is grounded in the philosophy of Edmund Husserl, considered to be the father of phenomenology (LeVasseur, 2003), and Martin Heidegger, a student of Husserl (Dombro, 2007). Husserl defined phenomenology as the study of a person’s actual life experiences or an attempt to gain understanding of what humans experience and undervalue as they go through life on a daily basis (Lavery, 2003). Furthermore, Husserl believed that obtaining knowledge about an individual’s own essence or real meaning could only be obtained and verified by that person, not others (Lauer, 1965). In other words, the actual individual is the most qualified person to provide understanding and meaning of one’s own lived experiences.

In Husserlian phenomenology, the researcher does not provide any interpretations of the participants’ descriptions of the phenomenon under investigation (Kleiman, 2004). Furthermore, the researcher listens to the lived experiences described, selects out essential meanings from the narratives, and then articulates these meanings and their interrelationships in a structured manner. Through phenomenology, participants can revisit or re-examine circumstances of life that were once accepted, such as physical inactivity and obesity, and then look for new meaning. Moreover, this type of descriptive phenomenology provided organization to the phenomenon under investigation (Kleiman, 2004).

Although Husserl inspired Martin Heidegger’s philosophical approach, he believed, not only should a phenomenon be explored and described, it should also be

understood and interpreted (Munhall, 2007). Similar to Husserl, Heidegger defined phenomenology as the study of lived human experiences with a focus on clearly identifying details and factors that occurred in life, but that are often taken for granted (Laverty, 2003). In other words, participants re-examine life experiences that initially appear unimportant in an effort to obtain meaning and understanding. Heidegger also believed that through phenomenology, a person's awareness, perceptions of the world, and the meaning of reality come from the individual's past personal experiences. Heidegger claimed that regardless of what people encountered in the world, they must use their own historical background as a reference point in order to be able to interpret life and have understanding (Koch, 1995; Laverty, 2003).

Phenomenology as a Research Tradition

Phenomenology is a popular research tradition among healthcare researchers. There are different types of phenomenological research that share some commonalities, nevertheless the lack of homogeneity among the sub-types remain (Dowling, 2007; Racher & Robinson, 2003). According to Patton (2002), the term "phenomenology" has become so popular and widely used that its definition has become diluted. In fact, "phenomenology may refer to a philosophy, an inquiry paradigm, an interpretive theory, a social science analytical perspective or orientation, a major qualitative tradition, or a research methods framework" (Patton, p. 104). However, what these different perspectives of phenomenology hold in common is a "focus on exploring how human beings make sense of experiences and how they transform experiences into consciousness, both individually and as shared meanings" (Patton, p. 104). Thus, with phenomenology as a research method, the researcher identifies and describes an

experience or a phenomenon as it is lived by the participant. Moreover, the researcher organizes and articulates the discovered meaning of the participant's lived experience and the associations among those meanings (Kleiman, 2004).

Descriptive Phenomenology

Descriptive phenomenology is a specific type of phenomenology and was followed as the research design for this study. Although Heidegger believed that phenomenology encompassed interpreting and understanding the human experience, not just describing it, descriptive phenomenology is the foundation of meaning, which requires a careful description of conscious, everyday experiences as people live them (Lauer, 1965; Miller, 2003). Descriptive phenomenology as a research approach includes four components: bracketing, intuiting, analyzing, and describing (Hamill & Sinclair, 2010). Bracketing is defined as the process in which researchers identify everyday assumptions or suspend judgment about a phenomenon by setting aside their own biases or opinions about the investigated phenomenon (Schwandt, 2007). Husserl believed "bracketing" to be an important, complex, methodological part of phenomenology (Gearing, 2004; Hamill & Sinclair, 2010) because bracketing allows the researcher the ability to work with data without any preconceived ideas about the phenomenon or the lived experience.

Husserl alleged that in order for the researcher to be able to understand an experience completely, there must not be any personal biases and that the researcher should attempt to look at the phenomenon or experience, as it actually is (Lavery, 2003). In other words, the researcher must not influence the informant's understanding of the

experience because it must be a description of the informant's reality (Hamill & Sinclair, 2010). Similarly, if pre-insightful appreciation (finding the hidden meaning) of a phenomenon is to emerge from qualitative narratives, any private perspectives or elements that would cause interference with obtaining pure information, should be set aside or bracketed (Racher & Robinson, 2003).

The second component of descriptive phenomenology is intuiting, which only transpires if the researcher is able to maintain objectivity regarding the meanings that participants have given to a phenomenon (Van Manen, 1990). Furthermore, intuiting is defined as the process in which researchers let the participants define the meaning of a phenomenon based on the participant's lived experience of that phenomenon. In other words, intuiting involves the researcher grasping the real meaning of an experience or phenomenon based on the informant's personal account. For this study, the researcher attempted to uncover the essence of the lived experience of southern AA older women who are overweight or obese and how these conditions impacted their functional status, mobility, and participation in regular physical activity.

The analysis stage is the next phase of descriptive phenomenology. The aim of the analysis is to obtain a thick, in-depth description of the phenomenon studied that accurately captures and conveys the meaning of the lived experience (Cohen, Kahn, & Steeves, 2000). Analyzing and making sense of large amounts of qualitative data involves sorting and organizing the data by comparing and contrasting the data, and then reducing, labeling, and developing categories of the data so that any connections within the data can be completely described (Bloomberg & Volpe, 2008; Schwandt, 2007). In other words, the analysis will help the researcher grasp the meaning of an enormous

amount of raw data and reduce it to manageable segments that can be described and disseminated in an understandable manner (Bloomberg & Volpe, 2008).

The last component of the phenomenological analysis is a description of the phenomenon. Phenomenological researchers are constantly seeking the meanings of a lived experience by participants because this allows researchers to become more experienced with the targeted population (Van Manen, 1990). By understanding the meaning of the phenomenon from the participants' perspectives, the researcher can provide an accurate representation of the lived experience (Bloomberg & Volpe, 2008).

Although both of these philosophers' positions on phenomenology have strong elements that could be beneficial to this study, Husserlian phenomenology was the most obvious choice for describing and examining the lived experiences of overweight or obese southern AA older women and how these conditions impacted their functional status, mobility, and participation in regular physical activity. With the Husserlian phenomenological approach, it was important for the participants to describe their lived experiences related to being overweight or obese as well as what constituted their meanings of this lived experience through conscious awareness. Furthermore, it was equally important to bracket out any particular beliefs about being overweight or obese and their impact on functional status, mobility, and regular physical activity participation in order to learn the lived experience from the participants without any biases (Hamill & Sinclair, 2010; Lavery, 2003).

Assumptions of Phenomenology

According to Marshall and Rossman (2006), phenomenology focuses on the assumption that the essence of a phenomenon that has been lived and shared by several people can be described. Phenomenologists believe everyone is different; therefore, what is significant and meaningful for one person may not be the same for another with the same circumstances. Mainly, phenomenologists believe that reality is individualized, diverse, subjective, and unique to the person experiencing it (Munhall, 2007). Thus, phenomenological inquiry is focused on what people experience and how they interpret the experience. Moreover, researchers can only do this through participant observation and/or in-depth interviewing (Patton, 2002) and reporting phenomenological research findings in “language and description that reawakens or shows us the lived quality and significance of the experience in a fuller and deeper manner” (Van Manen, 1990, p. 10).

Unique Features of the Phenomenological Approach

The phenomenological approach, as part of the naturalistic paradigm, has several unique features. As with most naturalistic designs, phenomenology enables the researcher to use a combination of strategies to collect data. In addition, the researcher had more flexibility to change the study’s objectives if unexpected findings occurred that interfered with understanding the phenomenon of interest (Munhall, 2007). This research method also allows the participant to have a voice regarding the phenomenon of interest. In other words, the findings or outcomes of this type of research are not converted into scientific language; therefore, the data are described from the participant’s point of view in their own words (Munhall, 2007).

The Husserl phenomenological approach allows the researcher the ability to formulate major themes from participants' descriptions or narratives regarding the phenomenon of interest (Sanders, 2003). In this study, the goal was to understand the lived experiences of overweight or obese southern AA older women and the impact that these diagnoses have on their functional status, mobility, and physical activity participation as viewed by the participants.

Study Design

Study Population

This study included ten community-dwelling, AA women age 65 years and older. Seven participants were currently classified as obese, two were classified as overweight, and one was classified as normal weight. Nine of these women (those classified as obese and overweight) were able to articulate their experiences of living with obesity and communicated their stories of how obesity affected or was affecting their functional status, mobility, and their ability to engage in regular physical activity. These nine participants were representative cases because their experiences and the meanings they attached to these experiences occurred with regularity throughout the data and across transcripts and encompassed the range of behaviors and responses (Morse & Field, 1995) identified during data analysis. Because negative cases are defined as “informants or behaviors that do not conform to the apparent patterns” (Morse, 1994, p. 229) that have been identified, the researcher’s “understanding of patterns and trends in the data is increased by considering the instances and cases that do not fit within the pattern” (Patton, 2002, p. 554).

Setting

Most qualitative researchers conduct their research in a naturalistic setting, such as the participant's home or place of business. The participant's own home was the setting for this study in an effort to decrease the need for traveling, decrease any anxiety because the participant would be in a familiar setting, and to facilitate participation in the study.

The participants' homes for this study are in Jefferson County, Alabama, which is one of Alabama's largest counties with a total population of 665,027 people. Of this number, 374,071 are EA and 290,956 are AA (Alabama Center for Health Statistics, 2009). There are 157,206 AA women in Jefferson County compared with 133,750 AA men. The overall obesity prevalence rate in Jefferson County is 31.9% (Centers for Disease Control and Prevention, 2012).

Procedures

Participant Recruitment

Participants were recruited from two predominately AA churches in Jefferson County, Alabama, each with a membership enrollment of 300-500 members. Because recruitment efforts were initially slow, an additional predominately AA church agreed to assist with recruitment efforts; however, no participants were recruited from this third church. The researcher met with the pastors of the first two churches to give them information about the study and to seek their assistance in recruiting eligible participants for the study. Both pastors served as gatekeepers and each appointed a person from the church to assist with recruitment and to provide information about the study to eligible participants.

In order to prevent the illusion of coercion or unethical recruitment practices, the researcher left colorful and informative study flyers at the churches with the gatekeepers. The flyers included the researcher's contact information so that potential participants could review the information at their leisure and contact the researcher if they decided to participate in the study. Eleven interested people contacted the researcher by telephone and were screened for eligibility using a screening instrument that included the study's eligibility criteria (Morse, 1994; Polit & Beck, 2008; Sandelowski, 1995). Once a potential participant had expressed an interest to participate in the study, the researcher obtained their self-reported height and weight as part of the screening. This allowed the researcher to calculate potential participants' BMI based on self-reported height and weight as the eligibility required a BMI value of $\geq 30 \text{ kg/m}^2$. Although eligibility was based on self-reported height and weight (i.e., the researcher calculated BMI during the telephone recruitment screening), once participants were entered into the study their actual height and weight were measured by the researcher at the first home visit after obtaining informed written consent and before beginning the first interview. This allowed the researcher to obtain an accurate and objective measure of each participant's BMI (see Appendix A for eligibility screening form).

Sample

Purposeful and snowball sampling strategies were used to identify and recruit overweight or obese AA older women. Purposeful sampling allowed for the selection of participants who had experienced or were experiencing the particular phenomenon (obesity) under study. This sampling technique allowed the researcher to elicit stories

from participants about their actual life experiences related to living with being overweight or obese (Miles & Huberman, 1994; Polit & Beck, 2008). Snowball sampling allowed current study participants to refer other women with the same experiences to participate in the study. Both of these strategies are fitting for phenomenological research and were used to obtain participants for this study (Kleiman, 2004; Morse & Niehaus, 2007).

Inclusion/ Exclusion Criteria

The researcher had the responsibility of identifying and defining the characteristics that a participant must possess in order to be included in the targeted population. All participants who met the following inclusion criteria were invited to join the study: (1) AA women; (2) 65 years and older; (3) community dwelling; (4) history of being or classified as obese with a BMI of $30\text{mg}/\text{k}^2$ or greater, or as overweight with a BMI of $24.5\text{-}29.9\text{ kg}/\text{m}^2$; and (5) English speaking. One negative case was recruited and entered in the study in an effort to increase credibility (Schwandt, 2007).

The exclusion criteria for this study included: (1) age younger than 65, (2) not AA, (3) male, (4) non-English speaking, (5) homebound, and (6) not classified as obese within the last 18 months.

The Negative Case

The normal weight participant was an anecdotal or negative case (Patton, 2002) because her data depicted a small range of events, behaviors, and responses that were atypical of the larger group (the representative cases), (Morse & Field, 1995). It is

important to realize that negative cases usually meet most of a study's inclusion criteria. In the current study, the one negative or anecdotal case differed from the other women in the study on only one inclusion criterion—she had a normal BMI. Moreover, the emphasis in a negative case is on the variation in data that is provided, not necessarily on the demographic characteristics of the negative case. In fact, “negative cases do not necessarily negate our questions or disprove them, rather they add variation and depth of understanding” (Strauss & Corbin, 1990, p. 109). Thus, further examination of the differences between the representative cases and the negative cases adds density and variation to the emerging patterns and themes (Strauss & Corbin, 1990). Indeed, according to Patton (2002) including and “dealing openly with the complexities and dilemmas posed by negative cases is intellectually honest while simultaneously enhancing credibility” (p. 555).

Sample Size

Sample size in qualitative research is mostly related to the purpose of the study, the research questions, the richness of the data obtained from the participants, the information needed, and the sampling strategy used (Polit & Beck, 2008). According to Sandelowski (1995), the type of qualitative method employed determines the appropriate sample size. Morse (1994) recommended at least six participants for phenomenological studies. However, with fewer participants, the data obtained must be from well-spoken, knowledgeable, and articulate people (Sandelowski, 1995); therefore, the minimum number of participants recruited for this study was 11. In fact, the first participant interviewed was not articulate and the data obtained from this interview was insufficient

and not used in the final analysis; therefore, the total sample size for this study was $n = 10$.

Data Collection

Interviews

The data collection method for this study was in-depth interviewing with the use of a pre-written, interview guide that consisted of open-ended questions to facilitate the interview process and field notes. Interviews provided the participants with the opportunity to provide their own perspectives of the phenomenon, in a conversation type format (Marshall & Rossman, 2006). Moreover, in-depth interviewing conveyed to the participants that their opinions, values, and views about the phenomenon of interest were useful and important. Data collection occurred over nine months. The researcher negotiated dates and times to interview each of the participants at their homes. Two interviews were conducted with each participant and the second interview was conducted approximately 2-3 weeks from the first interview. The purpose of the second interview was to gather additional information related to the investigated phenomena as well as to allow the participants a chance to add or clarify any information obtained or omitted from the first interview (Broussard, 2005). Every interview was tape-recorded, transcribed verbatim, and checked for accuracy by the researcher. Each transcript was assigned an identification number and participants' identifying information was removed from transcripts by the researcher. All tapes will be destroyed after the study is completed. All raw data are stored in a locked file cabinet and only the researcher has access to the information. In addition, electronic copies of data were stored on the researcher's office

computer, which was password protected and only the researcher had access. These steps were taken to ensure privacy and confidentiality of the participants' data.

Field Notes

Field notes were used to capture data not verbalized by the participants during the interview session. These field notes encompassed the following four topic areas: 1) context of the situation (meaning what happened during the interview); 2) a description of the physical environment; 3) theoretical insights (insights that occurred during or after the interview); and 4) personal reflections and emotions (Eaves, 1997). These notes were documented within 24-48 hours of the completed interview. (See Appendix B for qualitative instruments)

Quantitative Instruments

In this study, two quantitative instruments were used in combination with qualitative techniques in order to provide a fuller description (Sandelowski, 2000a) of functional status, mobility, and physical activity by the southern AA older women in the study. According to Sandelowski, the reason for using quantitative instruments and collecting quantitative data in qualitative research are for “complementarity” (Sandelowski, 2000a, p. 251). Hence, the quantitative data describes some aspect of the phenomenon or a related concept that is difficult to capture via qualitative description alone. Data or scores from these instruments were used to make comparisons to other participants in the study, but no generalizations from this study sample were made to other populations.

Life-Space Assessment

The University of Alabama at Birmingham Study of Aging Life-Space Assessment instrument was designed to measure life-space mobility in community-dwelling older adults (Peel et al., 2005). The scale consists of five “Life-Space” levels that are summed to provide an overall older adult life-space score. To obtain the overall score of 120, the tally for each level is achieved by multiplying the life-space level (1–5) by the amount of independence, defined as (2 = independent [i.e., no assistance from persons or equipment], 1.5 = uses equipment assistance only, 1 = uses personal assistance), and the value for movement frequency attainment (1 = < once a week, 2 = 1–3 times per week, 3 = 4–6 times per week, and 4 = every day) (Baker et al., 2003; Peel et al., 2005). Furthermore, the scores for this Life-Space scale ranged from 0-120 and the intraclass correlation coefficient (test-retest reliability) has been established at 0.96 (Baker et al., 2003; Peel et al., 2005).

Baker et al. (2003) studied the validity and reliability of the Life-Space mobility scale on 306 community-dwelling older adults. They also wanted to know if this scale would detect any changes in the older adult life-space mobility at 2-weeks and 6-month follow up. Their research validated that the Life-Space scale was able to measure mobility, demonstrate stability in 2-weeks, and detect sensitive changes in 6-months.

Katz-Basic ADL Scale/Lawton-Brody IADL

The Katz basic ADL scale and the Lawton-Brody IADL scale are two standardized instruments generally used, as a component of a detailed older adult assessment, to measure a patient’s functional status. Both of these instruments were used to measure whether the participant could function independently, function with

assistance, or function completely dependent on others (Besdine, 2009). The Katz basic ADL scale has been commonly used and is reported to consistently measure and demonstrate the ability to assess the functional ability of older adults in the community. The Katz basic ADL scale scoring system range from a score of six to zero; a score of six denotes high independence with ADLs and a score of zero denotes high dependence with ADLs (Shelkey & Wallace, 2007). Wallace and Shelkey (2008) documented the reliability and validity of the Katz ADL scale. They found that the reliability of the scale (internal consistency was $\alpha = 0.87-0.94$) and the validity of the scale (construct validity was 0.74 - 0.88) (Wallace & Shelkey, 2008).

The Lawton-Brody IADL scale is used to measure more complex skills than basic ADL skills (Graf, 2007) and women are assessed on all eight parts of the scale whereas men are only scored on five areas, which excluded housekeeping, laundering, and cooking. Moreover, the scores for women range from zero to eight; a score of zero indicates low functioning and high dependence whereas a score of eight indicates high functioning and high independence. Established reliability for this scale was 0.85 and the validity was tested and determined to be significant at the 0.01 or 0.05 level (Graf, 2007) (See Appendix C for Quantitative Instruments).

Phenomenological Data Analysis

In conducting phenomenological data analysis, there is a large amount of data obtained and it is overwhelming to analyze without a structured framework (Sanders, 2003). Therefore, Colaizzi's seven step method is the phenomenological analytic approach used to analyze data from this study (Sanders, 2003). Colaizzi's method to

analyzing qualitative data allows the researcher to identify and interpret clear meanings of lived experiences by identifying fundamental themes among the participants' narratives. What follows is a discussion of the seven steps of Colaizzi's data analysis method and how these steps unfolded in the current study. Because of the large amount of data generated from the 20 interviews (two interviews per participant), there were times when additional steps were added to Colaizzi's framework by a qualitative expert who also served as a committee member and reviewed the data analysis. These additional steps will be discussed as well.

Colaizzi's Seven Step Method

In step one, all interview transcripts were read in order to "acquire a feeling for them" (Colaizzi, 1978, p. 59). After completing each interview with all participants, the researcher transcribed all of the audiotaped interviews verbatim. Transcribing each interview took hours to complete in order to ensure accuracy. Considering that the researcher transcribed the interviews instead of a transcriptionist, this allowed for immersion of the data to occur. Immersion of the data is essential in phenomenological research because it helped the researcher describe and illustrate the meaning of the phenomenon being studied (Munhall, 2007). Next, the researcher read the transcripts in order to obtain a sense or feeling about the data as they related to the lived experience of the overweight or obese southern AA older women (Miller, 2003; Sanders, 2003). In addition, a reflective diary was started and maintained throughout data analysis to ensure credibility (Bloomberg & Volpe, 2008). This reflective journaling, which was performed

after reading each interview, provided the researcher with a way to record analytical concerns, speculations, or personal insights related to the research experience.

Step two involved evaluating each protocol (or transcript) and “extracting significant statements” (Colaizzi, 1978, p. 59; Sanders, 2003). During this phase of the analysis, the transcripts were read and re-read a few times and significant statements were extracted from each transcript as they related to being overweight/obese, functional status, mobility, and physical activity (Sanders, 2003). The researcher performed a line-by-line review of each transcript in which 980 significant statements were extracted from the twenty participant interviews. It was also during this step that a qualitative expert reviewed each original transcript and compared it to the significant statements generated by the researcher to guarantee credibility of the significant statements. Revisions were made to the significant statements based on the qualitative expert’s reviews. In addition, an audit trail was started and maintained to ensure dependability of the study (Bloomberg & Volpe, 2008). An audit trail is the process whereby the researcher maintains detailed records of the decision making process during the analysis. Moreover, an audit trail allows peer reviewers to track the rationale for the direction the researcher took during the data analysis process. In other words, the progression of the analysis is made transparent and is available for any investigator interested in the studied phenomenon (Wolf, 2007).

The third step was to formulate meanings. To do this, the researcher spelled out the meanings from the extracted significant statements from all of the transcripts (Colaizzi, 1978). During this stage of the analysis, the researcher identified key theme words to form each formulated meaning that were derived from participants’ significant

statements (Miller, 2003). The researcher used imaginative insight, which means that the researcher must make an examination of the participants' stories and then try to determine the real meaning of the statements (Colaizzi, 1978). This process was repeated with all the significant statements from each interview transcript. Due to the large amount of data, an additional step—organizing categories—was carried out prior to Colaizzi's fourth step. Thus, the formulated meanings were grouped into sets with similar meanings called 'categories' and given a short label such as 'physical activity', 'obesity', and 'exercise'. Next, all 980 formulated meanings were organized under a specific 'category'. Bracketing was another component of this stage. Bracketing helped the researcher to discover and set aside biases, to have an open mind throughout the entire analysis process, and to maintain focus on the goals of the study (Sanders, 2003). Moreover, during this phase, a qualitative expert reviewed 980 formulated meanings to ensure that the researcher accurately portrayed the participants' perceptions of the phenomenon (Bloomberg & Volpe, 2008). Revisions were made to the formulated meanings based on the qualitative expert's reviews.

The fourth step was to organize the aggregate formulated meanings into clusters of themes. Thus, the formulated meanings were clustered or organized into common themes with similar meanings across all of the transcripts (Colaizzi, 1978). Throughout this step, the researcher examined all of the formulated meanings. To justify the accuracy of the formulated meanings into the appropriate theme clusters, the researcher returned to the original raw data for verification (Kleiman, 2004). All 980 formulated meanings were categorized or reduced into 44 theme clusters based on similar meanings. Because of the large number of formulated meanings, only selected formulated meanings were

illustrated in the category tables. After reviewing the 44 theme clusters, the researcher identified overlap among the theme clusters; thus, the 44 theme clusters were then reduced to 13 categories. This reduction process involved several sub-steps developed and carried out with the assistance of the qualitative expert. First, the emergent themes were reduced into a fewer number by combining similar emergent themes and creating a label/title for them that encompassed all the emergent themes from which they were reduced. These were further collapsed by clustering emergent themes with similar meanings and then creating sub-themes to represent the clustered groupings of emergent themes. Lastly, tables were developed that listed the newly created sub-themes along with their corresponding emergent themes (Y.D. Eaves, personal communication, 2/27/2012). Because the main phenomena under study were obesity/overweight, mobility, functional status, and physical activity, the researcher had to determine if all 13 categories significantly contributed to the illumination of these phenomena and whether they contributed to answering the study research questions. After consultation with the qualitative expert, it was determined that eight categories explained and described the phenomena. Although the additional five categories provided useful information, the decision not to use them in this study was related to the fact that they did not produce a significant amount of data needed to explain and describe the phenomena. However, these five categories can be used in future analysis.

The fifth step of the analysis was to combine all of the results into a comprehensive picture of the phenomenon being investigated (Colaizzi, 1978). An exhaustive description included the examination of the emergent themes that materialized from the data. During this step, the researcher provided an exhaustive description of the

lived experiences of overweight or obese southern AA women and how these conditions impact their functional status, mobility, and physical activity participation that emerged from steps two, three, and four (Miller, 2003). The comprehensive list of emergent themes from all eight categories resulted into 16 emergent themes.

The sixth step was to “formulate an exhaustive description of the investigated phenomenon in as unequivocal a statement of identification of its fundamental structure as possible” (Colaizzi, 1978, p.61). This means that the researcher examined the existing data in a new light and detected the emergence of hidden meanings. Because the exhaustive descriptions of the phenomenon were very lengthy, the researcher limited this information to fundamental structures of the lived experience (Miller, 2003; Sanders, 2003). In other words, during this step, there was a final reduction of the emergent themes into meta-themes or fundamental structures (Colaizzi, 1978; Sanders, 2003) to shed light on undervalued meanings or meanings that people fail to appreciate.

In the seventh and final step of analysis, the participants are asked to validate the study’s findings (Colaizzi, 1978; Sanders, 2003). Thus, the researcher returns back to each participant in the study, to discuss the analysis results, to ascertain agreement with the themes and exhaustive descriptions, and to verify validity of the transcripts (Kleiman, 2004; Miller, 2003; Sanders, 2003). Schwandt (2007) calls this step member checking or respondent validation because the researcher attempts to obtain feedback from the participants about the findings of the study. However, Kleiman (2004) believes that the researcher should not return to the participants for verification because the participant is asked to focus on the previous two interview results instead of the lived experience

without any pre-thought, which is in contrast to Husserl's perspective. Therefore, for this study, this step was not performed. See Appendix E for details related to the analysis.

A caveat is needed here concerning the negative case data. The earlier discussion of the advantages of including negative cases implies that these cases are not examined apart from the data as a whole; to do so would be reductionist and would diminish the holism that is an inherent property of the naturalistic paradigm. The point is to discover the new dimensions that the negative cases add to the patterns and themes identified from the representative cases. A separate analysis for representative cases and negative cases would produce two different explanatory frameworks and this is not an appropriate use of negative cases. However, in the results (Chapter 4) the new dimensions or variations discovered in the negative case data will be discussed.

Scientific Rigor

Scientific rigor means that all decisions made by qualitative researchers were meticulously planned and all possible consequences considered (Kleiman, 2004). When demonstrating and ensuring the presence of rigor in phenomenological research, it is crucial to determine whether the study was believable, precise, and valuable to others (Priest, 2002; Sanders, 2003). Scientific rigor refers to the process of enhancing the quality and integrity of the qualitative study and this term is parallel to the quantitative term "validity" (Morse, 1994; Sandelowski, 1993). Scientific rigor is a component of trustworthiness (Bloomberg & Volpe, 2008; Priest, 2002).

Trustworthiness

Trustworthiness refers to a set of criteria that is used to evaluate the quality and worth of qualitative research (Schwandt, 2007). In other words, it is important that the researcher provide verification that the descriptions and analysis of the study gives an accurate and believable depiction of the participant's lived experience (Bloomberg & Volpe, 2008). The three most important criteria of trustworthiness include dependability, transferability, and credibility (Bloomberg & Volpe, 2008; Schwandt, 2007).

Dependability (equivalent to reliability in quantitative research) means that one researcher can follow the methods and procedures of another researcher's data collection and interpretation. Transferability refers to how well a project has been designed to the point that other researchers may decide whether comparable methods would work for them. In other words, transferability is the ability to transfer the findings of one study to a different group or setting (Bloomberg & Volpe, 2008; Priest, 2002; Sanders, 2003; Schwandt, 2007). The final criterion is credibility.

Credibility

Credibility, which is comparable to validity in quantitative research, refers to the researcher's ability to represent correctly and truthfully the participant's perception of a phenomenon (Bloomberg & Volpe, 2008). Three strategies were used to ensure and enhance the credibility of this study. First, bracketing was used in the current study to facilitate credibility of data collection and data analysis (Ahern, 1999). Bracketing is the removal of the researcher's own preconceived notions about a phenomenon in order to understand the meaning of a participant's lived experiences from her perspective (Cohen

et al., 2000; Gearing, 2004; Lavery, 2003). The researcher identified, acknowledged, documented, and reviewed any personal biases and presumptions about how obesity affects functional status, mobility, and regular physical activity participation of southern AA older women before initiating data collection.

Another strategy used to ensure credibility was reflexive journaling, through which the researcher was able to make herself critically aware of her own biases and was able to describe whether this self-inspection influenced any part of the research process (Schwandt, 2007). Reflexivity required the researcher to record and to maintain personal reflections about the study in a diary or journal. Therefore, reflective journaling was used throughout the entire research process in order to enhance credibility of the study.

The third strategy used to enhance the quality and credibility of the study was peer review and debriefing. During this process, all aspects of the data collection and analysis were reviewed and explored by a qualitative expert to ensure the quality and integrity of the study were maintained (Polit & Beck, 2008).

Human Subjects Protection

The University of Alabama at Birmingham Institutional Review Board (IRB) reviewed and approved this study. For each woman who met the eligibility criteria, the entire consent form was read to the participants by the researcher and then a written informed consent was obtained from the participants before conducting the interview (Schwandt, 2007). The researcher explained to each of the participants that participation in the study involved two separate 60-90 minute interviews, no administrations of treatments or interventions, and it was acceptable to discontinue the interview at anytime

without any repercussions. The informed consent form was signed after the study had been explained to the participants in detail and the participants were allowed time to ask questions. Each of the participants received \$20.00 for each interview completed. The researcher conducted each interview in the privacy of each participant's home.

The potential benefits of this study were expected to yield knowledge that informs health professionals about southern AA older women's perceptions about obesity and being overweight and how this condition influences functional status, mobility, and physical activity. This information is needed to potentially develop interventions that may motivate overweight and obese southern AA older women to practice behaviors that will help them to achieve and/or maintain a healthy weight, thereby decreasing the prevalence of obesity and the accompanying health risk factors. There were minimal risks with participating in this study. Although, it was possible that women in this study may have experienced fatigue or negative emotions, such as sadness, embarrassment, or anxiety during discussion and recollection of their lived experiences, such emotional risks were minimal and likely to dissipate soon after completion of the face-to-face interviews. (See Appendix D for Human Subject Protection Forms).

Summary

Because the Southeastern region of the U.S. is disproportionately affected by obesity (Centers for Disease Control and Prevention, 2009), the knowledge of culturally appropriate descriptions and meanings of obesity and its impact on functional status and mobility will assist the healthcare community with understanding why these AA older women do not adopt regular physical activity behaviors. Phenomenology allowed the

researcher the ability to understand the meanings and values that overweight and obese southern African American women allocated to their behaviors. Information obtained from this study can help healthcare providers understand how to encourage this population to engage in regular physical activity.

CHAPTER IV

FINDINGS

The purpose of this study is to examine and describe the lived experience of overweight or obese southern AA older women and how these conditions impact functional status, mobility, and physical activity. In this chapter, the results of the study findings are organized and described in three sections. First is a description of the sample, which encompasses the sociodemographic characteristics of the women. The second section presents the six sub-themes with the corresponding emergent themes, and the third section describes the findings based on the research questions. Quantitative data were analyzed using the SPSS statistics version 20 and qualitative data were analyzed according to Colaizzi's approach to phenomenological data analysis.

Description of the Sample

After obtaining approval from the University of Alabama at Birmingham Institutional Review Board, recruitment of participants began at three predominately AA churches in Jefferson County. Bright colorful flyers were provided to each church and were read to the congregation one Sunday as a part of the morning announcements. Over a nine-month period, eleven women who expressed interest in participating in the study were screened for eligibility and each woman consented to participate in the study. Two participants were recruited from church A, four participants were recruited from church

B, and zero participants were recruited from church C. In addition, five additional women were recruited to participate in the study through snowball sampling as currently enrolled participants referred other eligible women to be in the study. One participant was a poor respondent and the transcript of the first interview consisted of thin data as evidenced by one-line responses to the interview questions. Therefore, a second interview was not conducted with this participant and the data from her first interview was not included in the qualitative analysis (See Appendix A for Recruitment Materials).

A description of the sample demographics is presented in Table 1. Ages of the participants ranged from 65 to 82 years with a mean age of 75 years ($SD = 5.35$). The majority (70%) of the participants lived alone, 80% of the participants reported an annual income of less than \$12,000, and 60% of the participants were fully retired. Data were also collected regarding transportation, specifically, whether they had a car or access to a car and their current driving status. The majority of the women ($n = 6$) stated that they still drive, three of the women no longer drove, and one woman had never driven a car. The University of Alabama Study of Aging Life-Space Assessment scale was used to assess mobility and the Katz Basic Activities of Daily Living scale along with the Lawton-Brody Instrumental Activities of Daily living scale were used to measure functional status. Ten women's mobility status were measured using the University of Alabama Study of Aging Life-Space Assessment scale; the scores ranged from 22.50-100, with two women scoring in the 20s and two women scoring 100 and the mean score was 64. The scale measured the distance, frequency, and independence of these community-dwelling women's mobility, within and beyond their home into their community and surrounding areas, over a 4-week period. The women of this study

required either equipment (canes or walkers) or no equipment or personal assistance to maintain independence in their home. In addition, these women tended not to travel outside of their hometown and this could possibly be related to their limited finances, transportation, and decreased mobility (See Table 1). All of the women's functional status scores from the Katz Basic ADL scale and the Lawton-Brody IADL scale were used and indicated that they were independent because they scored all "ones" on each item of these two instruments. Note that one participant died before her functional status could be assessed.

Table 1

Sociodemographic Characteristics (n = 10)

Personal Factors	Frequency (%)	M (SD)	Range
Age in years		75 (5.35)	65-82
Resident location			
Birmingham	8 (80)		
Fairfield/ Midfield	2 (20)		
Marital status			
Single	2 (20)		
Married	2 (20)		
Widowed	3 (30)		
Divorced	3 (30)		
Number of children		3.8 (2.57)	0-8
Number of people in home		1.5 (0.97)	1-4
Highest education			
Attended high school	4 (40)		
High school graduate	4 (40)		
Some college	1 (10)		
Associate degree	1 (10)		
Employment status			
Works part-time	1 (10)		

Retired but work part-time	1 (10)
Fully retired	6 (60)
Disabled	2 (20)
Annual income	
Under \$8,000	3 (30)
\$8,000-\$11,999	5 (50)
\$12,000-\$14,999	0 (00)
\$15,000-\$19,999	1 (10)
\$30,000 and over	1 (10)

Because the study primarily focused on obesity, the participant's height, weight, and BMI were obtained. The BMI of each participant was calculated with the National Heart Lung and Blood Institute BMI calculator, which is located on the U.S. Department of Health and Human Services website. Seven women were classified as obese with a BMI ≥ 30 , two women were classified as overweight with a BMI of 25.0-29.9, and one woman was classified as normal weight with a BMI of 18.5-24.9. The total sample for this study was 10; the seven obese women and the two overweight women met the study inclusion criteria. The remaining participant was normal weight and thus, she was considered a negative case in an effort to seek alternative meanings or themes to thoroughly answer the research questions. Additionally, participants were asked the following questions, "1) Do you have scales in the home? 2) Do you weigh yourself?, and 3) How often do you weigh yourself?" Four of the women had scales in their homes but only three of them weighed themselves. These three women weighed themselves from once a week to once every two months. One of the participants with a scale in the home had a fear of falling and therefore refused to weigh herself.

The women in this study suffered from a variety of chronic illnesses and medical conditions with arthritis, diabetes, hypercholesterolemia, and hypertension being the most

common. See Table 2 for Chronic Health Conditions. Most of the women had co-morbid health conditions.

Table 2: Participant's Chronic Health Conditions

Chronic health conditions	<i>n</i>
Anemia	1
Anticoagulant therapy	1
Arthritis	6
Diabetes	5
GERD	1
Glaucoma	1
Gout	1
Heart problems.....	2
Hip surgery	1
Hypercholesterolemia	5
Hypertension	9
Insomnia	1
Leg cramps	1
Neck surgery	1
Osteoporosis	1
Poor circulation	1
Ruptured disc	2
Scoliosis	1
Shortness of breath	1
Sinus	2
Steroidal injections	2
Stress	1
Total knee replacement	2
Urinary frequency	1
Urinary incontinence	1

Note. *n* = 10 participants

Six Meta-themes Identified

The findings of this study revealed internal and external factors that influenced southern AA older women's understanding of being overweight and obese and the impact that these conditions had on participating in regular physical activity. All of the women viewed being overweight or obese as an unhealthy condition that negatively affected

functional status, mobility, and physical activity. Although knowledgeable of the harmful effects that can occur with obesity, the majority of the women found it difficult to participate in regular physical activity. The six meta-themes that were discovered through data analysis included: responsibility for controlling health and weight, preservation of function and mobility, beliefs and attitudes, impact of health conditions, control over health choices, and understanding of beneficial activities and treatments. These meta-themes were common to all of the women's narratives. Each meta-theme was comprised of two to four sub-themes. Interpretations of the meta-themes and sub-themes along with selected quotes from the women's transcripts are provided next in order to accurately illustrate their lived experiences of being overweight or obese.

Responsibility for Controlling Health and Weight

The meta-theme "responsibility for controlling health and weight" consisted of four sub-themes that included health status, differentiation between the terms overweight and obesity, awareness of overweight status, and independence. These four sub-themes were derived from 332 formulated meanings from categories one (seeking and receiving medical advice from health care providers), four (beliefs or perceptions), seven (varied weight statuses), and nine (levels of dependence and endurance), with 87 being selected to illustrate this meta-theme. The significance of this meta-theme was to identify internal and external factors that influenced the women's ability to organize and manage their overall health status, which encompassed their weight.

Health Status. When the participants were asked, “Can you tell me about your health?”, the main themes that emerged were musculoskeletal problems and hypertension. Arthritis was the most frequently cited musculoskeletal condition and treatment included corticosteroid injections and surgery. Ninety percent of the sample was diagnosed with hypertension. All of the women either sought and/or received medical advice or treatment from a healthcare provider in an effort to manage their overall health. For example, the following statement illustrated how one participant took responsibility and adhered to medical advice,

“Well I take the mammogram every time I’m supposed to take it. But I’ve been through with the radiation but I still have to go through that procedure [referring to her regularly scheduled mammogram]. But I go now just for check-ups you know I have to take it you know. And I still have to take that calcium D for my bones; you know I still have to take that”. (Client 002-A)

The common view among the women was that being healthy was important and essential to living a quality life. Therefore, each woman felt that it was ultimately her responsibility to adhere to medical advice in order to achieve and maintain good health.

Differentiation between the Terms. The women in this study had a difficult time distinguishing between the terms overweight and obese; most of the women indicated that there were no differences in the meaning of these words. The participants used words and phrases, such as, “fat”; “larger than you need to be”; and “more weight, more heavier, more fat, huge” to describe the terms overweight and obesity. One participant stated, *“To me they mean about the same (laughing)...it’s [overweight] just a cuter word*

they use, about obese, when you're overweight" (Client 010-A). Another woman stated, *"Obesity that's overweight. All that's in the same category. I think it's all the same category - fat. Obesity is a person that eats all of the time right?"* (Client 004-A). A third participant said, *"I define overweight as being fat and the same for obese"* (Client 005-A).

Awareness of Overweight Status. This meta-theme explained the women's perception of what it means to be classified as overweight and what factors influenced the formation of their opinion. One participant stated, *"You can't wear the same clothes you use to wear [when you are overweight]. You have to buy brand new everything [when you are overweight/ obese]"* (Client 002-A). Another participant stated, *"You be [are] tired and shortness at the breath you know when you are overweight. A lot of times you be tired"* (Client 003-A). A third participant stated, *"You can look at yourself and see you're overweight. Your clothes don't fit right. Your stomach hanging down over your belt. You know you're overweight. You can look in the mirror and tell you're overweight just look at yourself. You got to stop [eating]"* (Client 004-A). These comments represent common themes among all of the participants.

Independence. Independence was another theme that was valued and common among the women because they considered it an essential component for controlling one's own health and weight status. One participant stated, *"[when a person is overweight/ obese] you can't go every place you can't do everything for yourself. You know you're tired all the time. And you be depressed you know they be depressed. And*

they depend on someone else to help you” (Client 011-A). Another participant stated, “I have to do well it [trigger finger] pains me but I have to do [activities of daily living] cause you know I aint got nobody to do for me...But I just go on and I take my pain pills” (Client 003-B). A different woman indicated that the lack of her own transportation interfered with her independence. She stated,

“When I had my transportation, I would go you know and I would drive, you know I didn’t have to walk, I drove you know, and I still go but not as much as I use to go and I use to visit when I had transportation I would visit you know I could go and I wouldn’t have to ask somebody to come and pick me up or take me cause I had my own transportation. But now that I don’t have transportation, that’s out you know. I can’t do like that. And I would go to the grocery store and go and pick my medicine up but it’s a difference when you don’t have your own transportation, things that I use to could do, you know I can’t do that cause I really don’t have money to pay somebody every time you know they take me somewhere” (Client 002-B).

Preservation of Function and Mobility

The meta-theme, “preservation of function and mobility” consisted of two sub-themes: a) ambulation and b) function and mobility. With advancing age, preservation of ambulation, functional status, and mobility were common themes among the participants. Forty-eight formulated meanings emerged from the data that were related to ambulation, assistive devices, mobility, and movement.

Ambulation. Maintaining the ability to ambulate, with or without assistive devices was a common theme among all the women because ambulation promoted independence and overall good health. For example, one participant stated,

When I was young, I could just exercise, walk, and it just didn't bother me, it (walking) didn't hurt. A lot of times, I try to exercise, walk and I can't walk long, I can't stand long. But I do as much as I can because they say if you don't use it you will lose it and I don't want to lose it (laughing)"(Client 009-B). Another woman had a similar perspective, she said, *"I know you got to keep moving you know what I'm saying you got to do something to keep yourself from getting stiff I'll say. Where you gonna walk or exercise you know going to the mailbox you got to do something if you sit down, cause I learned that if you sit down you just get stiff and can hardly walk when you get up. But if I (started laughing) but if I stay busy I can um I can kind a make it pretty good* (Client 010-B).

Function and Mobility. Every participant indicated that, to a certain degree, functional status and mobility declined with aging. Moreover, they verbalized that being overweight or obese negatively affected mobility and functional ability as illustrated by one participant in the following statement, *"I use to could stand up and reach my toes and I can't do that anymore. Get up without bouncing and pull myself up"* (Client 005-A). Women also attributed certain chronic illnesses, especially arthritis, along with the concomitant burden of being overweight or obese as negatively impacting their mobility and self-care abilities. For instance, one participant stated, *"When you walk up and down that hall and out of breath you know you're overweight and you got to stop every time*

you walk some place” (Client 006-A). In the next passage, another woman explained how certain symptoms (pain and shortness of breath) combined with limitations of older age impacted her mobility and her ability to perform ADLs;

“The stairs, couldn’t go up and down the stairs. Lord that hurts me. Can’t go up and down stairs, breath gets short. When I went down to wash (at her old home), I would go down (stairs) and get everything done, and then I’ll make one trip up (the stairs). The more age on you, you can’t do the things you use to do” (Client 005-A).

Beliefs and Attitudes

Participants held certain beliefs and attitudes about obesity and obesity related concerns. Two hundred twenty-six formulated meanings were generated and subsequently materialized into Category 4, which included the following labels: beliefs and perceptions, perceptions of health; and Category 7, which encompassed the subsequent labels overweight/obesity, definitions of physical activity, exercise, physical therapy, normal weight, underweight/skinny, weight changes/status. Fifty-seven selected formulated meanings were used to describe this meta-theme called “Beliefs and Attitudes” which consisted of two subthemes: 1) obesity beliefs and stigmas and 2) prejudicial attitudes.

Obesity Beliefs. This sub-theme illustrated the women’s perception of what it is like to live with obesity and their rationale for why obesity has occurred. The participants were very vocal about their perceptions related to what constituted being

overweight or obese. One participant stated, *“It’s (obesity) where you let yourself get fat, out of proportion and some peoples can help it and some people can’t. But I do not want to be obese, ok (laughing). I try very hard”* (Client 006-A). Furthermore, it was clear that this participant believed that heredity played a role in obesity because she added, *“Sometimes you can be chubby and it can be a part of the family, somebody in the family could be (overweight) and it just run in your family”* (Client 006-A).

Another participant said,

“In society, being overweight you can’t sit anywhere. You can’t fit into just ordinary, [e.g. chairs] they gotta have something specially made and I have seen people in that shape. That they just... they breathe hard. They just like give out of breath too soon you know. They justit bothers me; it worries me to see people when they are just too fat because they just look so uncomfortable. All fat people don’t look uncomfortable. But some people do” (Client 008-A).

Stigmas and Prejudicial Attitudes. Some participants had intriguing views about obesity in today’s society. Overall, the women believed that the public discriminated against people who were overweight or morbidly obese in general because of their size and appearance. All of the women considered being classified as obese to have a negative connotation. In the following passage, one participant expressed her views about obesity among AAs.

“Well cause a lot of em eat pig feets and pig tails and all that (laughing). All that pig feets and pigtails and all that and see a lot of whites don’t eat no pig feets. I ain’t never see ’em buy none (laughing). That’s true, all I ever see them whites

buy was chuck and beef roasts, and pork chops and chicken; ain't never saw none buy pig feets and pig tails (laughing)''(Client 003-A).

Another participant stated,

“Some of them are big, they are just too big. They just don't care. I love to just look at them on TV...they look like big old hogs or pigs...after they have went through that exercise they look good, they look good but overweight is not good for nobody. Whether you're young or old, it's (obesity) not good” (Client 002-A).

A third participant said,

“(overweight/obese people) just sitting at the table and just eat, eat, eat, eat, eat, until you can't eat anymore...don't care about yourself. Just sit up there and eat and just don't you know. And sometimes we have problems you know, mental problems, ah physical problems or something you know and sometimes we just get to that place you don't care about yourself and that will make you do it to” (Client 006-A).

Additional stigmas voiced about obese or overweight people in general were related to riding in cars, on airplanes, or sitting in chairs in public places. For example, a few of the women believed that overweight and obese people were shunned because it was believed by some that obese people riding in cars could cause damage to modern vehicles because of the excess weight. Obese people also require more sitting room when riding in the coach section of airplanes and that many obese people are unable to sit comfortably in standard chairs, such as chairs located in the emergency room of a hospital.

Impact of Health Conditions

The meta-theme impact of health conditions consisted of the sub-themes chronic illness and pain. The participants shared that several factors, mostly physical ailments, impacted their overall health status. Although 97 formulated meanings emerged from the participant data, the highest responses related to pain.

Chronic Illness. Participants talked about chronic illnesses by describing their experiences with specific illnesses (e.g., arthritis, diabetes, and hypertension), procedures (e.g., surgery), and symptoms (e.g., pain). The women referenced chronic illnesses many times. For example, one participant experienced pain, surgery, and chronic illnesses. She stated,

“It’s just hard to get around like I use too. But I’m blessed and um my legs hurt, they started back to swelling again; I had surgery on them. I went to (the doctor) and he did surgery on my leg and the swelling went down and everything but then it started back again, hurting again because I have poor circulation. He told me I needed knee surgery but then I don’t want knee surgery, so I refuse to get knee surgery and (I’m) just trusting in the Lord you know to help me and I just do the best I can” (Client 002-A).

Another participant shared her views and stated,

“The disadvantages for being overweight for anybody is health problems. Cause a lot of health problems. Diabetes, number one, high blood pressure, arthritis all of that comes from obesity. Then when your family history, obese and diabetic, it’s time to check it out then. Diabetes runs (in) our family and I know from the

beginning about being overweight. Still didn't listen [she knew that being overweight could lead to obesity related illnesses but she still did not adhere to medical advice in regards to losing weight]" (Client 004-A).

In the next passage, a third participant described how obesity or overweight status could influence the development of new chronic illnesses or exacerbated current chronic illnesses.

"Your health is not the best when you are overweight. (Overweight status affects) your blood pressure. Overweight affect your cholesterol. Your breath is short" (Client 005-A).

According to another woman,

"(Being overweight) it can...run your blood pressure up and it can cause your knees and things, too much of weight on your knees and your back. Too much to carry around...the biggest thing I would say, is that overweight would cause your mobility to be slow. It's bad on your bones" (Client 009-A).

Pain. Experiencing pain of the musculoskeletal system was a common thread among this sample, with lower extremity pain being cited the most. Many of the women experienced pain with ambulation and they suffered with arthritis of the knees and spine. Although pain was an everyday occurrence for most of the women, they found ways to cope or manage the pain. One participant described her experience as follows:

"My legs hurt when I walk and [with] standing, when I stand too long it's my back. Look like I just have to sit to get relief. Standing up is very uncomfortable.

But the doctor did say my spine was crooked so evidently that has a lot to do with it” (Client 009-B)

A second participant provided the following as an example of her experience,

“It just get pains in it (knees). You can hear it (knee) pop by all of that stuff (cartilage), that whatever that in between them knees, them, bones its gone... when I was working in the hospital I found out then that knee replacement don’t work for everybody. And you take those shots for so long till they just last a little then baby you got the pain right back again”(Client 002-B).

The quote from the next participant illustrated how pain can make mundane tasks hard to achieve and enforces the notion that surgery is not always a viable option for older adults.

I can’t go through that exercise, honey my back be killing and hurting me now. I get up in the morning time and it be hurting me so bad I can’t go through with it. I just have to go slow and I have to put on my back brace sometimes and I don’t be doing nothing but just right there in the kitchen. But from the movement of my body it just keep a moving you know and I just be right there in that kitchen sometimes from the stove to the refrigerator but it’s the movement[of] my body that get ah irritated. See I got a ruptured disk and [her doctor] say the only thang [thing] he can do for a ruptured disc was for me to have surgery and it would be a major surgery. And my primary doctor advise me not to take cause she say I would have to have somebody with me all the time. And see I ain’t got nobody to be here with me all the time (Client 003-B).

Additional factors that were cited by some of the women as physical health conditions that impacted their ability to maintain mobility, to engage in regular physical

activity, and to continue social involvements were intermittent urinary incontinence, urinary frequency and urgency, lower extremity edema, genu valgum, and lower leg discrepancy. For example, one participant described her experiences that resulted in her current physical health condition,

I thank I den [have] had enough [surgeries]. Unless it [pain in shoulder] gets worse than what it is, I don't think I'm gonna have no more [surgeries]. Oh I had two on both hips, that's four, two knee, both my hips and knees, knees each one just one time. But they been revised twice on my hips. A revised procedure. You ought to see my x-ray...I got a rod in that right hip, going from my right hip to my knee a rod cause that bone had deteriorated so bad they had to put an artificial bone in that hip” (Client 004-A).

A different participant indicated,

“I don't go [to church] like I use to cause I have to go to the bathroom a lot and I don't like you know. Look like sometimes I go and then I go right back and then you know I don't like to go like that. You know how some people say she just went to the bathroom, now she got to go back again” (Client 003-B).

Although none of these conditions were considered life threatening, they do influence the type and frequency of activities with which these older AA women become involved.

Control over Health Choices

Motivation. Interestingly, all of the women whether they participated in physical activity or not, were able to suggest ways to motivate other southern AA older women to engage in regular physical activity. The women described motivational factors that were either internal (self-driven), external (outside influence), or a combination of both. Most

of the women cited good health, which encompassed mobility as a facilitator for engaging in physical activity. Encouragement from their healthcare provider or a peer to engage in physical activity was another common motivating factor. In contrast, the use of assistive devices, inadequate finances, or transportation to attend culturally and age appropriate exercise facilities, limited peer support, and pain were viewed as barriers to participating in physical activity.

One participant suggested that healthcare providers should instruct older AA women on physical activity in a culturally sensitive manner and suggested the following,

“[Tell them to] get out and exercise, meet people. So many thangs [things] you can do. Especially you [researcher], you know how to talk to people and give em [them] advice about thangs (things), show’ em [them] which way is good for them you know. Cause you have motivated me already, when you leave I’m a exercise”
(Client 004-B).

Several of the women suggested the use of a peer role model as a motivating technique. One of the women stated, “[the] *only thing I can do is talk to’ em [them] and tell’ em [them] to look at me. I don’t have all that weight I use to carry. [they say] but what are you doing? I say I’m exercising. I say it’s a stress reliever plus it’ll take some fat off of you*” (Client 008-B). Although this participant had functioned as a role model for others, she is self-motivated as well and added,

“My motivating factor is my heart. I had a problem with my heart and then I was diagnosed with for years with borderline [diabetes] but ah then they just say you got diabetes and I didn’t want diabetes to just take me out you know. And I did what I had to do in order to maintain some portion of my health and not have to

take medicine because see I'm not on medicine for diabetes. And I don't ever want to take it. I don't know whether in later years I'll have to end up with it. But right now as long as I can control it by exercising and doing the diet, that's a motivation for me" (Client 008-B).

Another woman suggested the following strategies to motivate other southern AA older women to engage in regular physical activity,

"You need to get up from there and take some exercise and your legs a feel better, and you can get around better. And you need to lose some weight because all that weight is just too much for your legs and that's, I mean really that's what you need to tell 'em [them]. And if it was me, I would say they just lazy like me but you [researcher] can't tell' em [them] that. But um that's what you could tell' em [them] though, really that will help them so much. And tell them that you could even ask [me] and she'll tell you exercise does help. You can carry me and I'll tell 'em how much it help. I know you can't" (Client 009-B).

Some women considered "energy" to be a motivating factor because they felt more vigorous after engaging in physical activity. One woman added, *"What motivates me, energy. I just love to get up and do things. You know, I don't like to sit around. Now if you weren't here, I wouldn't be in here. I'd be outside. Yeap and I want to be healthy"* (Client 006-B).

Desire. Desire or yearning to perform physical activity was the second sub-theme under the meta-theme of motivation and desire. Several women referred to the fact that they were no longer physically able to perform and function at the level they did when

they were younger however, many of these women desired to perform physical activity at the level they did when they were younger. Although the desire to perform is present, the body may not always be able to comply. They also expressed a desire to live longer and maintain their independence, which motivated most of the women to want to engage in physical activity. For example, one participant stated,

“When you get older, your bones, your body is not going to be the same; nothing last forever... [but] it’s good to keep active. I was 80 years old yesterday and I tell you right now if I could get up [she yearns to be able to function as she did when she was younger] and run through that back yard I’d be running. In other words, I wish I could work. I wish I could work. But I’m not able to work. I have to wash my clothes for myself, every thang (everything). Lord I hope I don’t get like that [she desires to stay independent] (laughing)” (Client 002-B).

Another participant illustrated her desire as

“I wish I was just a little stronger. I had four hip surgeries, and knee surgeries. That kind of handicapped me from doing a lot of thangs [things] I could do. I’m limited walking, standing up... I just wish I could do a little more and get out in the yard and thangs but I have to make the best of it... just get out there and pull up the grass and just plant flowers or do something. That was my favorite in my young days in the garden. Now all that’s behind me” (Client 004-B).

In some instances, desire was absent, which negatively affected physical activity participation. One participant was capable of performing regular physical activity, but stated, *“Sometimes I just don’t want to do it [no energy]...I don’t feel like it...it’s not often. You know sometimes I just come in here [and] get in the bed” (Client 006-B).*

Another woman stated,

“I just don’t have the “ups” to go to the thang [in the activity center]. I don’t have the energy cause at certain times look like I get up early and look like certain times I got to get ready to lay down and I lay down mostly after “Wheel of Fortune” go off” (Client 003-B).

Understanding of Beneficial Activities and Treatments

Not surprisingly, all of the women were aware of the positive benefits that accompany regular physical activity. However, despite this knowledge, there was no guarantee that all of these women would participate in regular physical activity. The women provided the subsequent examples to illustrate the benefits of participating in regular physical activity. In the next passage, one of the participants explained how participating in regular physical activity was essential for her to maintain a full range of motion of all four of her extremities as well as to increase her ability to have increased mental clarity. First illustration,

“I did it [Physical activity] for um just keep my limbs and thangs limber and you know... cause walking is good for you... its real healthy for you. It keeps your mind, it keeps your mind functioning, you know and it keeps your blood circulating you know to me” (Client 011-B).

A second participant stated,

“I mean my legs my legs feel more limber like they’re not as stiff. I mean they sort of hurt a little but not as stiff as when I just sit around, sit around two or three days not exercising, then I’m stiffer. Harder to get around but then if I

exercise just like for a good week or a good four days well my legs seem to be much limber. I can move em much better and they doesn't hurt as bad as I, they not as stiff I would say when I exercise regular so I think that's the greatest benefit of exercising for me" (Client 009-B).

Another benefit of engaging in physical activity expressed by many of the participants was related to the ability to maintain independence with all ADLs and IADLs. Preserving independence was valued among the entire sample. One woman described the benefits of physical activity as,

"I know you got to keep moving you know what I'm saying you got to do something to keep yourself from getting stiff I'll say. Where you gonna walk or exercise you know going to the mailbox you got to do something if you sit down, cause I learned that if you sit down you just get stiff and can hardly walk when you get up. But if I (started laughing) but if I stay busy I can um I can kinda make it pretty good" (Client 010-B).

Not only does physical activity help with mobility, additional identified benefits of performing physical activity were related to weight loss and stress management, which are considered important outcomes for overall good health. One participant described the physical and mental benefits she gained from performing regular physical activity,

"The first benefit is that I've lost and losing the weight has really helped me to be able to ah move faster. Um my mobility is a lot better than it used to be. I'm not as tired as I used to be. And ah, I just feel good! It has helped me with stress. I'm not as stressed out at this um, things at one time would, you know, would just

stress me to, I'm not there anymore. I can take more, I've learn to hear and don't hear, see and don't see you know" (Client 008-B).

Some women also described their experience with physical therapy after surgery or for restorative treatment. A few participants described how attending physical therapy classes were an essential part of their recovery period after surgery or an illness because it helped them to build up their endurance and strength, which was needed in order for the woman to be able to go home and function independently. For example, one woman stated,

"It was to help me to walk you know cause I couldn't walk without holding on to a walker. I had to do, you know, do my arms, exercise with my arms, exercise with my feet and um I had to learn how to use the wheelchair. Standing up then you know was on different machines, they used different machines. And buttoning clothes and using play dough" (Client 010-B). (See Appendix E for the Qualitative Coding and Analysis Audit Trail).

Variations Discovered from the Negative Case Data

The participant who was classified as normal weight had two obvious differences when comparing her raw data to the other nine women. First, she stated that God has blessed her to be able to maintain her active functional status even though she was classified as an older adult. She also referenced the fact that many older adults were very dependent on others for their ADLs and IADLs. The following quotes illustrated the normal weight participant's perception of her friends, who were overweight older adult,

"I have friends who can't even bend over to pick up (things) and I use to you know they say...and my nickname is "tiny" and they'll say will you pick that up

for me, I use to say they are using me. Then I thought about it, no they not using me. God has given me the strength where I can move and I'm grateful that I am able to stoop, bend cause I know they wish they could, you know. I'm being honest and they are younger than I am and they can't do it (bend). It is sad, it's really sad. I look at all of them that can't even bend down. They gain so much weight. That's bad" (Client 007-A).

The normal weight participant also stated,

"The only problem is all they [her overweight friends] do is sit and demand children to go get this for me, go get that for me, hand me that instead of getting up and do some exercise, walk, get out and give some free time or do something to help themselves because ah automatically when they get older they not gonna do nothing but sit and people, people should not come...people and your children and your family don't make them[older adults] invalid before time. If they can move, let em [them]move or if you hear them, sometimes you got to act like you don't hear them so that they will get up and move. I find that it's better for an older person to live by themselves unless they are really, really ill. Because if they live by themselves, nobody's there to hand them nothing. And when you have...you send your grandchildren or somebody there, they [older adults] not gonna move, they not gonna move. And I feel I might get in that stage now you know if somebody was here but nobody's here to move for me and I like that. I really like it. I could get in that stage very, very [easy] and in Alabama we got too many grandchildren, too many people waiting on them [older adults] and they could move and do things for themselves" (Client 007-A).

Secondly, the normal weight participant talked about her past enrollment in some college physical education courses. The information she gained from these college courses more than likely gave her an advantage over the other nine women because she was conscious of the benefits obtained from physical activity. She stated,

“I just never could see myself; I never believe I could ever get in that position specially in the field of physical education. couldn’t, I couldn’t [see herself as overweight]... that was the field I was in when I was at ah went to[an Alabama university] that’s what I was majoring in physical education. Yeah my daughter had got a little chubby and ah when she see me I would say such and such a thang [thing] and she says to me momma everybody can’t be small (laughing). So, I shut my mouth. Not that I be criticizing you know somebody in the family gain a little weight, I’m very sensitive to it” (Client 007-A).

Interpretation of Findings Based on Research Questions

The following five research questions were revisited:

1. What is the lived experience of being overweight or obese for southern AA older women?
2. What are southern AA older women’s perceptions of overweight, obesity, and physical activity?
3. How has being overweight or obese impacted functional status and life-space mobility in southern AA older women?
4. What factors, events, situations, or persons influence overweight or obese southern AA older women to engage or not to engage in regular physical activity?

5. What “emic” term(s) do southern AA older women who are overweight or obese use to describe the concept “motivation” concerning intent to participate in regular physical activity?

This section is organized by the six analytical sub-theme categories as they are related directly to each of the above research questions:

1. Impact of health conditions (Research Question 1)
2. Beliefs and attitudes (Research Question 2)
3. Preservation of function and mobility (Research Question 3)
4. Responsibility for controlling health and weight (Research Question 4)
5. Understanding of beneficial activities and treatments (Research Question 4)
6. Motivation and desire (Research Question 5)

Research Question 1:

The first research question sought to describe and examine how southern AA older women who are overweight or obese defined their lives as they lived and experienced it on a daily basis. The meta-theme “impact of health conditions” addressed the first research question. The women indicated that health conditions, usually chronic conditions, were the major factors that influenced the quality of their lives. The top two diagnoses among the participants were hypertension ($n = 9$) and arthritis ($n = 6$). The majority of the women provided significant statements that were related to pain, its impact on daily activities, and pain management strategies. Although arthritis was the most frequently cited pain related diagnosis, poor circulation, leg cramps, ruptured disc, and gout were also mentioned as being problematic for some of the women. These

participants attempted various pain management strategies to counteract the pain, such as corticosteroid injections, joint (hip, knee, and neck) surgery, and pain medication (oral and topical). Although the participants of this study cited various chronic health conditions that affected their ability to function in their daily lives, these women understood and acknowledged that it was important for them to engage in regular physical activity in spite of pain and existing chronic health conditions.

Research Question 2:

The second research question sought to describe and examine southern AA older women's perceptions of overweight, obesity, and physical activity. The meta-theme "beliefs and attitudes" answered the second research question. There was no consensus on how to define or to differentiate the terms overweight and obesity. The majority of the women stated that there was no difference between the two terms and they frequently used the terms interchangeably during the interviews. The word "overweight" was most often defined as "fat" and the term "obese" was defined in phrases that alluded to morbid obesity. Several of the women referred to popular extreme weight-makeover television programs (i.e., *The Biggest Loser*) that highlighted morbidly obese contestants who were subjected to intense diet and exercise modifications. The majority of the participants perceived the people on these types of television programs to be the typical representation for obesity.

When the participants were asked about physical activity, the majority of the women perceived physical activity to be the same as exercise and they often used these two terms interchangeably. All of the participants described usual daily activities that

involved the movement of all their extremities, such as jogging, walking, household chores, climbing stairs, raking leaves, and watering plants as exercise or physical activity.

All of the women acknowledged that being overweight or obese was an unhealthy condition that interfered with self-care, social encounters, and ADLs. Although seven of the women were classified as obese, the majority of the women made negative comments about people being classified as overweight or obese. One participant stated in part that “obese people [morbidly obese] do not look human”. Two participants referred to the fact that obese people have difficulty with transportation. For instance, they must purchase two airline tickets [for two seats] to travel by plane and this exposes obese people to discrimination. Although the participants recognized obesity as a preventable condition that has various degrees of severity, there was an overarching view that obesity is a serious public health issue and people must be accountable for their own health. In addition, all of the participants valued a healthy weight status but the majority of the women’s perceptions of a healthy weight were not congruent with the health care community’s standards of a healthy weight. In regards to being classified as underweight, there was only one woman who stated she would love to be “skinny” whereas, the majority of the other women frequently stated that being underweight was an unhealthy state.

Research Question 3

The third research question sought to describe and examine how being overweight or obese impacted functional status and life space mobility in southern AA older women. The meta-theme “preservation of function and mobility” provided an explanation to this research question. Although the majority of the women ($n = 8$) lived alone, all of the

women expressed value in maintaining independence which encompassed ambulation, self-care activities, and physical activity. Several of the participants were unable to walk or stand for long periods, seven of the women used assistive devices to ambulate, and they all recognized that mobility tends to decrease with age. Furthermore, all of the women acknowledged that being overweight or obese negatively influenced a person's ability to ambulate and to perform activities of daily living while decreasing the person's endurance and overall mobility. All of the participants verbalized the importance of sustaining their mobility and functional status because they did not want to lose their independence and they did not want to increase age-related declines in their physical health. In addition, the women that used assistive devices or that experienced more musculoskeletal problems expressed more frustration with their declines in functional status. However, despite pain or the age-related declines, all of the participants expressed the need to persevere and maintain or improve their current functional and mobility statuses.

Research Question 4

The fourth research question sought to describe and examine what factors, events, situations, or persons influenced overweight or obese southern AA older women to engage or not engage in regular physical activity. Two meta-themes "responsibility for controlling health and weight", and "understanding of beneficial activities and treatments" answered research question 4. A common belief among all of the participants was that it was important for people, especially older adult women, to seek and adhere to medical advice from their healthcare providers. Actually, women viewed

such advice as a strategy to control one's health and weight status. In fact, all of the women acknowledged that if they would follow or would have strictly followed medical advice, their current health and weight status would be improved and healthier. Lastly, women perceived normal weight as healthier because they usually have better mobility and endurance.

Even though 70% of the women were classified as obese, having the label of obesity appeared to have more of a negative connotation than the actual numerical weight value. All of the women were able to discuss weight management strategies to monitor and to lose weight. Most of the women believed that looking at one's own reflection in the mirror was a good way to monitor weight status and a few of the women stated that they used the comfort of their clothing to gauge weight status. Even though the women recognized that being obese was a challenging and complex condition to overcome, they all realized that obese persons must take an active role in reducing their own obesity status.

Independence was valued among all the women and it played a vital role in controlling their health and weight status. Thus, dependence on others for assistance was considered unacceptable and it had a disheartening undertone associated with it even though many of the women believed that dependence was inevitable with advancing age. The participants also recognized that an inadequate energy level was a barrier to monitoring one's health and weight status and performing regular physical activity. Knowledge of physical activity benefits did not usually motivate the women in this study to perform activities on a regular basis.

Although every woman acknowledged that engaging regular physical activity was essential for good physical and mental health, there was no consensus on exactly what regular physical activity encompassed. The women were not able to differentiate completely between the meanings of physical activity, exercise, and physical therapy; specifically, they used the terms physical activity and exercise interchangeably. This lack of understanding may be a barrier to engaging in these behaviors because the term “exercise”, among the majority of these women, appeared to have a negative undertone for them. The participants also recognized that inactivity was a barrier to good health in that it promoted obesity, functional decline, and decreased mobility. Even though the women in this study understood the benefits of participating in regular physical activity, most of them did not perform physical activity on a consistent basis. However, there was an overall agreement among the women that engaging in any type of regular physical activity was beneficial to one’s overall health.

Research Question 5

The fifth research question sought to describe and examine what “emic” term(s) do overweight or obese southern AA older women use to describe the concept of “motivation” and the intent to participate in regular physical activity. The meta-theme “Control over Health Choices” answered this question. The researcher attempted to gain insight to the research question by using the following interview question. The women were specifically asked, “*How best can I help motivate other older African American women to engage in regular physical activity behaviors?*” Although the participants were not able to provide a single term or two to illustrate motivation, they were able to

provide an array of responses that ranged from self-motivation to outside influences, such as family members or friends and motivation is dependent on the participant's likes and dislikes. To illustrate inside (self) motivation, several women stated that one's own health and the potential for increased longevity should be self-motivating factors to engage in regular physical activity because good health and long life are valued among the older adults. Another woman stated that one's appearance should self motivate people to participate in regular physical activity, where as others indicated that feeling of well-being, such as extremities are limber, blood pressure is decreased, weight loss occurred, and decreased stress and depression should motivate participation.

External motivating factors appeared to be more prevalent among the women. Several women recognized that physically active peers could serve as role models or motivators to adopt healthier lifestyle behaviors. Three participants who were not classified as obese all suggested themselves to function as role models for others because they do engage in regular physical activity. All of the obese women stated that they have family members or friends who constantly encourage them to engage in physical activity but the desire to engage in physical activity is impacted by factors out of their control, such as decreased energy level and functional status. For example, several of the women expressed a desire to perform physically at a previously higher level but the reality is that their desire is incongruent with their body's ability to function because of age-related changes. As some of the women spoke about their functional decline, it was painfully obvious that they yearned and missed the days when they were able to function without any restrictions. Whereas some others have the ability to participate in regular physical activity, but the desire is not strong enough to motive engagement.

Summary

This chapter described the sociodemographic characteristics of the participants. The second section of this chapter presented the six meta-themes with the corresponding sub themes that emerged from the qualitative analysis. Participant direct quotes from participants in the study were provided to enhance and illustrate the meaning of the meta-themes and sub-themes. Finally, the third section of this chapter provided detailed interpretations of the study findings and linked the interpretations of the meta-themes to the five research questions.

CHAPTER 5

DISCUSSION, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to examine and describe the lived experience of overweight and obese southern AA older women and how these conditions impact functional status, mobility, and physical activity. Bloomberg and Volpe (2007) stated that qualitative research does not seek to find a single causal relationship, to make predictions, or to generalize. However, the goal is to respect, to connect, and to provide a rich, in depth account of the participant's experiences and activities related to a particular phenomenon. Moreover, the researcher is responsible to explain, interpret, and provide new insights that emerged from the data and this was accomplished through qualitative analysis. The participants of this study provided rich data regarding their lived experiences of overweight and obesity statuses. From the data analysis, six sub-themes emerged. This chapter presented the following: (a) a discussion of the six meta-themes, (b) conclusions, (c) implications, and (d) recommendations for future research.

Discussion Based on the Six Meta-themes

The six meta themes were discussed based on the following three levels adapted from Bloomberg and Volpe (2007): (a) What is the meaning of each finding?, (b) Is there a connection between each finding?, and (c) Are there any similarities and differences between the participants?

What is the Meaning of Each Finding

Responsibility for Controlling Health and Weight

The women of this study assumed accountability for their current health status, including their weight, which is consistent with findings from a study conducted by Brown, Thompson, Tod, and Jones (2006). Brown et al. explored the experiences and perceptions of 28 obese participants with varied ages, backgrounds, and obesity levels and found similar results in that the participants possessed a strong sense of ownership and accountability for their weight status. Moreover, to obtain and maintain good health, participants must value and adhere to advice from their healthcare providers. Young and Cochrane (2004) stated that healthy aging among older women with impairments or diseases is imperative because they have an increased life expectancy compared to their male counterpart and older women are more likely to seek health promotion behaviors in an effort to manage their health and weight status. Similarly, women in the current study participated in health promotion and health maintenance activities in an effort to preserve and control their current health status.

Troutman, Nies, and Mavellia (2011) examined the perceptions of successful aging, which involved health among 99 older AA adults. They found that their sample consisted of more educated women (37.4% graduated high school and 30.3% attended college) who were married or widowed, with an income sufficient enough to live comfortable and were more likely to report their health as good. Women in the current study were slightly different in that they tended to be widowed or divorced, have an income less than \$11,999 a year, attended or graduated high school, and although they

were more likely to perceive their health as good, they had a myriad of chronic health conditions.

In the current study, it was evident that good health was valued because all of the women described the importance of keeping scheduled wellness visits with a healthcare provider and adhering to prescribed medication regimens even if they did not completely follow all of the healthcare advice. In fact, older adults who participate in health promotion activities, such as health screenings and disease management are more likely to improve and maintain quality health (Nelson, 2010). Although there were differences in the educational levels, income, and marital status between the current study sample and the study sample by Nelson, both groups tended to self-rate their health as good.

Preservation of Function and Mobility

All of the women in this study appreciated and realized the importance of being able to function independently and to maintain or improve their current mobility status. This discovery is closely related to self-care, which is a similar finding by Troutman et al. (2011). They also found that older AA participants in their study often identified being able to take care of oneself, to work, and to live independently as essential components that must be safeguarded and preserved for successful aging (Troutman, Nies, & Mavellia, 2011). The meta-theme, preservation of function and mobility, is similar to the tenant of the functional consequences theory, that “assumes that quality of life is integrated with functional capacity and dependency needs and that positive consequences are possible despite age-related limitations” (Lange & Grossman, 2010, p. 66). Although

the majority of the women in the current study used assistive devices, independence with ADLs and daily routine tasks influenced their quality of life perceptions.

Beliefs and attitudes

None of the participants in the current study had a favorable response to the term “obese”; even the participants who were not classified as obese voiced strong disdain for the term. In a study that examined the perception of obesity among 17 AA and 13 EA women whose ages ranged from 21 to 67 had similar findings (Thomas, Moseley, Stallings, Nichols-English, & Wagner, 2008). Although several themes emerged from their study, the participants expressed dislike for the word “obese”. To illustrate the intensity for disdain of the term, one of their participants stated that she changed doctors when she was diagnosed as obese. Similarly, although participants in another study lacked a complete understanding of the clinical definition for the term “obese”, these participants viewed the term “obese” as negative and an emotionally charged word (Ward, Gray, & Paranjape, 2009)

Unlike the participants in the study by Ward et al. (2009), several of the women in the current study referred to height and weight measurement charts to determine the “normality” of their weight status. In addition, the participants in the study by Ward et al. considered the word “obesity” to be discriminatory because obese people were perceived as lazy and eating constantly throughout the day. Similarly, none of the women in the current study, regardless of their weight classification, wanted to be classified as obese. Interestingly, several of the current participants perceived “obesity” to be what is clinically defined as morbid obesity and they cited examples of obese

persons depicted in extreme weight loss programs on television. Moreover, some of the women in the current study who were classified as obese also used the term “lazy” to describe the behavior of obese persons but seldom was the word “lazy” used to describe their own behavior.

Making positive changes in health behaviors can also be rooted in an individual’s perceptions and beliefs as this detail was illustrated in a qualitative study of 62 obese AA women (Befort, Thomas, Daley, Rhode, & Ahluwalia, 2008). Similar to other studies (Loeb, 2004; Thomas et al., 2008; Young et al., 2001), researchers found that perceptions of health concerns and social support were motivators for weight loss; but a negative perception of body image may also play an encouraging role to initiate behavior changes. Conversely, one study found that overweight people who inaccurately perceive themselves as being normal weight might not be motivated to adopt healthier behaviors (Schuler et al., 2008). Moreover, Thomas et al. (2008) found that AA women were likely to disagree with published BMI charts and they tended to be satisfied with their larger size when compared to their EA counterparts. In the current study, the participants who were found to be obese based on their BMI weighed 200 pounds or more. Thus, one might expect these women to have poor body images because popular societal norms attribute beauty to slender body types. However, several of the women classified as obese had positive body images and indicated that they “still looked good”.

Impact of health conditions

Women in the current study realized and understood that obesity and its long-term effects can be devastating to one’s overall health. Obesity can lead to many serious

health conditions such as hypertension, diabetes, heart disease, arthritis, lower quality of life, and stroke (American Obesity Association, 2005; Centers for Disease Control and Prevention, 2009). Despite this knowledge, AA are less likely to make modifications in their health behaviors until it is too late to prevent obesity related diseases (Coward et al., 2010). Coward et al. also found that 87% of their participants' clinical data classified them as overweight or obese but only 16% of the participants acknowledged that obesity was a medical health problem. Their findings suggest that the participants did not have a problem with being classified as obese, thereby making them more vulnerable to obesity-related illnesses that could have a harmful impact on their future health.

In contrast, all of the participants of the current study acknowledged that obesity was a serious health condition that needed to be addressed and they most frequently cited mobility problems as a negative consequence of obesity. In addition, the majority of the women had two or more chronic illnesses, which affected their mobility status and complicated their weight management status. This finding is similar to a study by McDonald et al., 2010 who examined the functional status of 16 AA and 46 EA older adults and found that the greater the number of chronic illnesses a person had, the poorer their functional status. Therefore, the healthcare community must be more aggressive in the fight against obesity by encouraging southern AA older adults to engage in regular physical activity that is consistent with the interests and functional capabilities (Newman, 2009).

Control over Health Choices

Motivation and desire are inward feelings that can drive a person to act in a particular way (Loeb, 2004; Ryan & Deci, 2000). A person's emotions or feelings at a given point in time will determine whether an activity will be performed. Furchtgott (1999) argued that some older adults do not have the desire to achieve or maintain health promotion behaviors because of lifelong habits that are difficult to change. However, there is growing evidence that older adults can successfully adopt healthier lifestyle behaviors with the appropriate motivation (Dacey et al., 2008; Newsom et al., 2004). There are two main forms of motivation, intrinsic and extrinsic. According to Ryan and Deci (2000), intrinsic motivation is the instinctive predisposition of a person to investigate and explore one's own ability to be creative, unique, and resourceful when it comes to learning and meeting challenges. Although humans are born with intrinsic motivation, Ryan and Deci reasoned that this natural tendency must be supported in order for it to be sustained. In contrast, extrinsic motivation is the drive or desire a person may have to perform a task or an activity in order to obtain an outside reward (Ryan & Deci, 2000). In other words, intrinsic motivation involves the drive, desire, or emotions within a person to achieve a particular goal, whereas extrinsic motivation is the outside event that causes a person to act (Ferguson, 2000).

Dacey et al. (2008) examined internal and external motivation in older adults as it related to physical activity. There were 645 adults in the study and the participants were primarily white, married females, who self-rated their health as excellent. These researchers found that increased intrinsic and extrinsic motivation positively corresponded with increased physical activity. Although age and gender for this study is

comparable to the targeted population, only 5% were minorities (Dacey et al.).

Moreover, findings from this study suggest that it is important to examine the role that intrinsic and extrinsic motivation play in older AA women's choice to adopt healthier lifestyle behaviors. Similarly, it was apparent that the majority of the women had a desire to make healthier lifestyle choices, such as engaging in regular physical activity, but a lack of external factors, such as no transportation or no peers with whom to exercise were barriers.

When participants of the current study were specifically asked, "How best can I help motivate other older AA women to engage in regular physical activity behaviors?", the most commonly cited response was related to good mental or physical health. This finding related to the health benefits of regular physical activity are supported by other studies (Bopp et al., 2007; Dunn, 2008). The second frequently quoted responses were, "role modeling or support from peers" and "healthcare provider encouragement". Bopp et al. reported similar findings that their participants indicated having social support from friends and family members and a competent and knowledgeable physical activity leader could serve as an enabler or motivator to increase physical activity. Fallon, Wilcox, and Laken (2007) found that healthcare providers tended to promote health behavior changes based on the presence of a chronic health condition. Moreover, in this sample of 407 women and 165 men ($n = 572$) whose ages ranged from 18-102, only 47% of the participants reported that healthcare providers would recommend physical activity and just 39% received advice for achieving a healthy weight. Interestingly, many of the women believed that if healthcare providers would just "tell" this population the importance and benefits of regular physical activity, the women of this age group would

adhere to the advice (Fallon, Wilcox, & Laken, 2006). However, it is apparent from the sample in the current study that knowledge does not always translate into behavior for everyone.

Finally, for the women in the current study, an important motivator to increase participation in regular physical activity was the resulting positive health outcomes, such as living longer, weight loss, and socialization. Many of the women believed that if older AA obese women were informed that engaging in regular physical activity would promote longevity, this would increase physical activity participation and thereby lead to attaining a healthy weight. Several women expressed the need to have a partner or access to a place where they could participate in age appropriate activities of interest as strategies to increase physical activity as well as to promote socialization and consistency.

Understanding of Beneficial Activities and Treatments

All of the women in the current study, despite their health conditions or level of participation, reported that they should perform physical activity on a consistent basis. Physical activity is essential for improving overall quality health, obesity management, and a sense of well-being among older adults (Kennedy, Malabu, Kazi, & Shahsidhar, 2008). Several women in the current study expressed that engaging in physical activity or exercise would improve mental status, mobility, social interaction, and weight status. These findings are consistent with previous research in which participants reported that physical activity promotes positive outcome expectations, that include improvements in

brain health, mental health, blood circulation, companionship, and weight management (Mathews et al., 2010).

Linkages Between Meta-Themes and Sub-Themes

The overarching theme or thread that connected the six meta-themes and sub-themes was the notion that the women wanted and valued a good quality of life. Quality of life is defined as an intricate, multidimensional, subjective appraisal of an individual's existing life circumstances and satisfaction as it relates to a person's well-being, culture, values, and psychosocial and spiritual dimensions (Haas, 1999; Hardin, 2010). In other words, quality of life is a nonspecific label that encompasses contentment with the physical and psychosocial elements of an individual's life. All of the women in the current study lived in the community; the majority of them lived alone ($n = 8$), and they commonly expressed their need to be able to function independently with no or little outside assistance. In a similar study, researchers found that older people were motivated to participate in physical activity because of fear that they may lose their independence or develop health conditions that may decrease their quality of life and overall well-being (Korkiakangas et al., 2011). In the current study, although none of the women expressed end-of-life issues or concerns, they all wanted to live the rest of their lives with as much quality as they could.

Similarities and Differences Among Participants

Overall, there were more similarities that emerged than differences among the participants. All of the women assumed personal ownership for the status of their current health and weight status. Nine of the participants had at least one diagnosed chronic

condition that required prescription medication to manage. One participant sought medical treatment years ago for a musculoskeletal disease but managed her condition with over-the-counter medications or home remedies. In other words, all of the women believed that they were accountable for their current health status.

Although the majority of the women were classified as obese, they all acknowledged that being obese was not healthy and that it could lead to other health problems. Several of the women ($n = 7$) did not perceive themselves as obese even after being informed of their calculated BMI; they also expressed disapproval for the term “obesity” because of its negative connotation. Interestingly, only two of the women desired to be “skinny”, while the others believed that their current body looked good regardless of their overweight or obese status.

Another similarity across all the participants was their inability to distinguish between the definitions for the terms “physical activity” and “exercise”. They would name different activities to illustrate their understanding of the terms but no one was able to give a definition or explanation of either term. Each participant recognized that physical activity was an important component of maintaining good physical and mental health. However, the participants who were classified as obese mentioned more perceived barriers to engaging in regular physical activity than the other women.

As expected, the normal weight participant (the negative case) displayed some different behaviors in regard to physical activity from the other women in the study. She was extremely active and although she stated that she had never been classified as obese, she voiced many of the same concerns related to obesity and its influence on a person’s

health as the other women. She was adamant about encouraging others to increase their physical activity and about maintaining her current health and weight status.

Implications for Healthcare Research

Findings from this study have several implications for healthcare research. There is limited research that focuses on southern AA older women, their perceptions of obesity, and the impact of being overweight or obese on their functional status, mobility, and physical activity engagement. An essential implication for healthcare research is related to the terminology used when addressing physical activity with southern AA older adults. First, findings from this study suggest that there is some confusion on the difference between physical activity and exercise. Furthermore, the term “exercise” evoked negative images and fears of inability to perform which was similar to what Tudor-Locke et al (2003) described when they examined the definitions and interpretations of physical activity among 30 AA and 26 American Indian women. Tudor-Locke et al. found that the term “exercise” was frequently perceived to be negative and it created a sense of resistance in relation to incorporating exercise in their lives. Therefore, the healthcare community may need to eliminate the term “exercise” when trying to get this segment of the population to increase their physical activity.

Second, healthcare providers must carefully consider perceived or real barriers when counseling older patients with functional limitations about increasing their physical activity (Mathews et al., 2010). Several of the women in the current study mentioned transportation, lack of access to physical activity programs exclusively aimed at older adults, and use of assistive devices as barriers to engaging in regular physical activity. Furthermore, all of the participants stated that they sought or used healthcare advice

related to their health and weight status but the frequency and the extent of the medical advice was not clear.

A third implication is the need for researchers to develop and design culturally, age-appropriate, cost-efficient interventions. The results of this study support the fact that this group is financially disadvantaged and therefore low-cost interventions must be considered to accommodate the southern AA older adult's lifestyle while simultaneously fitting their financial means. Mathews et al. (2010) found similar results in that older AA adults in their study often had a lower income and frequently cited financial cost as an obstacle to engaging in physical activity. This issue may be addressed by collaborating with AA community churches in an effort to design culturally appropriate physical activity programs for older AA adults.

Implications for Practice

With the continuous growth of the older adult population and the growing national obesity rate, it is imperative that the healthcare community, political organizations, and society as a whole seek cost-effective methods and strategies needed to increase quality of life, decrease obesity rate, and to preserve independence among this population (Hirvensalo et al., 2005; Kumanyika et al., 2005; Yancey et al., 2006).

Healthy People 2010 challenged individuals and the public as a whole to promote increasing the years of healthy, quality of life for all people. In order to promote and increase successful aging, society and healthcare professions are required to have a positive attitude towards aging (Lehman & Poindexter, 2010). Results from the current study suggested that healthcare providers play an important role in patients' lives and as

such should be cognizant of the physical activity advice they provide to older adults in order to prevent inadvertently discouraging them from needed behavior changes (Hirvensalo et al., 2005).

Understanding the shared perspectives of overweight or obese southern AA older women and how these conditions affect their functional status, mobility, and physical activity are essential for healthcare practice and research. Findings from the present study suggest that age suitable, culturally appropriate, and interesting interventions are needed to promote regular physical activity among southern AA older women. Because of the low-income class of the current population, healthcare providers need to provide individualized care planning to increase physical activity that is easily accessible, affordable, or free of cost.

Limitations

A few limitations of this study should be noted. First, the sample for this study was obtained using convenience, purposeful sampling techniques. Secondly, the sample's sociodemographic characteristics showed that almost all of the women were at or below the national poverty level. Educationally, the majority of the women only obtained a high school diploma or less; only one participant obtained an associate degree. Third, because the sample was only comprised of southern AA older women, the findings of this qualitative study cannot be generalized to populations of other minorities or other geographical regions of the country.

Another limitation of the study was the inclusion of only one negative case, who was classified as normal weight. The normal weight participant engaged in regular

physical activity and her responses regarding physical activity, mobility, and functional ability were in extreme opposition to the other nine participants. It is unclear whether other normal weight southern AA older women would have similar results. The study could have been enhanced if there were an even number of participants from three weight categories: normal, overweight, and obese. A fifth limitation is that the researcher did not perform a member check or return to the participants to discuss, validate, or obtain feedback about the qualitative findings and interpretations.

Strengths

This study was conducted and documented in such a manner that other qualitative researchers may decide if the research context or findings of this study are pertinent to other cases or studies with similar conditions (Bloomberg & Volpe, 2008; Schwandt, 2007). The findings from this study may lead to the development of culturally appropriate interventions to promote regular engagement in physical activity among southern AA older women. For example, the healthcare community could develop partnerships with local churches or neighborhood associations that have transportation and access to community centers, which could offer affordable age appropriate physical activity programs. In addition, use of the term “physical activity” instead of the term “exercise” is imperative for the healthcare community to remember when working with this population. More education on the therapeutic levels of physical activity for older adults is needed for healthcare providers and patients. With this knowledge, southern AA older women could increase their physical activity levels to meet the recommended requirements set by the U.S. Department of Health and Human Services (2008) “Physical

Activity Guidelines for Americans”. While the health benefits of regular physical activity are well documented, knowledge or awareness of this activity does not translate into behavior change or action to change in people, especially AAs (Robinson & Wicks, 2010).

All of the women verbalized that physical activity was important to good mental and physical health but knowledge and awareness of benefits of physical activity were not enough to promote an increase in physical activity. Being overweight and obese are major risk factors for many health conditions; therefore, it is imperative that healthcare providers counsel older AA adults to engage in regular physical activity in order to prevent or manage overall health (Fallon et al., 2006). Thus, healthcare providers need to be more diligent in advising southern AA older women to engage in physical activity, to develop a specific physical activity routine based on participants’ health status, and to follow up on the women’s adherence to the healthcare advice.

Recommendations for Future Research

Reducing or eliminating sedentary lifestyles among southern older AA women, especially women who are classified as overweight or obese continues to be a major public health concern that needs further research (Alabama Center for Health Statistics, 2007). The state of Alabama is located within the Bible Belt, which encompasses the southeastern parts of the U.S. and religion is valued (Vazsonyi & Jenkins, 2010).

Religion is a fundamental component of AA culture (Robinson & Wicks) and many of the women in this study highlighted the importance of their religion and spiritual life by referring to God and the church several times during their interviews. Because AA

women are more likely to attend church and less likely to be physically active (Robinson & Wicks, 2010), future research may focus on implementing age appropriate physical activity programs in neighborhood churches with peer leaders or role models in each facility.

Future research is also needed to examine healthcare provider's beliefs and attitudes regarding regular physical activity counseling to older adults, especially AA women. The majority of the women in the current study stated that healthcare providers encouraged them to participate in physical activity, but there was no clear indication of the frequency, duration, or amount of physical activity that was needed in order to be therapeutic. In other words, there was no indication that the healthcare provider considered an individualized care for the participant based on her functional ability and financial status.

In slight contrast, Hirvensalo, Heikkinen, Lintunen, and Rantanen (2005) conducted a study with 580 older adults whose ages ranged from 73-92 in order to describe whether healthcare providers warned against or recommended physical activity. These researchers found that 77% of the older adult participants received either no encouragement (9%), conflicting encouragement (34%) or did not recall receiving any encouragement (34%) concerning physical activity engagement from their healthcare providers. Only 23% of the participants received exclusive encouragement from their healthcare providers to engage in physical activity. They also found that sedentary older adults were less likely to recall physical activity advice from their healthcare provider. These findings suggest the need to incorporate direct observation in future studies in

order to gain firsthand knowledge of instructions provided to older adults regarding physical activity.

Future research is needed for the development and evaluation of age-appropriate and cost-efficient interventions that are interesting to southern AA older women. Many of the women in this current study indicated that they would engage in activity that was more physical if there were resources (transportation, safe environment, role models) available in their communities that would accommodate them.

The performance of a mixed-method pilot study with a different population of overweight or obese southern AA older adults would increase trustworthiness of this qualitative study. The inclusion of age appropriate physical activity interventions with future participants is fundamental for older adults. The women in the current study suggested that physical activity interventions should be available in their local, safe neighborhoods in order to increase participation. The results may be used to assist healthcare providers with prescribing therapeutic and suitable physical activity counseling for southern AA older women who are obese or overweight.

Conclusion

Physical activity is vital for everyone (U.S. Department of Health and Human Services, 2008). All of the women in the current study acknowledged that being overweight or obese could negatively influence one's functional status, mobility, and physical activity level. Engaging in regular physical activity was commonly reported by the current participants to be a beneficial activity for overall health and well-being but many of the women identified several physical and psychosocial barriers, such as no

energy, no partner, lower extremity pain, use of assistive devices, and lack of access to an age appropriate physical activity place. Phillips et al.,(2004) found that barriers to older adults adopting and maintaining regular physical activity or exercise included fear of potential injury, lack of an exercise partner, unsafe environments, and current morbidities. These findings are similar to barriers identified by Belza, et al., (2004) such as health concerns, environmental factors (transportation), and the need for culturally appropriate exercise facilities. Moreover, a study by Newsom et al. (2004) found that 44.6% of older adults in the sample stated no willpower as the most frequent barrier, 19% stated disability reasons, and 13% stated not enough time to devote to making healthy behavior changes.

In summary, the current study found three points to consider. First, the words “obese” and “exercise” should not be used with this group of overweight or obese southern AA older women, especially when promoting physical activity. Second, although these women were aware of the advantages to engage in regular physical activities, they wanted safe, culturally-and age-appropriate resources made available to them in their neighborhoods. Finally, it was apparent that if the healthcare provider was respectful and gave compassionate care, the majority of women were more likely to attempt to adhere to the medical advice offered. Therefore, healthcare providers should be consistently more instrumental in promoting appropriate regular physical activity for this group.

References

- Administration on Aging. (2010a). *Aging statistics*. Washington, DC: Department of Health & Human Services Retrieved from http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx.
- Administration on Aging. (2010b). *A statistical profile of Black older Americans aged 65+*. Washington, DC: Department of Health and Human Services Retrieved from www.aoa.gov.
- Administration on Aging. (2011). *A profile of older Americans: 2010*. Washington, D.C.: U.S. Department of Health and Human Services Retrieved from http://www.aoa.gov/aoaroot/aging_statistics/Profile/2010/docs/2010profile.pdf.
- Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research*, 9, 407-411. doi: 10.1177/104973239900900309
- Alabama Center for Health Statistics. (2007). *Vital statistics at a glance: Alabama 2006*. Montgomery: Alabama Department of Public Health, Retrieved from www.adph.org/healthstats/assests/ataglace06.pdf.
- Alabama Center for Health Statistics. (2009). *Demographics/Population*. Montgomery: Alabama Department of Public Health Retrieved from <http://www.adph.org/healthstats/Default.asp?id=1516>.
- Alabama Department of Public Health. (2005). *Alabama Obesity Task Force: Strategic plan for the prevention and control of overweight and obesity in Alabama*. Montgomery: Office of Professional and Support Services Retrieved from <http://www.adph.org/contactus.asp?id=464>.

Alabama Department of Public Health. (2007). *Obesity Trends*. Montgomery: Alabama

Department of Public Health Retrieved from

<http://www.adph.org/obesity/Default.asp?id=1983>.

Alabama Department of Public Health. (2011). *Vital statistic at a glance: Alabama 2010*.

Montgomery: Alabama Department of Public Health Retrieved from

<http://www.adph.org/healthstats/assets/AtAGlance2011.pdf>.

American Obesity Association. (2005). AOA fact sheets. Retrieved from

<http://obesity1.tempdomainname.com/subs/fastfacts/aoafactsheets.shtml>

Arcury, T. A., Snively, B. M., Bell, R. A., Smith, S. L., Stafford, J. M., Wetmore-

Arkader, L. K., & Quandt, S. A. (2006). Physical activity among rural older adults

with diabetes. *The Journal of Rural Health*, 22(2), 164-168. doi: 10.1111/j.1748-

0361.2006.00026.x

Arterburn, D. E., Crane, P. K., & Sullivan, S. D. (2004). The coming epidemic of obesity

in elderly Americans. *Journal of the American Geriatrics Society*, 52(11), 1907-

1912. doi: doi:10.1111/j.1532-5415.2004.52517.x

Auslander, W., Haire-Joshu, D., Houston, C., Rhee, C., & Williams, J. H. (2002). A

controlled evaluation of staging dietary patterns to reduce the risk of diabetes in

African American women. *Diabetes Care*, 25, 809-814.

Baker, P. S., Bodner, E. V., & Allman, R. M. (2003). Measuring Life-Space Mobility in

community-dwelling older adults. *Journal of the American Geriatrics Society*,

51(11), 1610-1614. doi: 10.1046/j.1532-5415.2003.51512.x

Befort, C. A., Thomas, J. L., Daley, C. M., Rhode, P. C., & Ahluwalia, J. S. (2008).

Perceptions and beliefs about body size, weight, and weight loss among obese

- African American women: A qualitative inquiry. *Health Education & Behavior*, 35(3), 410-426. doi: 10.1177/1090198106290398
- Bellar, A., Jarosz, P. A., & Bellar, D. (2008). Implications of the biology of weight regulation and obesity on the treatment of obesity. *Journal of the American Academy of Nurse Practitioners*, 20(3), 128-135. doi: 10.1111/j.1745-7599.2007.00299.x
- Belza, B., Walwick, J., Shiu-Thornton, S., Schwartz, S., Taylor, M., & LoGerfo, J. (2004). Older adult perspectives on physical activity and exercise: Voices from multiple cultures. *Preventing Chronic Disease* 1(4), A09.
- Besdine, R. W. (2009). Evaluation of the elderly patient. In R. S. Porter & J. L. Kaplan (Eds.), *The Merck Manuals*. Whitehouse Station, NJ: Merck Sharp & Dohme Corp. Retrieved from [http://www.merckmanuals.com/professional/geriatrics/approach_to_the_geriatric_patient/evaluation_of_the_elderly_patient.html?qt=katz basic ADL&alt=sh](http://www.merckmanuals.com/professional/geriatrics/approach_to_the_geriatric_patient/evaluation_of_the_elderly_patient.html?qt=katz+basic+ADL&alt=sh).
- Blair, S. N., LaMonte, M. J., & Nichaman, M. Z. (2004). The evolution of physical activity recommendations: How much is enough? *The American Journal of Clinical Nutrition*, 79(5), 913S-920S.
- Bloomberg, L. D., & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end*. Los Angeles: Sage Publications.
- Bopp, M., Lattimore, D., Wilcox, S., Laken, M., McClorin, L., Swinton, R., ...Bryant, D. (2007). Understanding physical activity participation in members of an African American church: A qualitative study. *Health Education Research*, 22(6), 815-826. doi: 10.1093/her/cyl149

- Broussard, B. (2005). Women's experiences of bulimia nervosa. *Journal of Advanced Nursing*(49), 43-50.
- Brown, C. J., Roth, D. L., Allman, R. M., Sawyer, P., Ritchie, C. S., & Roseman, J. M. (2009). Trajectories of life-space mobility after hospitalization. *Annals of Internal Medicine*, 150(6), 372-378.
- Brownson, R. C., Eyster, A. A., King, A. C., Brown, D. R., Shyu, Y. L., & Sallis, J. F. (2000). Patterns and correlates of physical activity among US women 40 years and older. *American Journal of Public Health*, 90(2), 264-270. doi: 10.2105/ajph.90.2.264
- Bryant, L. L., Grigsby, J., Swenson, C., Scarbro, S., & Baxter, J. (2007). Chronic pain increases the risk of decreasing physical performance in older adults: The San Luis Valley Health and Aging Study. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 62(9), 989-996.
- Caspersen, C. J., Powell, K. E., & Christenson, G. M. (1985). Physical activity, exercise, and physical fitness: Definitions and distinctions for health-related research. *Public Health Reports*, 100(2), 126-131.
- Centers for Disease Control and Prevention. (1999). *Physical activity and health: A report of the Surgeon General*. Washington,DC: National Center for Chronic Disease Prevention and Health Promotion Retrieved from <http://www.cdc.gov/nccdphp/sgr/index.htm>.
- Centers for Disease Control and Prevention. (2003). Morbidity and Mortality Weekly Report. 52(21), 489-491. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5221a1.htm>

- Centers for Disease Control and Prevention. (2009). *Obesity: Halting the epidemic by making health easier*. Atlanta, GA National Center for Chronic Disease Prevention and Health Promotion Retrieved from <http://www.cdc.gov/chronicdisease/resources/publications/AAG/obesity.htm>.
- Centers for Disease Control and Prevention. (2012). *Adult obesity facts*. Atlanta, GA Retrieved from <http://www.cdc.gov/obesity/data/adult.html>.
- Cohen, M., Kahn, D., & Steeves, R. (2000). How to analyze the data. In M. Cohen, D. Kahn & R. Steeves (Eds.), *Hermeneutic phenomenological research: A practice guide for nurse researchers* (pp. 71-83). Thousand Oaks, CA: Sage Publications.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential phenomenological alternative for psychology* (pp. 48-71). New York: Oxford University Press.
- Conn, V. S., Tripp-Reimer, T., & Maas, M. L. (2003). Older women and exercise: Theory of planned behavior beliefs. *Public Health Nursing*, 20(2), 153-163.
- Cowart, L. W., Biro, D. J., Wasserman, T., Stein, R. F., Reider, L. R., & Brown, B. (2010). Designing and pilot-testing a church-based community program to reduce obesity among African Americans. *Journal of the Association of Black Nursing Faculty*, 21(1), 4-10.
- Dacey, M., Baltzell, A., & Zaichkowsky, L. (2008). Older adults' intrinsic and extrinsic motivation toward physical activity. *American Journal of Health Behavior*, 32(6), 570-582.

- Dombro, M. (2007). Historical and philosophical foundations of qualitative research. In P. Munhall (Ed.), *Nursing Research: A Qualitative Perspective* (4th ed.). Sudbury, MA: Jones and Bartlett.
- Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44(1), 131-142. doi: 10.1016/j.ijnurstu.2005.11.026
- Drayton-Brooks, S., & White, N. (2004). Health promoting behaviors among African American women with faith-based support. *Journal of the Association of Black Nursing Faculty in Higher Education*, 15(5), 84-90.
- Drewnowski, A., & Evans, W. J. (2001). Nutrition, physical activity, and quality of life in older adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 56(suppl 2), 89-94. doi: 10.1093/gerona/56.suppl_2.89
- Dunlop, D. D., Semanik, P., Song, J., Manheim, L. M., Shih, V., & Chang, R. W. (2005). Risk factors for functional decline in older adults with arthritis. *Arthritis & Rheumatism*, 52(4), 1274-1282. doi: 10.1002/art.20968
- Dunn, M. Z. (2008). Psychosocial mediators of a walking intervention among African American women. *Journal of Transcultural Nursing*, 19(1), 40-46. doi: 10.1177/1043659607309138
- Dutton, G. R., Martin, P. D., Welsch, M. A., & Brantley, P. J. (2007). Promoting physical activity for low-income minority women in primary care. *American Journal of Health Behavior*, 31(6), 622-631. doi: 10.5993/ajhb.31.6.7

- Eaves, Y. D. (1997). *Caregiving in rural African American families for elderly stroke survivors. Unpublished doctoral dissertation*. The University of Michigan. Ann Arbor, MI.
- Fallon, E. A., Wilcox, S., & Laken, M. (2006). Health care provider advice for African American adults not meeting health behavior recommendations. *Preventing Chronic Disease*, 3(2), 1-12.
- Ferguson, E. D. (2000). *Motivation: A biosocial and cognitive integration of motivation and emotion*. New York: Oxford University Press.
- Folta, S., Goldberg, J., Lichtenstein, A., Seguin, R., Reed, P., & Nelson, M. (2008). Factors related to cardiovascular disease risk reduction in midlife and older women: A qualitative study. *Preventing Chronic Disease*, 5, 1-9.
- Furchtgott, E. (1999). *Aging and human motivation*. New York: Plenum.
- Gallagher, N. A., Gretebeck, K. A., Robinson, J. C., Torres, E. R., Murphy, S. L., & Martyn, K. K. (2010). Neighborhood factors relevant for walking in older, urban, African American adults. *Journal of Aging & Physical Activity*, 18(1), 99-115.
- Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research*, 14(10), 1429-1452. doi: 10.1177/1049732304270394
- Geelen, R. J. G. M., & Soons, P. H. G. M. (1996). Rehabilitation: An "everyday" motivation model. *Patient Education and Counseling*, 28(1), 69-77.
- Graf, C. (2007). The Lawton Instrumental Activities of Daily Living Scale. *The Hartford Institute for Geriatric Nursing*, 108(4), 1-2. Retrieved from Best practices in nursing care to older adults website:
http://consultgerirn.org/uploads/File/trythis/try_this_23.pdf

- Haas, B. K. (1999). Clarification and integration of similar quality of life concepts. *Journal of Nursing Scholarship*, 31(3), 215-220. doi: 10.1111/j.1547-5069.1999.tb00483.x
- Hamill, C., & Sinclair, H. A. (2010). Bracketing - practical considerations in Husserlian phenomenological research. *Nurse Researcher*, 17(2), 16-24.
- Hardin, S. (2010). Promoting quality of life. In K. Mauk (Ed.), *Gerontological nursing: Competencies for care* (pp. 688-716). Boston: Jones and Bartlett.
- Haskell, W. L., Lee, I.-M., Pate, R. R., Powell, K. E., Blair, S. N., Franklin, B. A., ...Bauman, A. (2007). Physical activity and public health: Updated recommendation for adults from the American College of Sports Medicine and the American Heart Association. *Circulation*, 116(9), 1081-1093. doi: 10.1161/circulationaha.107.185649
- He, W., Sengupta, M., Velkoff, V. A., & DeBarros, K. A. (2005). *65+ in the United States: 2005*. U.S. Department of Commerce: Economics and Statistics Administration Retrieved from <http://www.census.gov/prod/2006pubs/p23-209.pdf>.
- Hirvensalo, M., Heikkinen, E., Lintunen, T., & Rantanen, T. (2005). Recommendations for and warnings against physical activity given to older people by health care professionals. *Preventive Medicine*, 41(1), 342-347. doi: 10.1016/j.ypmed.2004.11.020
- Houston, D. K., Stevens, J., Cai, J., & Morey, M. C. (2005). Role of weight history on functional limitations and disability in late adulthood: The ARIC study. *Obesity*, 13(10), 1793-1802. doi: 10.1038/oby.2005.218

- Imai, K., Gregg, E. W., Chen, Y. J., Zhang, P., de Rekeneire, N., & Williamson, D. F. (2008). The association of BMI with functional status and self-rated health in U.S. adults. *Obesity*, 16(2), 402-408. doi: 10.1038/oby.2007.70
- International Obesity Taskforce. (2002). *The developing world's new burden: Obesity*. International Association for the Study of Obesity Retrieved from <http://www.ietf.org/popout.asp?linkto=http://www.fao.org/FOCUS/E/obesity/obesity1.htm>.
- Jakicic, J. M., & Otto, A. D. (2006). Treatment and prevention of obesity: What is the role of exercise? *Nutrition Reviews*, 64(2), S57-S61.
- Jensen, G. L. (2005). Obesity and functional decline: Epidemiology and geriatric consequences. *Clinics in Geriatric Medicine*, 21, 677-687. doi: 10.1016/j.cger.2005.06.007
- Jensen, G. L., & Hsiao, P. Y. (2010). Obesity in older adults: Relationship to functional limitation. *Current Opinion in Clinical Nutrition and Metabolic Care*, 13, 46-51. doi: 10.1097/MCO.0b013e32833309cf
- Johnson, R. L., & Nies, M. A. (2005). A qualitative perspective of barriers to health-promoting behaviors of African Americans. *Journal of the Association of Black Nursing Faculty in Higher Education*, 16(2), 39-41.
- Kane, R. L., Ouslander, J. G., Abrass, I. B., & Resnick, B. (2009). Immobility. In Author (Ed.), *Essentials of clinical geriatrics* (6th ed.). New York: McGraw- Hill.
- Kennedy, R., Malabu, U., Kazi, M., & Shahsidhar, V. (2008). Management of obesity in the elderly: Too much and too late? *The Journal of Nutrition, Health & Aging*, 12(9), 608-621. doi: 10.1007/bf03008271

- King, D. E., Mainous, A. G., Carnemolla, M., & Everett, C. J. (2009). Adherence to healthy lifestyle habits in U.S. adults, 1988-2006. *The American Journal of Medicine*, 122(6), 528-534. doi: 10.1016/j.amjmed.2008.11.013
- King, W. C., Belle, S. H., Brach, J. S., Simkin-Silverman, L. R., Soska, T., & Kriska, A. M. (2005). Objective measures of neighborhood environment and physical activity in older women. *American Journal of Preventive Medicine*, 28(5), 461-469. doi: 10.1016/j.amepre.2005.02.001
- Kirchhoff, A. C., Elliott, L., Schlichting, J. A., & Chin, M. H. (2008). Strategies for physical activity maintenance in African American women. *American Journal of Health Behavior*, 32(5), 517-524. doi: 10.5555/ajhb.2008.32.5.517
- Kleiman, S. (2004). Phenomenology: To wonder and search for meanings. *Nurse Researcher*, 11(4), 7-19.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21(5), 827-836.
- Korkiakangas, E., Taanila, A. M., & Keinänen-Kiukaanniemi, S. (2011). Motivation to physical activity among adults with high risk of type 2 diabetes who participated in the Oulu substudy of the Finnish Diabetes Prevention Study. *Health & Social Care in the Community*, 19(1), 15-22. doi: 10.1111/j.1365-2524.2010.00942.x
- Koster, A., Bosma, H., Broese van Groenou, M., Kempen, G., Penninx, B., van Eijk, J., & Deeg, D. (2006). Explanations of socioeconomic differences in changes in physical function in older adults: Results from the Longitudinal Aging Study Amsterdam. *Biomed Central Public Health*, 6(1), 244-256.

Kruger, J., Carlson, S. A., & Buchner, D. (2007). How active are older Americans?

Preventing Chronic Disease 4(3), A53.

Kruger, J., Ham, S. A., & Prohaska, T. R. (2009). Behavioral risk factors associated with overweight and obesity among older adults: The 2005 national health interview survey. *Preventing Chronic Disease* 6(1), A14.

Kumanyika, S. K., Shults, J., Fassbender, J., Whitt, M. C., Brake, V., Kallan, M. J., ...Bowman, M. A. (2005). Outpatient weight management in African-Americans: the Healthy Eating and Lifestyle Program (HELP) study. *Preventive Medicine*, 41(2), 488-502.

Lang, I. A., Llewellyn, D. J., Alexander, K., & Melzer, D. (2008). Obesity, physical function, and mortality in older adults. *Journal of the American Geriatrics Society*, 56(8), 1474-1478. doi: 10.1111/j.1532-5415.2008.01813.x

Lange, J., & Grossman, S. (2010). Theories of aging. In K. Mauk (Ed.), *Gerontological nursing competencies for care* (pp. 50-73). Boston: Jones and Bartlett.

Lauer, Q. (1965). *Phenomenology: Its genesis and prospect*. New York: Harper and Row.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological consideration. *International Institute of Qualitative Methodology*, 2, 1-29.

Lehman, C., & Poindexter, A. (2010). The aging population. In K. Mauk (Ed.), *Gerontological nursing competencies for care* (pp. 26-49). Boston: Jones and Bartlett

LeVasseur, J. J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research*, 13(3), 408-420. doi: 10.1177/1049732302250337

- Loeb, S. J. (2004). Older men's health: Motivation, self-ratings, and behaviors. *Nursing Research*, 53(3), 198-206.
- Makhija, S. K., Gilbert, G. H., Clay, O. J., Matthews, J. C., Sawyer, P., & Allman, R. M. (2011). Oral health-related quality of life and life-space mobility in community-dwelling older adults. *Journal of the American Geriatrics Society*, 59(3), 512-518. doi: 10.1111/j.1532-5415.2010.03306.x
- Marshall, C., & Rossman, G. (2006). *Designing qualitative research* (4th ed ed.). Thousand Oaks: Sage.
- Mathews, A. E., Laditka, S. B., Laditka, J. N., Wilcox, S., Corwin, S. J., Liu, R., ...Logsdon, R. G. (2010). Older adults' perceived physical activity enablers and barriers: A multicultural perspective. *Journal of Aging & Physical Activity*, 18(2), 119-140.
- McAuley, E., Konopack, J. F., Morris, K. S., Motl, R. W., Hu, L., Doerksen, S. E., & Rosengren, K. (2006). Physical activity and functional limitations in older women: Influence of self-efficacy. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 61(5), P270-P277.
- McDonald, P. E., Zauszniewski, J. A., Harvey, K. H., & Bekhet, A. K. (2010). Cultural comparison of chronic conditions, functional status, and acceptance in older African-American and white adults. *Journal of National Black Nurses Association*, 21, 1-6.
- Miles, M. B., & Huberman, A. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

- Miller, A. M., & Iris, M. (2002). Health promotion attitudes and strategies in older adults. *Health Education & Behavior, 29*(2), 249-267. doi: 10.1177/109019810202900209
- Miller, S. (2003). Analysis of phenomenological data generated with children as research participants. *Nurse Researcher 10*, 68-80.
- Mokdad, A. H., Ford, E. S., Bowman, B. A., Dietz, W. H., Vinicor, F., Bales, V. S., & Marks, J. S. (2003). Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001. *Journal of the American Medical Association, 289*(1), 76-79. doi: 10.1001/jama.289.1.76
- Moody-Ayers, S. Y., Mehta, K. M., Lindquist, K., Sands, L., & Covinsky, K. E. (2005). Black-white disparities in functional decline in older persons: The role of cognitive function. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 60*(7), 933-939. doi: 10.1093/gerona/60.7.933
- Moons, P. (2004). Why call it health-related quality of life when you mean perceived health status? *European Journal of Cardiovascular Nursing, 3*(4), 275-277. doi: 10.1016/j.ejcnurse.2004.09.004
- Moons, P., Budts, W., & De Geest, S. (2006). Critique on the conceptualisation of quality of life: A review and evaluation of different conceptual approaches. *International Journal of Nursing Studies, 43*(7), 891-901. doi: 10.1016/j.ijnurstu.2006.03.015
- Morse, J. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oak, CA: Sage.

- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA Sage.
- Morse, J. M., & Niehaus, L. (2007). Combining qualitative and quantitative methods for mixed-methods for mixed-method designs In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (4th ed., pp. 541-554). Sudbury: Jones and Bartlett
- Munhall, P. (2007). A phenomenological method. In P. Munhall (Ed.), *Nursing Research: A Qualitative Perspective* (4th ed.). Sudbury, MA: Jones and Bartlett.
- Munhall, P. L. (2012). *Nursing research: A qualitative perspective* (5th ed ed.). Sudbury, MA: Jones & Bartlett Learning.
- National Centers for Health Statistics. (2007). *Defining Overweight and Obesity*. Retrieved from <http://www.cdc.gov/obesity/index.html>.
- National Heart Lung and Blood Institute. (2011). *Calculate your body mass index*. Washington, DC: U.S. Department of Health and Human Services.
- Nelson, J. (2010). Identifying and preventing common risk factors in the elderly. In K. Mauk (Ed.), *Gerontological nursing: Competencies for care* (pp. 354-380). Boston: Jones and Bartlett.
- Newman, A. M. (2009). Obesity in older adults. *The Online Journal of Issues in Nursing*, 14(1). doi: 10.3912/OJIN.Vol14No1Man03
- Newsom, J. T., Kaplan, M. S., Huguet, N., & McFarland, B. H. (2004). Health behaviors in a representative sample of older Canadians: Prevalences, reported change, motivation to change, and perceived barriers. *The Gerontologist*, 44(2), 193-205. doi: 10.1093/geront/44.2.193

- Newton, R. A., Cromwell, R. L., & Rogers, H. L. (2009). The relationship between physical performance and obesity in elderly African-American women. *Physical & Occupational Therapy in Geriatrics*, 27(6), 423-440. doi: 10.3109/02703180902937883
- Office of Disease Prevention and Health Promotion. (2011). *2008 Physical Activity Guidelines for Americans*. Washington, D.C.: U.S. Department of Health and Human Services Retrieved from <http://www.health.gov/paguidelines/>.
- Ogden, C. L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2012). *Prevalence of obesity in the United States, 2009–2010*. Hyattsville, MD: National Health and Nutrition Examination Survey.
- Ogden, C. L., Carroll, M. D., McDowell, M. A., & Flegal, K. M. (2007). *Obesity among adults in the United States--no statistically significant change since 2003-2004*. Hyattsville, MD: National Center for Health Statistics.
- Ory, M., Kinney, H., Melane, Hawkins, M., Sanner, B., & Mockenhaupt, R. (2003). Challenging aging stereotypes: Strategies for creating a more active society. *American Journal of Preventive Medicine*, 25(3, Supplement 2), 164-171. doi: 10.1016/s0749-3797(03)00181-8
- Paschal, A. M., Lewis, R. K., Martin, A., Dennis-Shipp, D., & Simpson, D. S. (2004). Baseline assessment of the health status and health behaviors of African Americans participating in the activities-for-life program: A community-based health intervention program. *Journal of Community Health*, 29(4), 305-318.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed ed.). Thousand Oaks, CA: Sage.

- Peel, C., Baker, P. S., Roth, D. L., Brown, C. J., Bodner, E. V., & Allman, R. M. (2005). Assessing mobility in older adults: The UAB study of aging life-space assessment. *Physical Therapy*, 85(10), 1008-1019.
- Phillips, E. M., Schneider, J. C., & Mercer, G. R. (2004). Motivating elders to initiate and maintain exercise. *Archives of Physical Medicine and Rehabilitation*, 85(Supplement 3), 52-57. doi: 10.1016/j.apmr.2004.03.012
- Polit, D., & Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott.
- Priest, H. (2002). An approach to the phenomenological analysis of data. *Nurse Researcher*, 10(2), 50-63.
- Racher, F. E., & Robinson, S. (2003). Are phenomenology and postpositivism strange bedfellows? *Western Journal of Nursing Research*, 25(5), 464-481. doi: 10.1177/0193945903253909
- Ritchie, C. S., Locher, J. L., Roth, D. L., McVie, T., Sawyer, P., & Allman, R. (2008). Unintentional weight loss predicts decline in activities of daily living function and life-space mobility over 4 years among community-dwelling older adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 63(1), 67-75.
- Robinson, B., & Wicks, M. (2010). Religiosity, self-efficacy for exercise, and African American women. *Journal of Religion and Health*, 1-11. doi: 10.1007/s10943-010-9397-9
- Ryan, R. M., & Deci, E. L. (2000). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, 25(1), 54-67.

- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Sandelowski, M. (1995). Focus on qualitative methods: Sample size in qualitative research. *Research in Nursing & Health*(18), 179-183.
- Sandelowski, M. (2000a). Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed-method studies. *Research in Nursing & Health*, 23(3), 246-255. doi: 10.1002/1098-240x(200006)23:3<246::aid-nur9>3.0.co;2-h
- Sandelowski, M. (2000b). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334-340.
- Sanders, C. (2003). Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse* 14 292–302.
- Sanderson, B. K., Cornell, C. E., Bittner, V., Pulley, L., Kirk, K., Yang, Y., ...Raczynski, J. M. (2003). Physical activity patterns among women in rural Alabama. *American Journal of Health Behavior*, 27(4), 311-321.
- Satia, J. A., & Galanko, J. A. (2007). Intrinsic and extrinsic motivations for healthful dietary change in African Americans. *American Journal of health Behavior*, 31, 643-656.
- Satia, J. A., Walsh, J. F., & Pruthi, R. S. (2009). Health behavior changes in White and African American prostate cancer survivors. *Cancer Nursing* 32(2), 107-117. doi: 10.1097/NCC.0b013e3181982d4c

- Schoenborn, C. A., & Heyman, K. M. (2009). *Health characteristics of adults aged 55 years and over: United States, 2004–2007*. Hyattsville, MD: National Center for Health Statistics.
- Schuler, P., Vinci, D., Isosaari, R., Philipp, S., Todorovich, J., Roy, J., & Evans, R. (2008). Body-shape perceptions and body mass index of older African American and European American women. *Journal of Cross-Cultural Gerontology*, 23(3), 255-264.
- Schwandt, T. (2007). *The sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage.
- Shelkey, M., & Wallace, M. (2007). Katz index of independence in activities of daily living. *The Hartford Institute for Geriatric Nursing*, 1-2. Retrieved from Best practices in nursing care to older adults website:
http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf
- Sherman, B., Gilliland, G., Speckman, J. L., & Freund, K. M. (2007). The effect of a primary care exercise intervention for rural women. *Preventive Medicine*, 44, 198-201.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* Thousand Oaks, CA Sage.
- Sutbeyaz, S. T., Sezer, N., Koseoglu, B. F., Ibrahimoglu, F., & Tekin, D. (2007). Influence of knee osteoarthritis on exercise capacity and quality of life in obese adults. *Obesity*, 15(8), 2071-2076.

- Tak, E., Staats, P., Van Hespen, A., & Hopman-Rock, M. (2005). The effects of an exercise program for older adults with osteoarthritis of the hip. *The Journal of Rheumatology*, 32(6), 1106-1113.
- Thomas, A. M., Moseley, G., Stallings, R., Nichols-English, G., & Wagner, P. J. (2008). Perceptions of obesity: Black and white differences. *Journal of Cultural Diversity*, 15(4), 174-180.
- Tilghman, J. (2003). Obesity and diabetes in African American women. *Journal of the Association of Black Nursing Faculty*, 14(3), 66-68.
- Tortolero, S. R., Mâsse, L. C., Fulton, J. E., Torres, I., & Kohl, H. W. (1999). Assessing physical activity among minority women: focus group results. *Women's Health Issues*, 9(3), 135-142. doi: 10.1016/s1049-3867(99)00004-3
- Troutman, M., Nies, M., & Mavellia, H. (2011). Perceptions of successful aging in Black older adults. *Journal of Psychosocial Nursing & Mental Health Services*, 49(1), 28-34.
- Tudor-Locke, C., Henderson, K. A., Wilcox, S., Cooper, R. S., Durstine, J. L., & Ainsworth, B. E. (2003). In their own voices: Definitions and interpretations of physical activity. *Women's Health Issues*, 13(5), 194-199.
- U.S. Census Bureau. (2012). *State & county quick facts*. Washington, DC: Retrieved from <http://quickfacts.census.gov/qfd/index.html>.
- U.S. Department of Health and Human Services. (1996). *Physical activity and health: A report of the surgeon general* Centers for Disease Control and Prevention.
- U.S. Department of Health and Human Services. (2000). *Healthy People 2010* (Conference Edition, in Two Volumes). In U.S. Department of Health and Human

Services (Ed.). Washington, DC: Office of Disease Prevention and Health Promotion.

U.S. Department of Health and Human Services. (2007a). *Older Persons' Health*.

Retrieved from http://www.cdc.gov/nchs/fastats/older_americans.htm.

U.S. Department of Health and Human Services. (2007b). *Statistics related to overweight and obesity*. Retrieved from

<http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf>.

U.S. Department of Health and Human Services. (2008). *2008 Physical activity*

guidelines for Americans: Be active, healthy, and happy! : Retrieved from

www.health.gov/paguidelines.

U.S. Department of Health and Human Services. (2010). *Physical Activity*. Washington,

DC Retrieved from

<http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf>.

Van Manen, M. (1990). *Researching lived experience: Human science for an action*

sensitive pedagogy. London: State University of New York Press.

Vazsonyi, A. T., & Jenkins, D. D. (2010). Religiosity, self-control, and virginity status in

college students from the "Bible Belt": A research note. *Journal for the Scientific*

Study of Religion, 49(3), 561-568. doi: 10.1111/j.1468-5906.2010.01529.x

Villareal, D. T., Apovian, C. M., Kushner, R. F., & Klein, S. (2005). Obesity in older

adults: Technical Review and Position Statement of the American Society for

Nutrition and NAASO, The Obesity Society. *Obesity*, 13(11), 1849-1863.

- Wallace, M., & Shelkey, M. (2008). Reliability and validity of Katz ADL Index. *AJN The American Journal of Nursing*, 108(4), 1-2. doi: 10.1097/01.NAJ.0000315266.66521.e7
- Wang, Y., & Beydoun, M. A. (2007). The obesity epidemic in the United States” gender, age, socioeconomic, racial/ethnic, and geographic characteristics: A systematic review and meta-regression analysis. *Epidemiologic Reviews*, 29(1), 6-28. doi: 10.1093/epirev/mxm007
- Wang, Y. C., Colditz, G. A., & Kuntz, K. M. (2007). Forecasting the obesity epidemic in the aging U.S. population. *Obesity*, 15(11), 2855-2865.
- Ward, S., Gray, A., & Paranjape, A. (2009). African Americans' perceptions of physician attempts to address obesity in the primary care setting. *Journal of General Internal Medicine*, 24, 579-584.
- Wilbur, J., McDevitt, J. H., Wang, E., Dancy, B. L., Miller, A. M., Briller, J., ...Lee, H. (2008). Outcomes of a home-based walking program for African-American women. *American Journal of Health Promotion*, 22(5), 307-317. doi: 10.4278/ajhp.22.5.307
- Wolf, Z. (2007). Ethnography: The method. In P. Munhall (Ed.), *Nursing research: A qualitative perspective* (pp. 293-330). Boston: Jones and Bartlett Publisher.
- World Health Organization. (2006). *Obesity and overweight*. WHO Media centre Retrieved from <http://www.who.int/mediacentre/factsheets/fs311/en/index.html>.
- Yancey, A. K., McCarthy, W. J., Harrison, G. G., Wong, W. K., Siegel, J. M., & Leslie, J. (2006). Challenges in improving fitness: Results of a community-based,

randomized, controlled lifestyle change intervention. *Journal of Women's Health*, 15(4), 412-429. doi: doi:10.1089/jwh.2006.15.412

Young, D. R., Gittelsohn, J., Charleston, J., Felix-Aaron, K., & Appel, L. J. (2001).

Motivations for exercise and weight loss among African-American women: Focus group results and their contribution towards program development. *Ethnicity & Health*, 6(3/4), 227-245.

Young, H., & Cochrane, B. (2004). Healthy aging for older women. *Nursing Clinics of North America*, 39(1), 131-143. doi: 10.1016/j.cnur.2003.11.008

Zamboni, M., Mazzali, G., Zoico, E., Harris, T., Meigs, J., Di Francesco, V., ...Bosello, O. (2005). Health consequences of obesity in the elderly: A review of four unresolved questions. *International Journal of Obesity*, 29, 1011-1029.

APPENDIX A
RECRUITMENT MATERIALS

Screening Criteria Telephone Script Form

TITLE OF RESEARCH: A Phenomenological study of Obesity and Its Impact on Functional Status, Mobility, and Physical Activity in Southern African American Older Women

IRB PROTOCOL: **X100730012**

INVESTIGATOR: **Pamela G. Bowen**

Date_____ **Time**_____

Hello, my name is Pamela Bowen; I am a doctoral student from the University of Alabama at Birmingham School of Nursing. I am working on a research study to find out from older African American women how being overweight or obese impacts your functional status or your ability to move around. I am looking for 10-12 older African American women who are 65 years and older.

Is it okay if I ask you a few questions to find out if you qualify to be in the study and if you want to be in the study?

- If the person says, “No”, thank the person for her time and politely end the call.
- If the person says, “Yes”, continue the phone call by asking the following list of questions.

		Yes	No
1.	What is your date of birth?		
2.	Do you know how much you weigh?		
3.	Have you loss or gain weight in the last 18 months		
4.	What is your current weight? Measurement		
5.	What is your current height? Measurement		

Calculated BMI based on your answers is _____

Because of your answers to these questions, you do qualify for the study. Thank you for taking the time to talk with me today.

OR:

Because of your answers to these questions, you do not qualify for the study. Let me tell you a little more about the study and what will happen if you decide to be in the study.

Continue with the statement below:

I would like for you to consider letting me learn about your personal experiences of what it is or was like for you to be classified as obese and its impact on your functional status, everyday living activities, and your ability to move during the past 18 months. I will come to your home or church to interview you. There will be two face-to-face interviews. The second interview will occur 1-2 weeks after the first interview. Being in the study will not cost you anything. You will be given \$20.00 at the end of each interview for which you participate.

Do you have any questions?

- *Allow the person to ask questions about the study, and then answer her questions. Be sure to write down the questions posed in the space below.*

Do you think you would like to take part in this research study?

Yes_____ No_____

- *If the person says "No", thank the person for taking time to participate in the telephone conversation and then end the call.*

If yes, then continue with:

Because you have expressed an interest in taking part in this research, we can go ahead and schedule a time for me to come to your home or church for the first interview. At the start of the interview, you will be given more information about the study and you will be able to ask any questions. Then you will be asked to sign a form giving your consent to be in the study. If you have any questions about the study before your first interview appointment, you can call me (Pamela Bowen) at 205-934-2778 or Dr. Yvonne Eaves, my advisor at 205-934-6224. I will give you a call 1-2 days before our scheduled appointment in order to remind you.

- *Record date and time for the first interview below.*

Interview#1 Date_____ Time_____

I appreciate the time you have taken to talk with me today. Thank you and good-bye (end call).

Antioch Missionary Baptist Church

400 Miltstead Road
Fairfield, AL 35064
205.786.5302
O.C. Oden, Jr., Pastor

July 22, 2010

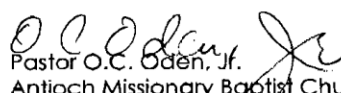
Pamela G. Bowen, MSN, FNP-BC
1701 University Blvd
NB 416
Birmingham, AL 35294

Dear Ms Bowen:

This letter is to inform you that the Antioch Missionary Baptist Church has reviewed and support you research study titled, "**Motivation of obese African-American older women to adopt healthier lifestyles**". It is our understanding that the project will begin in the Fall of 2010. We are very interested in your efforts as well as excited about the prospect of helping our older population and gaining insight into this health concern.

With questions or further assistance, do not hesitate to contact us; our doors are always open. You may contact me directly at the church or, my administrative assistant, Lynda Williams at the same number.

Yours in Christ,


Pastor O.C. Oden, Jr.
Antioch Missionary Baptist Church
Fairfield, AL 35064

Mt. Zion Missionary Baptist Church
 1661 Cedar Avenue Southwest
 Birmingham, Alabama 35211
 205-925-7888
 Email: mountzion@bellsouth.net

Dr. Walter Sims, Pastor
 Sister Jahnne A. Levert, Secretary


July 14, 2010

Pamela G. Bowen, MSN, FNP-BC
 1701 University BLVD
 NB 416
 Birmingham, Alabama 35294

Dear Ms. Bowen:

This letter is to inform you that the Mt. Zion Missionary Baptist Church of Ishkooda has reviewed and supports your research study titled, "**Motivation of obese African American older women to adopt healthier lifestyles**". It is our understanding the project will begin Fall 2010. We are very interested in your efforts that may help improve our understanding of women's health among our older adult African American population.

If you have any questions or need further assistance, please contact us at 205-925-7888 or 205-335-2435.

Sincerely,

 Pastor Walter Sims
 Mt. Zion Missionary Baptist Church
 1661 Cedar Avenue Southwest
 Birmingham, Alabama 35211

Ebenezer Baptist Church

726 5th Avenue North
Bessemer, Alabama 35020
Phone: 205.425.2829
Rev. Sylvester Henderson

January 21, 2011

Pamela G. Bowen, MSN, FNP-BC
1701 University Boulevard
NB 416
Birmingham, Alabama 35294

Dear Ms. Bowen:

This letter is to formally accept your invitation to participate in the study titled, "Obesity and Its Impact on Functional Status, Mobility, and Physical Activity in Southern African American Women". We are very excited about the impact that your research will have on this generation and the generations to come.

Please feel free to contact myself or the church staff if there is any other assistance we can provide.

Sincerely,

A handwritten signature in black ink, appearing to read "Rev. Sylvester Henderson", written in a cursive style.

Pastor Sylvester Henderson
Ebenezer Baptist Church

APPENDIX B

QUALITATIVE INSTRUMENTS

Interview Guide

Introduce myself

Review the consent form

Thank you for coming here today. I appreciate your willingness to help me with my dissertation research. Today, we are going to talk about what it means to be classified as overweight or obese and how it affects your ability to function and move in general. We are also going to talk about your current physical activity habits, and how these habits have changed or stayed the same over the last 18 months. Your answers will help me figure out what southern obese AA older women want and need to learn about watching their weight in order to improve and maintain their functional and mobility status. With this information, I will learn how to encourage older AA women to engage in regular physical activity, which will help them to decrease functional decline and maintain good mobility.

Before we start,

I have a few simple requests that will help make things run more smoothly.

1. I will be tape recording the discussion here so that we will have an accurate record of what is said. However, all comments made here today will be confidential. Your name or any other identifying information will not be included in my report.
2. Please speak loudly enough for the tape-recorder to record your voice.
3. Say what is true for you, even if you think you are the only one who thinks that way.

Key Questions:

1. Can you tell me about your health? (Introductory question)
2. Do you think there is a difference between being overweight and being obese?
Probe: How are they different?
3. How do we know if we are overweight?
4. What are some advantages to being overweight?
Probe: Are there times when we think that being a little chubby is a good thing? Is it bad to be too skinny?
5. What are some concerns or disadvantages that come from being overweight? (these may be aesthetic, medical etc.)
Probe: How serious would that problem be for you?
6. Do you think that being overweight is a problem for older AA living in AL?
7. Has your weight changed over the past 18 months?
Probe: (If yes) What are the reasons you think that has happened?
8. How about your physical activity behaviors, would you say you are more or

less active now that you are older? Probe: In what ways?

9. What are the factors that can improve your physical activity level?
10. Are there any factors that negatively affect your participation in regular physical activity? If so, what are they?
11. What keeps you from engaging in regular physical activity?
12. What would you need to know to increase your physical activity?
13. Are there people important to you that would recommend that you participate in regular physical activity?
14. If you participated in regular physical activities, how would the people important to you respond?
15. Are there benefits that come with participating in regular physical activity?
Probe: What are they?
16. How best can I help motivate other older AA women to engage in regular physical activity behaviors?

A. Cherrington (personal communication, September 24, 2010)

Fieldnotes Format Guide

Fieldnotes will be made in much detail as soon as possible after the interview.

Participant ID#

Interview Date

A. Context of Situation: (What happened during the session?)

B. Physical Environment:

C. Theoretical Insights (Describe any insights that occurred during or after the interview?
What was the context of the insight?)

D. Personal Reflections/ Emotions (what were feelings during and after the interview?)

E. Additional Notes (Any additional information that relates to the interview.)

(Eaves, 1997)

APPENDIX C

QUAUNTITATIVE INSTRUMENTS

UAB Study of Aging Life-Space Assessment

Name:						Date:	
These questions refer to your activities just within the past month.							
LIFE-SPACE LEVEL		FREQUENCY				INDEPENDENCE	SCORE
During the past four weeks, have you been to . . .		How often did you get there?				Did you use aids or equipment? Did you need help from another person?	Level X Frequency X Independence
<i>Life-Space Level 1 . . .</i> Other rooms of your home besides the room where you sleep?	Yes 1	No 0	Less than 1 /week 1	1-3 times /week 2	4-6 times /week 3	Daily 4	1 = personal assistance 1.5 = equipment only 2 = no equipment or personal assistance
Score		(LS1) X		(LS1F)		X	(LS1I) = Level 1 Score
<i>Life-Space Level 2 . . .</i> An area outside your home such as your porch, deck or patio, hallway (of an apartment building) or garage, in your own yard or driveway?	Yes 2	No 0	Less than 1 /week 1	1-3 times /week 2	4-6 times /week 3	Daily 4	1 = Personal assistance 1.5 = Equipment only 2 = No equipment or personal assistance
Score		(LS2) X		(LS2F)		X	(LS2I) = Level 2 Score
<i>Life-Space Level 3 . . .</i> Places in your neighborhood, other than your own yard or apartment building?	Yes 3	No 0	Less than 1 /week 1	1-3 times /week 2	4-6 times /week 3	Daily 4	1 = Personal assistance 1.5 = Equipment only 2 = No equipment or personal assistance
Score		(LS3) X		(LS3F)		X	(LS3I) = Level 3 Score
<i>Life-Space Level 4 . . .</i> Places outside your neighborhood, but within your town?	Yes 4	No 0	Less than 1 /week 1	1-3 times /week 2	4-6 times /week 3	Daily 4	1 = Personal assistance 1.5 = Equipment only 2 = No equipment or personal assistance
Score		(LS4) X		(LS4F)		X	(LS4I) = Level 4 Score
<i>Life-Space Level 5 . . .</i> Places outside your town?	Yes 5	No 0	Less than 1 /week 1	1-3 times /week 2	4-6 times /week 3	Daily 4	1 = Personal assistance 1.5 = Equipment only 2 = No equipment or personal assistance
Score		(LS5) X		(LS5F)		X	(LS5I) = Level 5 Score
TOTAL SCORE (ADD)							<i>Sum of Levels</i>

R. Allman (personal communication December 16, 2010)

Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) NO supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) WITH supervision, direction, personal assistance or total care
BATHING POINTS: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS: _____	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS = _____ 6 – High (patient independent) 0 – Low (patient very dependent)		

Shelkey, M., & Wallace, M. (2007). Katz index of independence in activities of daily living. *The Hartford Institute for Geriatric Nursing*, 1-2. Retrieved from Best practices in nursing care to older adults website:
http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf

The Lawton Instrumental Activities of Daily Living Scale

Ability to Use Telephone

1. Operates telephone on own initiative; looks up and dials numbers..... 1
2. Dials a few well-known numbers..... 1
3. Answers telephone, but does not dial..... 1
4. Does not use telephone at all..... 0

Shopping

1. Takes care of all shopping needs independently..... 1
2. Shops independently for small purchases..... 0
3. Needs to be accompanied on any shopping trip..... 0
4. Completely unable to shop..... 0

Food Preparation

1. Plans, prepares, and serves adequate meals independently..... 1
2. Prepares adequate meals if supplied with ingredients..... 0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet..... 0
4. Needs to have meals prepared and served..... 0

Housekeeping

1. Maintains house alone with occasion assistance (heavy work)..... 1
2. Performs light daily tasks such as dishwashing, bed making..... 1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness..... 1
4. Needs help with all home maintenance tasks..... 1
5. Does not participate in any housekeeping tasks..... 0

Laundry

1. Does personal laundry completely..... 1
2. Launders small items, rinses socks, stockings, etc..... 1
3. All laundry must be done by others..... 0

Mode of Transportation

1. Travels independently on public transportation or drives own car..... 1
2. Arranges own travel via taxi, but does not otherwise use public transportation..... 1
3. Travels on public transportation when assisted or accompanied by another..... 1
4. Travel limited to taxi or automobile with assistance of another..... 0
5. Does not travel at all..... 0

Responsibility for Own Medications

1. Is responsible for taking medication in correct dosages at correct time..... 1
2. Takes responsibility if medication is prepared in advance in separate dosages..... 0
3. Is not capable of dispensing own medication..... 0

Ability to Handle Finances

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income..... 1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc..... 1
3. Incapable of handling money..... 0

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

Graf, C. *The Lawton Instrumental Activities of Daily Living Scale*. The Hartford Institute for Geriatric Nursing, 2007. **108**, 1-2.

APPENDIX D

HUMAN SUBJECTS PROTECTION DOCUMENTS



Institutional Review Board for Human Use

Form 4: IRB Approval Form
Identification and Certification of Research
Projects Involving Human Subjects

UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The Assurance number is FWA00005960 and it expires on September 29, 2013. The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56.

Principal Investigator: BOWEN, PAMELA G

Co-Investigator(s):

Protocol Number: **X100730012**

Protocol Title: *A Phenomenological Study of Obesity and Its Impact on Functional Status, Mobility, and Physical Activity in Southern African American Older Women*

The IRB reviewed and approved the above named project on 8-23-11. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received EXPEDITED review.

IRB Approval Date: 8-23-11

Date IRB Approval Issued: 8-23-11

Marilyn Doss, M.A.

Vice Chair of the Institutional Review
Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.

470 Administration Building
701 20th Street South
205.934.3789
Fax 205.934.1301
irb@uab.edu

The University of
Alabama at Birmingham
Mailing Address:
AB 470
1530 3RD AVE S
BIRMINGHAM AL 35294-0104

Informed Consent Document

TITLE OF RESEARCH: A Phenomenological Study of Obesity and its Impact on Functional Status, Life-Space Mobility, and Physical Activity in Southern African American Older Women

IRB PROTOCOL: X100730012

INVESTIGATOR: Pamela G. Bowen, PhD(c), FNP-BC

SPONSOR: Family/ Child Health and Caregiving Department

Explanation of Procedures

This research study will require 10-12 participants in order to explore (1) how southern African American older women who are overweight or obese believe that obesity affects their functional status and mobility and (2) who or what encourages or prevents these women to engage or not to engage in regular physical activity. If you agree to be in the study, you will be asked to take part in two face-to-face tape recorded interviews in which you will be asked questions about what it is or was like for you to live with being classified as overweight or obese. You will also be asked some general questions about yourself, such as your age, marital status, education, activities of daily living, and instrumental activities of daily living (using the KATZ Basic Activity of Daily Living (ADL) tool and the Lawton-Browdy Instrumental Activity of Daily Living tool [IADL]). In the second interview, you will be asked to respond to questions about personal behaviors and physical activities. You will also have an opportunity to clarify any information you gave in the first interview. The second interview will occur one to two weeks after the first interview. Each interview will last 60-90 minutes. You will be provided a one-page abstract of the study results.

The interviews will be audio recorded and will take place at your church or your home. Participation in this study is voluntary and you can refuse to answer any question and/or quit the study at any time. If you do decide to quit the study, no one will be upset with you and your information will be destroyed right away.

Risks and Discomforts

There may be a risk that answering the questions on the KATZ Basic ADL and the Lawton-Browdy IADL tools and talking about the experience during the two interviews may bring up sad memories; make you feel tired, embarrassed, or anxious. Remember, you can stop the interview at any time you feel tired or for any other reason. Here are the numbers for the Crisis Center (205) 323-777 or "Senior Talk Line" (205) 328-8255 for further emotional support if needed.

UAB IRB

Date of Approval 8-23-11

Not Valid On 8-23-12

Benefits

You may not benefit directly from taking part in this study. However, information you provide may help healthcare providers learn how to assist older African American women who live with being overweight or obese to make healthier lifestyle choices that would maintain or improve their functional status and mobility.

Confidentiality

Information obtained about you for this study will be kept confidential to the extent allowed by law. However, research information that identifies you may be shared with the UAB Institutional Review Board (IRB) and others who are responsible for ensuring compliance with laws and regulations related to research and the Office for Human Research Protections (OHRP). The results of this study may be put into print for research purposes. However, your identity will not be given out because we will use codes instead of using your name or any other information that would identify you. Our talk will be tape-recorded and someone will type the conversation word for word. However, once our talk has been typed, the tapes will be erased by 6/30/12.

Refusal or Withdrawal without Penalty

Whether or not you take part in this study is your choice. There will be no penalty if you decide not to be in the study. You are free to withdraw from this research study at any time.

Alternatives

Your alternative to this study is not to participate

Cost of Participation

There will be no cost to you for taking part in this study.

Payment for Participation in Research

You will be paid \$20 at the end of each completed interview.

Significant New Findings

Significant new findings that develop during the course of the research that may relate to your willingness to continue your participation in this study will be provided to you.

Questions

If you have any questions, concerns, or complaints about this study, please contact Ms. Pamela Bowen. She will be more than happy to answer any of your questions or concerns. Ms. Bowen's number is 205-934-2778. After hours, you may email her at pbowen@uab.edu.

If you have questions about your rights as a research participant, or concerns or complaints about the research, you may contact the Office of the IRB (OIRB) at (205) 934-3789 or 1-800-822-8816. If calling the toll-free number, press the option for "all other calls" or for an operator/attendant and ask for extension 4-3789. Regular hours for the OIRB are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday. You may also call this number in the event the research staff cannot be reached or you wish to talk to someone else.

Legal Rights

You are not waiving any of your legal rights by signing this informed consent document.

Signatures

Signature of Participant

Date

Signature of Principal Investigator

Date

APPENDIX E
QUALITATIVE CODING AND ANALYSIS AUDIT TRAIL

Qualitative Data Analysis

The information in this appendix is available to illustrate the data analysis process and interpretation performed for this study. The following data analysis steps were used: 1) transcribed all transcripts (participant interviews not included); 2) extracted significant statements (not included); 3) formulated meanings; 4a) organizing formulated meaning (44 categories), 4b) reduction of 44 categories to 13 categories, 4c) 13 categories with formulated meanings, 4d) reduction of 13 categories to 8 categories based on study's phenomena; 5) final reduction of emergent sub-themes from all 8 categories; and 6) meta-themes with corresponding sub-themes.

STEP 3: THEME CLUSTERS__ (980 Formulated meanings)

Seeking and receiving medical advice from healthcare provider

1. Believes that it is important to maintain a sense of control over health by keeping medical appointments
2. Because of breast cancer diagnosis, it is important to maintain her regular mammogram appointments
3. Maintains mammogram schedule and regular medical follow-up visits in order to monitor current health status
4. Healthcare provider beliefs about treatment in older adults appears to be that pain management does not always work
5. Keeping medical appointments is a way of managing health
6. Even though she was informed by medical personnel that she was overweight, she failed to change her diet and eating habits
7. Failed to follow medical advice to lose weight and eat healthy because she was not having any adverse effects from her weight at the time.
8. She now knows firsthand the consequences of being overweight because the risk factors that she was advised of years ago have come to fruition. She did not translate information into behavior modification in her younger years.
9. She acknowledges some of the benefits of regular physical activity (PA) because her doctor made her aware. However, she still states that is difficult for her to engage in PA/exercise because of her current health status.
10. Although her doctor recommended dietary changes because of her diagnoses of high cholesterol and hypertension, she does not follow the recommended diet.
11. Although she does not adhere to her diet, she states that she does take her medications as prescribed. She does not appear to understand that both treatment complement each other
12. Her healthcare provider encouraged her to participate in sexual activity but she does not have a partner and does not want a partner
13. At one time she was advised to eat more protein in order to gain some weight
14. She has an upcoming doctor's appointment so she is adhering to her diet in an attempt to have normal lab results
15. Perceives that obesity may be a contraindication to some medical treatments
16. Believes that obese persons may not be able to perform activities (e.g. exercise programs) recommended by physicians.
17. Some medical interventions require the obese person to lose weight first but the person was too obese to exercise in order to aid in weight loss. There needs to be different weight loss strategies for different people

18. With physical therapy (PT), the therapist provides the patients with home exercises that should be performed at the frequency prescribed.
19. She adheres to exercise regime and medications but her weakness is eating sweets.
20. Her healthcare provider encouraged her to continue her current PA level because her test results were normal and better than most people of similar age.
21. Healthcare professionals have been discussing an appropriate weight for her height with client.
22. The client and the doctor negotiated a weight range that was acceptable to both. Client realizes that carrying excess weight is not good for her heart.
23. She has been informed by her healthcare professional that she has arthritis all over her body.
24. Her insurance company representative encouraged her not to regain all of her weight back.
25. Television doctor stated that people need to walk/exercise for at least one hour a day but it was okay to start at 30 minutes and then build up to an hour.
26. An example of a disadvantage of being overweight was described as when some obese people depending on their illness must lose weight first before they can receive treatment. She believes that it is harder for an overweight person to heal than a smaller person. Believes it is more difficult for health care providers to treat obese people when they are ill.

Age related changes

27. Believes that weight loss occurs normally with aging
28. Weight loss occurs with aging regardless of whether a person is ill
29. Believes that weight loss occurs with aging because the fat deteriorates.
30. Loss of appetite may occur with aging, but not for everyone
31. Believes that with aging comes the deterioration of bones so It is important to stay busy/active to prevent further decline
32. Perceives that her mobility has declined with age
33. Mobility pace has declined with age and arthritis
34. Anticipating that one day, she will not be able to maintain housework, but not yet.
35. Appears to anticipate a decline in ambulation and the future need for an assistive device
36. Believes that activity level decreases with age and this change is irreversible.
37. Perceives functional decline occurs with aging ; body and physical changes that come with aging are permanent
38. Aging changes one's ability to be physically active
39. Anticipates physical and health decline with aging and she expects family to assist her if and when the time comes

40. Belief that declining health occurs with age, but it does not occur at the same rate or degree for all people
41. Acceptance of old age is necessary for making the needed lifestyle changes
42. Older adults will eventually regret not making necessary lifestyle changes
43. Believes that older overweight women in their 70s and 80s eventually develop hypertension or diabetes
44. Decreased appetite with aging
45. Has noticed a decline in mobility and functional status in her older age, which she associates with the changes in the condition of her body
46. Decline in mobility and functional status has occurred with aging. However, arthritis has also contributed to limiting her activity level. In her younger days, she participated in several recreational physical activities.
47. Tries to accept the fact that her mobility is not what it used to be when she was younger. There is some remorse regarding her decline in mobility.
48. Believes that her functional status and mobility decline d with age and that she will never regain the independence she had during her youth. Envious of other's independence
49. Believes that one's ability to perform usual/routine tasks/activities decline with age
50. Believes that her activity level is less now that she's older.
51. Believes that physical abilities and mobility decreases with age
52. Increased satiety occurs with aging
53. Leg discomfort, which has increased with age, prevents the performance of regular PA
54. Also believes that PA automatically decreases with age
55. Moved into a one-level home prior to older adulthood. One-level allow for easier access with assistive devices in future years and /or as mobility / ambulation becomes impaired. Has made some modifications to home so that she only uses a few rooms during the winter months. (This cuts down on heating cost).
56. Being an older adult does not have to inhibit a person from performing ADL. God has provided everyone with the necessary tools to take care of one's own personal needs.
57. Client has the perception that as people get older, they need to have some fat reserve just in case they get sick or to prevent looking sick
58. The pain intensity of the arthritis increases with age.
59. Has difficulty with walking and running and these activities become even more slower with aging.
60. Client has become less active with age. She is unable to perform activities that she has performed for years such as maintaining a garden and cutting her own grass

- 61. Believes that weight loss can occur with aging because older adults tend to eat less
- 62. As she aged, she decreased her walking frequency because of age, work schedule, and church activities on Sundays.

Ambulation:

- 63. Ambulating up and down stairs is a hindrance because it is difficult to ambulate and stabilize self.
- 64. Now that the client is older, she moved from her home because she was having difficulty climbing up and down stairs on a daily basis.
- 65. Client has a history of walking in her former community but stopped walking because her ambulation became slower
- 66. Knows that some overweight people do not have problems with ambulation while others fatigue easily and requires frequent rest periods.
- 67. Her musician is overweight but she is able to ambulate without difficulty or dyspnea. The client considers her musician a “healthy fat person” because she does not experience these problems.
- 68. Believes that walking is a healthy activity that makes you feel better
- 69. When people become short of breath with ambulation and unable to walk for long distances then the person should know that they are overweight.
- 70. Realizes that she is able to ambulate better and her mobility is better when she loses some weight.
- 71. Decreased ability to walk or stand for long periods of time. However, she tries to perform these activities any way to prevent further decline.

Appearance/ Embarrassed:

- 72. She is embarrassed about her feet edema and the inability to wear acceptable/ appropriate dress shoes to church
- 73. How she looks and dresses is important to her. Her appearance is so important that she limits her social outings because of swelling in her feet.
- 74. Believes that overweight/ obesity is unattractive to look at
- 75. Acknowledges that she has gained some weight and she attributes her arm flabbiness to weight gain and not the loss of muscle tone.
- 76. Perceives that being Overweight or chubby is not attractive
- 77. Acknowledges that she has a history of some abdominal weight gain
- 78. Perceives flabbiness of arms to be unattractive so she covers them with clothing
- 79. Perception that in younger years she could disguise her overweight appearance
- 80. Perception in her younger days was that she looked good but her perception now is that thinner is healthier

81. Perceives that “chubby” or having curves is okay or is attractive but more obvious physical changes are indicative of being obese or overweight.
82. Attractiveness of her shoes was an issue for her when she first started wearing the platform shoe; but now she does not let the look of the shoe bother her anymore. She has accepted her prosthetic-raised shoe
83. Believes that being too skinny is not attractive and that skinny person’s are unhealthy
84. Perceives her overweight status as attractive
85. Believes that people with abdominal obesity should not wear certain clothing items
86. Perceives that her niece is classified as obese but not her. Some styles of clothing/fashion are unattractive when worn by obese women
87. Does not consider being skinny an attractive weight status. Also considers a skinny person to be malnourished and sickly.
88. Believes that older women who are overweight simply do not care about their appearance but denies that there is a serious obesity problem among older AA women
89. Older AA women tend to take care of themselves and their appearance better than younger AA women
90. Believes that older women do not want to be classified as overweight or obese. Older women have decreased physical attributes to compete for companionship Being normal weight or not being overweight is one of the few things older women have going for them
91. Believes that older women take pride in their appearance
92. Believes that overweight people (especially younger people) are not concerned about their weight but older adults do care about their appearance
93. Believes that the overweight women in her apartment building care about their appearance but believes that there are no obese people in her building because the older adults care about their appearance.
94. Believes that cosmetics are used to hide physical flaws but if obese people lose weight they would be in better shape
95. Being beautiful on the outside is not as important as being physically healthy
96. Client has increasing awareness that a person does not have to look fat to be classified as obese
97. Believes that there are medical issues related to being overweight but there are no cosmetic issues. There are some beautiful overweight people. Skinny people do not translate to beautiful people.
98. When your clothes have become too tight then the person should know that they are overweight because they have gained weight
99. Believes that a person can look in the mirror and see if they are overweight or not.

- 100. Client did not like the way she looked after weight loss so she decided to gain some of her weight back because she believed that she looked sick.
- 101. Believes that her appearance was much better after she regained some of the weight she lost. She looked ill to herself.
- 102. Believes that her daughter would not have told her that she looked ill but she was not happy with her appearance after her weight loss so she regained some of her weight and she feels comfortable with her appearance.
- 103. Believes that overweight people should be able to look at themselves in the mirror and know if they are overweight or not.
- 104. Clothes do not fit anymore because the person has gained weight.
- 105. Client does want to be taller because she perceives that taller people look better in their clothes.

Assistive Device

- 106. Weak bladder requires bedside commode at night
- 107. Without bed side commode, incontinence would soil clothes and home
- 108. Requires assistive devices to ambulate
- 109. Adaptive devices are required outside the home but inside can hold onto things
- 110. Must hold on to walls and furniture to support ambulation
- 111. Must use assistive devices when ambulating outside of her home
- 112. Has been using assistive devices to ambulate for 12 years
- 113. Requires an assistive device to bathe
- 114. Maintain ambulation independence as long as possible. Try to put off the use of assistive ambulation devices as long as possible.
- 115. Anticipating the potential need for ambulation assistive devices in the future but wants to delay the need as long as possible. Start off by using the minimum supportive assistive device
- 116. Functional Assistive device (back brace) is needed to perform routine house work
- 117. She uses a walker for ambulation and the building does have elevators
- 118. Requires an assistive device to maintain some independence and for mobility around her home.
- 119. Believes that everything (assistive devices) that she needs to increase her PA is available in her home, but has to be motivated and “feel” like engaging in PA .
- 120. Believes that her PA level would increase if she did not have to use an assistive device (a cane) to ambulate.
- 121. Client has seen many other older adults start off walking with assistive devices but they eventually become more independent and do not require such devices.

Beliefs or Perception

- 122. Belief or perception that a person should not become overweight

123. Believes that being overweight can decrease a person's mobility
124. Believes that weight gain was related to pregnancies not to amount of food intake
125. Believes past weight loss has put weight at a "good place"
126. Perceives weight to be "fine". Does not want to be overweight.
127. No difference between obesity and overweight
128. Perceives that she has a large body frame
129. Believes that overweight people have fat accumulation around their heart, which is unhealthy
130. Believes that people should weigh a certain amount
131. Perceives that extreme underweight and overweight are both unhealthy statuses but believes that obesity is the worse out of the two conditions
132. Does not believe that there is a problem with obesity among older AA women in Alabama. Appears to base this reasoning on one of her neighbors who weighs 120 pounds and is very active.
133. Perceives herself to be "a little obese" but not overweight
134. Believes that a person can look in the mirror and know if they are overweight or obese
135. She is aware that being overweight may affect a person's blood pressure, cholesterol, and endurance
136. There are no health advantages that accompany being overweight
137. Does not think that there is an overweight problem among older AA women just in Alabama. She thinks that there is a problem in the U.S.
138. Acknowledges that there are a small number of older AA women who are overweight and lives in her building.
139. Believes that PA involves helping others and she wishes that she was able to help others more
140. Appears to be proud that she does not have to take any medication for any condition. She bases her perceptions on comparing her health status to other older women in her building.
141. She realizes that a person's weight distribution varies based on height
142. Believes that increased height can increase a person's weight on the scales
143. Believes that her body frame is small in comparison to her younger friend whose body frame is large
144. Believes that her niece will eat food even if she has just eaten
145. Being overweight means that the person does not care about themselves
146. Perceives older women in her building to just being a "little heavy" but not really overweight or obese.
147. Believes that PA is healthy for a person to perform
148. She informed her choir member that she was too young to be obese and that she needed to decrease her food intake.

- 149. Perceives that some of her neighbors are envious of her ability to ambulate and of her functional status
- 150. Recognizes that the height of a person can change the perception of that person's weight status
- 151. Good health and being active are important to client
- 152. This client has never had a weight problem and she does not know the role that "overweight" plays with "obesity". She believes that people who are overweight or obese are that way because of genetics.
- 153. Believes that many obese people cannot bathe themselves, which results in skin breakdown. Perceives that being obese makes a person more apt to perspire quickly and develop body odor
- 154. Only parks close to the store if she has her husband with her who has difficulty with ambulation. She views the handicapped sticker as a stigma.
- 155. There are no advantages to being overweight. She does not like to be overweight
- 156. Client perceives herself to be more active. She travels, performs ADLS and perceives herself as being a busy person.

Chronic Illness

- 157. Cancer did not spread to lymph nodes so chemotherapy was not necessary
- 158. After her cancer went into remission, her appetite slowly returned and she began to slowly regain the weight lost.
- 159. Knee joint (cartilage) health has declined
- 160. Family history of arthritis but her sister has transportation to get to therapy
- 161. She is aware of several obesity-related illnesses and genetics can play a role
- 162. Believes that her health problems (diabetes, hypertension, joint pain) started when she was younger but she was unaware of the problems at the time
- 163. Recognizes that diabetes is a serious condition that can affect her eyes and kidneys; aware of the downward trajectory of diabetes.
- 164. Joint health is an integral part of one's mobility and the cartilage in her joints has deteriorated, which causes her pain
- 165. Accepted arthritic condition of extremities and refuses to have anymore surgeries
- 166. Experiences shortness of breath now that she is overweight
- 167. Realizes that being overweight increases the amount of pressure exerted on her weight bearing joints and exacerbates arthritis
- 168. Gout is a form of arthritis that may cause extreme pain and edema in the joints of the body especially the big toe. Knowledgeable about gout and takes medication to control gout.
- 169. Her health condition prevents her from performing regular PA
- 170. Diminished eye sight may be a contributing factor to regular PA

- 171. Has been experiencing intermittent weakness and dizziness after working out in the yard. She knows to check her blood sugar and blood pressure. Engaging in strenuous activities (like yard work) before eating leads to extreme hunger and weakness.
- 172. The only time the client is not active is when she experiences dizziness or light-headedness
- 173. Attributes re-occurrence of her heart disease to husband's illness
- 174. Has a 25 year diagnosis history of arthritis
- 175. Being overweight can cause HTN, knee and back pain
- 176. Belief that overweight is harmful to skeletal system.
- 177. If she developed diabetes that would be a stressor for her because of the changes she would have to make in order to manage the disease. She believes that she would have to have more assistance from others to manage the disease.
- 178. Has a history of scoliosis
- 179. Realizes that hyperglycemia can cause damage to the blood vessels of the eyes. She does not want to experience eye problems related to DM but she is still does not adhere to her diet.
- 180. Believes that she has arthritis because several members of her family have arthritis.
- 181. Was interested in knowing the cause of arthritis because she knows many people with the condition.

Control

- 182. She also believes that some people can control their weight gain and others cannot.
- 183. Believes that she can control her medical diagnoses with lifestyle behavior modifications
- 184. Believes that purchasing expensive shoes that are more supportive will prevent damage occurring to her feet

Definition of Obesity/Overweight

- 185. Perceives morbid obesity as seen on TV as what is considered overweight.
- 186. Defines overweight as a person who carries excess weight and pressure on the joints of their extremities.
- 187. Considers the term obesity and overweight as having the same meaning, being too fat. Perceives no differences between what the terms mean
- 188. Believes that morbid obesity as seen on television represents overweight people in general
- 189. Denies knowing whether she is overweight; unable to determine whether she is overweight

190. Provides an illustration of overweight as a person who requires two chairs in order to sit down in the waiting room of a hospital.
191. Believes that obesity and overweight are in the categories. Does not or cannot discern between obesity and overweight.
192. Belief that anyone over 200 pounds is fat/obese. Believes that the classification of obesity occurs when a person weighs 200 pounds or greater
193. Believes the word obese means the same as the word overweight
194. Defines obesity as fat
195. Defines overweight as fat
196. Believes that obesity and overweight means the same thing. There is no difference in the two terms
197. Perceives someone who is overweight as being fat. Just a change in terminology only
198. Believes that the word stout is just another way of saying overweight
199. Believes people are considered obese if they weigh 300-400 pounds
200. Believes that people who weigh 200 pounds are considered overweight. States that her weight is almost at the 200 mark but she is planning to prevent herself from reaching 200 pounds
201. Believes that there is no difference in the meaning of the words “chubby” and “obese”
202. When she was younger, people perceived chubby children as healthy and happy children.
203. Believes that obesity means fat. Although she has never had problems with being overweight, she has sympathy for their plight
204. Defines the word obesity as fat but also states that a person who is obese is overweight. She uses all of the terms interchangeably
205. Defines overweight as the person is “a little larger” than normal weight
206. Does not believe that there is a difference between being obese or overweight
207. Overweight means you are too fat
208. Believes that overweight and obesity means the same thing.
209. There is no difference between the words obese and overweight. Believes that the word overweight does not have as much stigma as the word obese.
210. Believes that overweight means that you are too large and that you can pinch an inch or more abdominal fat
211. Believes that obesity and overweight mean the same.
212. Believes that there is a difference in the terms obesity and obese but was adamant to state that she was not obese
213. Associates obesity with people who weigh between 180-300 pounds.
214. Obesity and overweight are considered to have the same meaning
215. Defines the word obese as very overweight

- 216. Was unable to provide a definition for overweight
- 217. Obesity and overweight are different words but they have the same meanings.
- 218. People use the word overweight instead of obese because it is perceived to be less offensive
- 219. States AAs like to use the term “big-bone” instead of using the term overweight or obese.
- 220. Believes that obesity is a condition where the person has gained too much weight. She does not consider herself obese or overweight.

Definition of Physical Activity (PA) /Exercise/Physical Therapy (PT)

- 221. PA, PT and exercise mean the same thing. There is no difference in meanings
- 222. PA and exercise are considered to have the same meaning based on the examples provided.
- 223. (meet people, piece of mind) Examples of the benefits of regular PA
- 224. Client is not sure how to define PA and she was asking the interviewer to confirm her answer
- 225. Client described household chores as PA
- 226. Stated that jogging, walking and exercising were forms of PA
- 227. When asked what was exercise, she changed and stated that jogging and walking were exercise but eventually stated that exercising and PA had the same meaning.
- 228. Believes that PT involves medical personnel working with clients to exercise their extremities
- 229. Believes that PA is a form of exercise that involves any movements of the body
- 230. PA is a form of exercise
- 231. Believes that PT is when a health care provider/ personnel teaches you about exercise and the benefits
- 232. Believes that PA and exercise mean the same. Both involve moving your body.
- 233. Believes that PT is a technique used to get people to exercise their extremities to prevent stiffness and to help with the restoration of independent ambulation
- 234. Believes that PA includes walking, cleaning, and climbing stairs

Dependent

- 235. Without her own transportation, she is more dependent on others to get to medical appointments and the taxi service is not reliable.
- 236. Belief that one should not depend on others unless absolutely necessary.
- 237. Believes that overweight people are lazy and that they like being dependent on others for their needs and that’s why they do not participate in regular PA
- 238. It is acceptable to be dependent on others only when a person is not capable of performing certain tasks for him/herself

- 239. Loss of independence would occur with surgery because she would need major assistance from others post surgery
- 240. Lacks independence in regards to gardening. Pain makes it difficult to garden outside in the yard.
- 241. Regrets the loss of Independence which was very important to her during her youth. Now she has to rely on others to do ordinary things such as walk outside her home by herself. Concern of family members is irritating to her.
- 242. Recognizes that many older adults her age are no longer able to perform many ADLs without assistance from others
- 243. Believes that obese people are dependent on others for assistance.
- 244. Believes that obese people cannot perform ADL without the assistance of others

Desire:

- 245. If she could physically perform more activities she would do it. The desire to be active remains; but the reality is her body cannot perform as it did prior to old age.
- 246. Desire to be active is stronger than the desire to be inactive
- 247. Yearns for the ability to perform some of the same activities she did when she was younger such as gardening. She does not believe that she will ever be able to garden again because of her health
- 248. The loss of her independence causes episodes of depression. Desires to be more independent in the care of her home and doing things outside the home.
- 249. Does not have a rationale for why her weight virtually remains the same. She desires to lose weight because of her HTN and she denies having a large food intake.
- 250. Verbalizes understanding that walking would be beneficial to her health if she would engage but she has not committed to walking with him yet.
- 251. Admits she is capable of engaging in PA but frequently does not have the desire to engage.
- 252. Occasionally the desire to engage in PA is absent.
- 253. Recognizes that sexual activity would be one way to increase PA level but she does not have a desire to have sex
- 254. Admits to having the desire to engage in sexual activity but does not want to participate anymore. Believes that some older women who engage in sexual activity with younger men are paying the men for their services.
- 255. Because she has sympathy for overweight persons, she has a desire to assist them with weight loss through exercise and diet
- 256. Client is currently very active. Only wishes she could add swimming to her list of activities

Energy/endurance

257. It does not matter whether an overweight person has energy because their size limits their physical abilities
258. Decreased energy level can cause decreases in physical activity level. Attributes low PA level to her decreased level of energy.
259. Decreased energy leads to decreased PA and the need to conserve energy
260. Decreased energy leads to decreased participation in activities.
261. Tried vitamins to increase energy level
262. Decreased energy leads to decreased participation in activities
263. Cooking style now appears to be a way to preserve energy.
264. Regardless of information that would be provided about PA, decreased energy is her plays a major role in her functional limitations
265. Decreased energy reduces her ability to performing household chores and it increases her functional limitations regardless of the family support
266. Difficult to shop because she does not have the energy to walk around large stores.
267. Decreased energy is a barrier to PA
268. Knowledgeable of the benefits of regular PA but does not have the energy everyday to perform regular PA.
269. Decreased energy is a barrier to performing daily PA
270. Client has decreased endurance with standing activities such as when cooking. This has caused her not to cook as much as she used to.
271. Experiences shortness of breath when she performs ADL but she compensates by resting between activities before continuing her activities.
272. Does not let shortness of breath with activities deter her from performing needed activities. She rests between activities.
273. She admits that she had to have rest periods in order to complete her walk.
274. Decreased ability to walk or stand for long periods of time. Feet will swell if she stands for long periods of time
275. Shortness of breath with activity appears to be her major barrier to performing regular PA
276. Started experiencing an exacerbation of shortness of breath within the last year and this caused her PA level to decrease more
277. Older adults should use frequent, small rest periods to complete tasks and activities. Suggests standing rest periods because sitting decreases motivation to continue with activity
278. Knows that some overweight people do not have problems with ambulation while others fatigue easily and requires frequent rest periods.
279. Paces herself when performing household chores. This keeps her from becoming too fatigued

280. She has decreased endurance with performing household chores. She becomes fatigued much faster than she used to. She has to sit down to wash, iron or fold clothes or wash dishes.
281. Overweight people fatigue easily with activity.
282. There are no advantages to being overweight. Some overweight people have to sit down to perform some ADLs or have frequent rest periods to complete ADLs. She classified herself as obese but stated that her ability to climb up and down stairs is not impaired.

Exercise

283. Exercise programs are good for overweight people to participate in because it helps them lose weight
284. Believes that it is difficult for older adults to use exercise machines
285. Considers watering her flowers a form of exercise
286. Considers yard work to be a form of exercise
287. Performs light yard work on regular basis and she considers this exercise
288. The perceived benefit of regular exercise is that it makes a person feels better
289. Engaging in light yard work is equivalent a form of exercise for her
290. Exercise is more difficult for overweight people but it is good for them.
291. Believes that if obese people perform regular exercise this will lead to extreme weight loss
292. Believes that participating in regular exercise will lead to weight loss and it will relieve stress on the knee and hip joints
293. Knowledgeable of some upper extremity exercises even though she does not perform them on a regular basis
294. History of exercise classes at her apartment complex. They would perform arm exercises without free weights
295. Recognizes walking as a form of exercise
296. Knowledgeable of some upper extremity exercises with hand weights even though she does not perform regular UE exercises. She no longer does UE exercises with free weights because it causes are pain and soreness.
297. Post exercise soreness became a barrier to performing regular upper extremity exercise
298. Perceived post exercise soreness as an abnormal result and therefore she discontinued performing regular upper extremity exercise
299. Exercise group and convenient location for exercise was discontinued from her apartment building
300. She had access to a weight room at the community center but she did not use it.
301. Knowledge is not enough to overcome perceived difficulties with mobility to increase participation in regular exercise

- 302. Range of motion (ROM) of upper and lower extremities is essential to functional status and mobility and she has limited ROM in all four extremities.
- 303. (running, walking, swimming) Examples of exercise
- 304. Stated that PT was a form of exercise
- 305. Knowledgeable of the benefits of regular PA and she tries to perform upper extremity exercises in order to improve UE ROM
- 306. Recognizes that exercise is important and that she needs to participate
- 307. Demonstrating what exercise is to her by standing up and forward flexing
- 308. Demonstrating other forms of exercise by extending and flexing her knees and ROM of shoulders. She realized that exercise helps the extremities of the body remain mobile
- 309. Believes that push-ups is a form of exercise that she would not be able to perform
- 310. Believes that PT is a form of exercise designed to work out a person's extremities
- 311. Client mostly walked once a week prior to retirement because she was working through the week
- 312. Believes that walking would help improve her arthritic pain and her decreased endurance. Also realizes that a sedentary lifestyle is not good for one's health.
- 313. Understands that walking can improve arthritic pain
- 314. Believes that walking the hallways of her apartment helps her maintain her current weight status.
- 315. Walks intermittently and short distances with one of her neighbors
- 316. swimming and walking are good activities for the body because they tone and condition the extremities and the body in general so that the person can ambulate and function without difficulty
- 317. Believes that exercise involves a person using all body parts. Because ADLs requires the use of all (or most) body parts, ADLs are a form of exercise.
- 318. Recognizes to lose weight in a healthy manner, exercise is an essential component
- 319. Exercise consist of performing activities that tones the body and it will aid in obtaining longevity
- 320. Performs regular exercise six days a week unless she is sick
- 321. Believes that exercise is the key to her overall good health, but especially for her heart disease and diabetes
- 322. Performs UE and LE exercises in her bed at infrequent intervals. Believes that she is performing adequate amounts of exercise.
- 323. Considers exercise to be activities such as aerobic dance because the person is moving the body in different directions. Also considers walking, riding a bike, and working in the yard as exercise.
- 324. Changed the form of exercise she was using from riding a stationary bike to attending water aerobics

325. Water aerobics exerts less pressure on joints but she does not attend water aerobics in the wintertime because she does not like getting out of the water into the cold air.
326. People who cannot walk should perform UE exercises and LE exercises while sitting in a chair. There is some form of exercise any person can perform
327. Believes that if she had additional information about back/ upper body strengthening exercises and ROM exercises for the upper and lower extremities, she would participate in more PA.
328. Contemplating the start of a walking regime in her neighborhood or just walking up and down her driveway.
329. Client thought that she was obtaining adequate amounts of exercise when she was performing yard work in her younger days, therefore she did not think that she needed to increase her walking.
330. She thought that because she was working everyday and cutting the lawn in two yards, she was getting adequate exercise.
331. Believes that exercise is staying busy, [walking running, cooking and jogging] and includes formal activities as well as household chores.
332. Believes that walking is a healthy activity even though she started walking because she was bored.
333. Walking improves blood flow and mental functioning. Walking for long periods of time may cause LE pain or discomfort
334. The timing of the water aerobics class was a barrier to her participation but now that she knows that there are some alternative times, she plans to attend.

Family –Friend Support/ Influence

335. Son doesn't understand the importance of PA and the implications related to decreased activity
336. Son thinks that resting and elevating her LE s will improve the pain and swelling but he doesn't understand the risks associated with decreased activity
337. Family members can contribute to or hinder diet compliance because they do the shopping for the client
338. A family member suggested surgery as a quick fix verses a lifestyle change of regular exercise but client did not agree with that suggestion
339. Others make it convenient for this client to increase her homebound status and decrease her social outings. Church attendance has decreased but church members deliver sacrament to her at her home.
340. Grandson tries to encourage her to increase her walking but although pain is a barrier, she tries to increase her walking
341. Family members perform instrumental ADLs because she is unable.

342. there appears to be a self imposed barrier because she feels rushed when she goes to the store with people other than her son who died
343. Mobility is limited and she requires moderate assistance from others. She feels that she is a burden to her grandson because he has to help her with mobility issues such as traveling in the car.
344. Independent with small tasks in the home and has sufficient help and support from adult children.
345. Pain makes PA difficult despite family member encouragement. She gets upset with her grandson because he does not understand how she feels but she does not say anything
346. She also allows her family members to shop for her because they are able to walk faster than her, but this decreases her PA. passed on shopping duties to family members because they are more proficient at it; shopping has become difficult for her and she moves about the store very slowly.
347. She chooses to let her grandchildren perform her grocery shopping instead of doing it herself.
348. Acknowledges that letting her kids shop for her has caused her not to even attempt to shop for herself. It is easier to let the kids shop for her.
349. Has no motivation to shop for herself now that she has retired and she has family members who are willing to shop for her, so there is no need for her to go.
350. Her brother constantly tries to encourage her to participate in regular PA
351. Some family members believe that the client is too sedentary and she needs to increase her PA level.
352. Her brother uses walking as a stress reliever and to improve his overall health
353. Does not have any family who would encourage her to participate in regular PA
354. Believes that older adults with children or grandchildren make them get things for them instead of getting up themselves, which would be PA.
355. Believes that some family members encourage older adults to lead a more sedentary lifestyle because the family members do many activities that the older person could do for themselves. Family members are at fault for causing/ encouraging premature dependency.
356. Family members promote sedentary lifestyles of older adults
357. No one would encourage her to increase her PA but one of her grandsons. She believes that other people would tell her to stop doing as much as she is currently doing.
358. Grandson is the only person who does not discourage her from performing regular PA
359. People important to her would try to discourage her from walking because they believe that she is over exerting herself.
360. Friends who have limited mobility and overall functional status are trying to discourage the client from performing regular PA.

- 361. Her friends do not understand why it is so important for the client to engage in regular PA before socializing
- 362. Family does not adhere to eating foods that are healthy. Client is making changes in her diet in order to eat healthier despite her family's disapproval
- 363. Family members do not encourage client to participate in regular PA. All of her encouragement comes from medical personnel
- 364. She remembered that her son who lives out of town was proud of her PA routine and he encourages her to continue with her daily routine.
- 365. She is attempting to find her an exercise partner because she believes that would motivate her to do more.
- 366. Family member encourages her to perform regular PA but she believes laziness is a barrier.
- 367. She realizes that her family member only encourages her to increase her PA in order to help her mobility and overall health. Attempts to hide amount of time spent lying down from family.
- 368. Her grandson also encourages her to increase her PA.
- 369. She has a family member who is a strong proponent of healthy lifestyle behaviors. This family member tries to encourage her to adopt a healthy lifestyle of diet and exercise.
- 370. Believes that her family members would be happy if she would engage in regular PA. Some members would even be willing to walk with her.
- 371. In the past, she has tried to encourage her daughters to lose weight but she met a lot of resentment from them so she stopped. She realizes that there are health related illnesses that accompany obesity and she does not want her daughters to experience these problems.
- 372. Client stopped walking with a partner because she walked at a faster pace than her walking partner
- 373. Her friends give her reasons for not participating in regular PA such as knee pain.
- 374. Her daughters tell her that it is good that she exercises but they are not going to exercise
- 375. One daughter lives close to a nice walking track but she does not take advantage of this amenity. The client is concerned about her daughter's health and weight status. She yearns to participate in PA (e.g. walking) with her daughter but is waiting for an invitation.

Faith or Spirituality

- 376. Perceives self as blessed
- 377. She chooses to believe in God to help her cope with knee pain.
- 378. Expresses thankfulness to God that she is her current size
- 379. Faith in God is an important coping mechanism to use when you have an illness

- 380. She feels grateful to God that she is able to perform as well as she does because there are other older adults whose health conditions are worse than hers.
- 381. She is grateful to God that her health is as well as it is because it could be worse.
- 382. Spirituality is an important to help her deal with LE pain that she experiences. She refuses to contemplate knee surgery
- 383. She uses her religion as an important coping mechanism to help her stay physically active. Staying active helps keep the mind and brain intact.
- 384. Uses prayer to give thanks to God for her family and her current health
- 385. Believes that she has been blessed by God because she was not sickly the majority of her life. Perception that her poor health was caused by aging not other conditions
- 386. Belief in the serenity prayer. Accepts her pain and believes that God will help her endure and cope with pain.
- 387. Believes that God will help the person accomplish goals if she put forth an effort.
- 388. Believes that family members do not understand that she does not walk more with her walker because of LE pain
- 389. Perception that family members would be happy if she had more independence. Family members wish for a better state of health for her.
- 390. She described an overweight woman who was older than her but was able to ambulate better than her. She considers this neighbor as being blessed because she is oriented and appropriate at 95 years old.
- 391. She uses prayer to help her cope with leg pain . She considers herself to be a spry person.
- 392. She believes that she is blessed by God to be able to perform the activities that her friends cannot
- 393. At first she felt like people were using her to help them but now she feels that she is blessed to be able to help others who cannot perform all of their ADLs
- 394. Believes God purposefully designed her body to withstand work even in old age.
- 395. Believes that God will give a person the strength to perform any activities that they need to perform. The person just has to make the effort and not complain
- 396. Although she is 74 years old, her health is still a priority for her. She is thankful to God that she has lived this long but she wants to continue living a healthy life
- 397. Tries to encourage family members to eat healthy but they do not want to make any changes so now she prepares two different meals.
- 398. She thanks God for being able to perform ADLs alone

Finances

- 399. Being overweight can cause a financial burden because you have to purchase new clothes
- 400. Notion that bigger things (i.e. clothes and shoes) cost more money

- 401. Not having one's own transportation and the increased co-pay for doctor visits is an increased burden because she previously did not have to pay anything for transportation. Money is attributed to doctor or PT visits, not transportation
- 402. Money is limited among some older adults because they are on a fixed income. They have to prioritize their spending because of financial restraints.
- 403. Limited income is perceived as a barrier to performing regular PA because she believes you need to go "somewhere" to participate
- 404. Unable to go to the YMCA as desired because she has to work to pay her bills.
- 405. Consider it a blessing from God that you can afford to purchase certain materials, but do not misuse blessings to pay someone to do the actual job (work) for you.
- 406. Understands that a lack of finances prevents some people from buying foods that are healthier.
- 407. Believes that people today are trying to cook healthier but there are obese people who probably lack adequate finances to purchase healthy foods
- 408. Believes that community gardens would be one strategy to assist people with inadequate finances to obtain healthy foods

Grief or Depression

- 409. Believes that after her grief resolved her appetite returned
- 410. Grief can lead to a decreased appetite
- 411. There are different levels of grief which can cause various effects on one's appetite
- 412. Grief because of the death of a loved one can cause a person to lose one's appetite
- 413. Grief has also contributed to decreased participation in activities that use to be considered fun
- 414. Recalling the activities of her youth brings to light her current limitation; this causes a great deal of sadness
- 415. Becomes depressed when she thinks about her current health status
- 416. She has periods of depression
- 417. Does admit that when she does perform regular PA she feels better. Important not to give in to sadness/ depression or feeling sorry for one's self.
- 418. Realizes that although she moves slower now than she did during her youth, she needs to stop feeling sorry for herself because she can still perform some activities just at a slower pace
- 419. Becomes depressed in the winter months. Recognizes depression may be responsible for a decreased appetite. Depression in winter months causes increased social isolation.
- 420. During the winter months the client stops participating in outdoor activities which is a major component of her life. She becomes depressed and this leads to a decreased

appetite. Depression and social isolation led to infrequent church attendance (a change from the usual).

421. Believes that obese people suffer with depression

Healthcare Provider Mistrust

422. Believes that Caucasians classify AAs as having weight problems. Believes that other races have problems with weight and she is not going to accept the obesity classification for AAs.

423. Finds it offensive that AAs are classified with so many health disparities.

424. Believes that AA women are classified with so many diseases because healthcare providers interpret the test incorrectly for AAs. Does not know if the same is occurring among AA men because they typically do not go to the doctor.

Incontinence

425. Pt has intermittent incontinence

426. Has trouble holding her urine and this results in intermittent incontinence.

427. Intermittent urge incontinence especially after drinking a large amount of liquids

428. Has tried different techniques to control urinary intermittent incontinence

429. Urge incontinence without pain

430. (A natural disaster interfered with MD appointment and remembering to reschedule appointment. Incontinence is embarrassing and it is often difficult for women to talk with healthcare providers about this issue).

431. History of increased urinary frequency contributes to her increased homebound status.

432. Concerned about how others regarding perceive her urinary frequency

Independence

433. Independence is important so she tries to stay busy

434. Being overweight worsens one's condition and leads to a loss of independence

435. Remaining independent is important and this is accomplished by performing her own routine tasks at home

436. She is still capable of performing her own housework without outside assistance

437. She is still capable of putting on her own clothes without assistance

438. Believes that it is important to be able to maneuver around her house and care for herself without assistance.

439. Believes that keeping active is important to her independence but regrets the inability to attend church regularly because of edema in her feet.

440. Independence is important to her . She does not want to become dependent on others.

441. Believes that even though physical functioning can decline with aging, it is important to accept the changes that come with aging, but at the same time to stay independent as much as possible. Don't become dependent
442. One's own independence is important because other people have their own responsibilities which makes it more difficult to get assistance from others especially if they work
443. Independence is important. Believes that God will help you to remain independent if you keep active and help others
444. Self-Independence is important to her. As long as she can perform all of her ADLs and IADLs she is happy
445. Performing her own household tasks and not depending on others is important to her
446. Refused to allow poor health to force dependence on others
447. Not having her own transportation is a barrier to her social independence. Continues to perform ADLs and light housekeeping without help from others. Not at the point of dependence.
448. Believes that older adults should maintain independence as long as possible
449. Lives alone with intermittent outside help. Perceives that she would not have anyone to assist her full time if she consented to have the surgery
450. She paces herself when performing household chores. This method helps her to remain self-sufficient
451. Able to live in assistive living complex and maintain some independence with assistance which is available free of cost
452. Maintaining independence is important. Whenever her pain is under control, she tries to do all of her household chores in one day but the next day she will be in a lot of pain because she would have overworked her body. Has not learned how to pace her activities to prevent pain and fatigue
453. She used to shop for herself before she retired
454. Living alone helps older adults remain independent.
455. Prides herself on being able to perform all of her yard work without any assistance from her children
456. Does not want to be dependent on anyone for anything. She likes to perform activities as she deems necessary. Is willing to help others with activities and chores.
457. She is proud that she is able to perform household chores with asking for assistance from others. Many of the household chores she undertakes are very strenuous activities.
458. People need to rely on themselves for as long as they can.
459. Client is able to perform ADLs without assistance at this time.

Lifestyle habits:

460. Lifestyle habits are routine and very hard to break. She keeps this schedule regardless of planned activities.
461. She has had this daily routine for years so it is difficult for her to change.
462. Realizes that she didn't make the best lifestyle choices when she was younger.
463. She chose to buy larger clothing sizes rather than to modify her life-style behaviors.
464. Knowledge of obesity related illnesses still did not translate into lifestyle behavior modification
465. Knowledge of the importance of performing PA and exercise does not necessarily translate into behavior modification. She mostly uses her motorized wheelchair to get around her home.
466. Considers herself as always being an active person but she is more active as an older adult because her residential building is more suitable for PA.
467. She uses the stairs in order to increase her daily activity level
468. She has always been active but the type of activities she participates in now are different from her younger days. However, she perceives that she is more active now than when she was younger.
469. Believes that she is the most active person in her apartment building
470. She perceives herself as a leader for the rest of the tenants in her apartment building
471. There was a person who provided exercise classes for the tenants but the client believes that because she did not attend, others in the building would not attend
472. Believes that people who do not adopt a healthy lifestyle do not care about their health
473. Perceives her activity level to be the same as in her younger years.
474. Client has a difficult time sitting still for long periods of time. Her mind is constantly thinking of activities for her to do around the house.
475. She is not only active at her home, she will help someone at their home if they are working on a project
476. Has always been a very active person since childhood
477. Contributes her active lifestyle to her childhood responsibilities. She was responsible for helping her mother care for her sick brother.
478. Had a very strong curiosity for anything that would keep her busy and physically active
479. She does not like exercise equipment. She prefers to perform yard work or walk outside where she can commune with nature.
480. Client has been active all of her life. If she ever gets to the point where she would not be able to perform yard work or take care of her own housework, she would be ready to die instead of having to depend on others.

- 481. Understands that in order to lose weight, there needs to be lifestyle changes in regard to eating and exercise.
- 482. She has made a lifestyle change regarding her diet despite her family's refusal to change.
- 483. Although years ago people ate foods high in fat, they walked more and lead more active lifestyles than people do today
- 484. She has since learned that it is difficult to get adults to make changes in their lifestyle so she has decided not to worry about her family making changes anymore.
- 485. She feels proud of her accomplishment and her ability to be active at her age.
- 486. Believes that older overweight people stay indoors more so than younger overweight people, who are more visible.
- 487. No matter what the season, in Alabama older overweight adults stay indoors because their mobility is slow.
- 488. Follows a very strict walking schedule regardless of the weather or the planned events of the day

Meal preparation/ Eating habits

- 489. Believes that overweight people eat excessive amounts of food
- 490. Believes that overweight people partake of too much of traditional southern AA foods, which is perceived as unhealthy diet
- 491. Overweight people consume too much food and it is not equivalent to the amount of energy they expend.
- 492. Perceives that most overweight people eat too much and they have sedentary lifestyles
- 493. Perceives that older people have early satiety
- 494. Devised methods to cook and store large amounts of food for one person
- 495. Her eating and cooking habits have changed now that she is older
- 496. Does not routinely eat a regular well-balanced meal; eats according to how she feels and what she craves.
- 497. Does not eat breakfast in the early morning hours
- 498. Appears to use coffee as a appetite suppressant
- 499. Appears to skip breakfast and just wait until lunch to eat.
- 500. Does not have a regular scheduled time for any of her meals. She only eats when she "feels" hungry
- 501. Overweight people and those with diabetes should follow a special (low calorie, low fat) diet especially when purchasing and preparing food and a history of diabetes
- 502. Possesses the knowledge about what is appropriate to eat based on her medical history of diabetes but she does not always adhere to diabetic diet

503. Even though she knows that some foods she eats are not appropriate for her medical condition she attempts to limit the intake amount of that inappropriate food. However, she should eat the no sugar added ice cream
504. Believes that the southern, traditional “soul food” diet of AA’s contributes to AA weight gain
505. Believes that Caucasians do not purchase or eat the southern, traditional “soul foods” that some AA’s eat.
506. Believes that Caucasians have a better diet or food choices than most Southern older AAs
507. Believes that AAs eat a lot of pork which contributes to overweight status
508. AA food choices lead to many AA being overweight
509. Believes that eating a healthy diet prevents people from becoming overweight
510. Believes that decreasing food intake has contributed to her weight loss. Does not appear to eat a well balanced diet
511. Eating habits have changed. Appears to have become bored with her food choices which leads to a decreased food intake.
512. Food intake decreased because of boredom with food choices. Has difficulty selecting new/ different menus/ foods cook.
513. Some of her food choices are congruent with what she previously stated AAs eat
514. Perceives that obese people eat in excess and continuously
515. She enjoyed eating traditional southern” soul food” despite the knowledge that this type of food was contributing to her overweight status.
516. Appetite fluctuates and it decreases with exacerbations of sinus flare-ups
517. Belief that weight has remained stable because she routinely eats the same amount and does not overeat.
518. She appears to eat meals on a regular basis. Tries to be adhere to medical advice regarding meals.
519. Appears to eat at regular meal times but likes to eat potato chips. She is aware that potato chips are high in fat and calories
520. She eats regular potato chips by the handful. She does not eat the baked or low fat versions and she realizes that this is not a healthy food choice.
521. She is knowledgeable of some foods to avoid that can increase cholesterol. Her family has stopped eating beef and pork but she still likes to indulge every once in a while.
522. She is trying to make some healthier diet choices by using ground turkey instead of ground beef
523. She does not consider herself to be a big eater and that’s why she believes she is not overweight

- 524. Believes that eating a meal and immediately laying down after the meal contributes to a person gaining weight. Therefore it is important to find something to do after a meal other than going to bed
- 525. Having mental or physical problems can also contribute to overeating
- 526. Likes to cook southern “soul food” and share it with others
- 527. Uses pig tails to season greens and cabbage and believes that these vegetables will not taste good if they are not cooked with pig tails
- 528. Perceives herself as being able to eat in moderation. Her meals do not appear to be balanced meals (meals appear to be deficient).
- 529. When she observes large amounts of food being prepared and people eating, that sight temporarily diminishes her appetite
- 530. Participant eats only a small amount of food but her friend will eat whatever the participant doesn’t eat.
- 531. She has problems eating meat other than chicken. She can only eat half of a chicken breast but that would count as two servings for her. She likes to eat vegetables instead of meat.
- 532. Although she is aware that she should not eat sweets, she continues to eat sweets but she attempts to burn the calories by performing yard work
- 533. Loves to eat watermelon because it suppresses her appetite and it doesn’t raise her blood sugar the next day
- 534. Likes to eat junk food but knows that it is not good for her
- 535. Concerned that she gets involved in daily activities before eating breakfast and as a result, her BP and BS become elevated. Concerned that she gets involved in daily activities before eating breakfast and as a result, her BP and BS become elevated.
- 536. She is aware of the correct foods to eat but she often eats foods (like sweets) that are not part of a diabetic diet
- 537. Knowledgeable of alternative choices to eating sweets but refuses to use them because of the potential side effects.
- 538. Has learned to read food labels and what foods to avoid.
- 539. Decreased appetite was also related to her husband’s food choices. He wanted fast-food and she did not. But her husband is now better and she thanks God for bringing her through that stressful situation.
- 540. Loves to eat but she is trying to eat in moderation because it is healthier
- 541. Eating regular serving sizes now
- 542. Decreased intake of sweets and eating more normal serving sizes contributed to her losing weight
- 543. Client does not adhere to her ADA diet even though she has a history of diabetes. Knowledge does not always translate into behavior modification. It’s difficult to change long term eating habits

- 544. Believes that if she drinks only water that will counter balance the sweets that she eats. She is aware that she should not be drinking regular sodas or eating sweets but she regularly indulges in these.
- 545. Monitors blood sugar more frequently when she is eating something that she should not be eating.
- 546. Believes that older Alabamians overeat on foods that are high in fat because this is what they were raised on when they were children.
- 547. Cooking preferences include cooking most vegetables with ham hocks or the like
- 548. Older adults cook food the way their parents cooked food (traditional southern cooking)
- 549. Believes that her weight has decreased because she is eating healthier, decreased her sweet intake, and caloric intake/ serving size(s).

Medication/ Alternative treatment

- 550. Treatment (corticosteroid injection) relieved knee pain and made ambulation easy and comfortable
- 551. The corticosteroid injection therapeutic effect was short term
- 552. Pain treatment modalities do not work for everyone
- 553. An alternative pain treatment (salve) modality used to decrease pain and swelling
- 554. A home remedy method (soak in a hot tub) to decrease pain in LEs
- 555. Pain management strategies to decrease discomfort and to make it easier to ambulate
- 556. Uses pain management strategies to keep active and perform light household chores.
- 557. Belief that taking multiple medications may be effecting appetite
- 558. After receiving the steroid injection, she denies having any exacerbation of knee pain that would cause her to seek medical treatment
- 559. Perceives that birth control pills are also contributing to her niece's weight gain
- 560. PT is used by persons who have a chronic medical condition that requires massages or injections for treatment
- 561. There are no quick fixes like pills that will accomplish long-term results
- 562. Client suffers from back and LE pain but she takes medication for the pain which helps with her mobility
- 563. Uses hot water (moist heat) as a pain management strategy for knee and back arthritic pain
- 564. Uses topical pain medicine for arthritic pain
- 565. Went to a chiropractor for her back pain because standing is painful and obtained some relief
- 566. Pain management strategies were used to decrease pain and increase mobility.

Mobility

- 567. Mobility is limited and difficult
- 568. Mobility only with assistive device
- 569. Mobility is limited
- 570. Mobility is slow and it takes time to prepare for outings, so she has to get up several hours before appointment time.
- 571. Worked in a hospital as one of the cooks
- 572. Being overweight can decrease your mobility.
- 573. Decreased mobility has lead to decreased PA with aging
- 574. Being overweight/ obese leads to a decrease in mobility status.
- 575. There no advantages to being overweight. Being overweight slows down your mobility status
- 576. Decreased mobility and endurance when performing ADL such as cooking
- 577. Being overweight decreases a person's ability to ambulate, perform yard work, LE joints become stiffer, and fatigues sooner
- 578. Obese people have difficulty with their mobility
- 579. Does not believe that all overweight older AA women have problems with mobility or traveling because of her 90 –year- old aunt who was overweight and did not experience any problems with mobility or functional status.

Motivation:

- 580. Believes that if overweight people could read her information they would be motivated to increase their PA
- 581. Motivated to repot flowers because they are a memorial to her son despite decreased energy level
- 582. Would be motivated to participate in social activities that she is interested in. Personal interests lead to motivation.
- 583. Current illnesses and the fear of new illnesses are motivation to adopt a healthier lifestyle, such as increasing exercise and eating a healthy diet
- 584. Believes that people will be motivated to participate in regular PA if people are informed of the benefits of regular PA
- 585. Belief that encouraging women to find exercise partners and to seek support from others would be a motivator for PA.
- 586. Teaching women the consequences of PA (that it promotes a healthy life) is a motivator.
- 587. To motivate, emphasize that there will be problems and hurdles in life but PA is necessary even during these times.
- 588. Her brother's health condition is what motivates him to walk on a regular basis but his condition has not motivated the client. Although she is aware of the benefits and

consequences for participating and not participating in regular PA, knowledge does not translate into behavior modification.

589. Believes that if you tell people the benefits of regular PA, they will be motivated to engage

590. Longevity is a motivator to engage in regular PA

591. Needs ideas on how to motivate herself to increase engagement in PA.

592. She motivates some of her neighbors to walk

593. Believes that some tenants would participate in exercise classes and some people would not be motivated despite the incentive

594. Believes that food would motivate people in her building to exercise

595. Having energy and being healthy are motivating factors for this client to participate in regular PA

596. Believes that food and games would motivate some of the older adults in her building to participate in PA

597. Client believes that she would want to participate in an intervention study because she would want to help overweight people lose weight but she does not want to hurt anyone's feelings.

598. Believes that it is important to work with obese people to help them with strategies to lose weight instead of focusing on cosmetics

599. Because of her physical education background, she tries to encourage family members not to become overweight or obese. When she chastises others about gaining weight, she meets resentment.

600. Does not understand how an overweight person could look at themselves and not be motivated to lose weight on their own

601. Tries to encourage others to walk. Believes that it is important for people to be self motivated when it comes to participating in PA

602. Client is self motivated when it comes to performing PA. Working in her yard is therapeutic to her and a time to meditate on God, and provides her with a sense of peacefulness.

603. Believes that her neighbors are motivated to participate in yard work as regular PA because of her example and the presentation of her yard

604. Believes that using herself as an example (to illustrate all of the things she is able to do at her age would be a motivational technique for other older AA women.

605. Recommends an informal structure without use of a pulpits or podiums. Recommends informing women about an appropriate routine or schedule of physical activities and the need to incorporate breaks/ rest periods

606. Self-directed/ motivated to obtain information on her chronic illnesses and health promotion

607. When people see that she has lost weight they ask her about the strategies she uses

608. She tries to motivate other older AA women to participate in regular PA by example. She lets them know what she is doing to lose weight and become healthier.
609. Believes that showing older AA women before and after pictures of herself would motivate them to want to participate in regular PA
610. Because she has been attending an exercise program where she has been taught about proper diet and exercise, she is motivated to adapt her lifestyle based on what she has learned
611. Her motivating factor to participate in regular PA is her overall health and the fact that she does not want to add any additional medications to her daily routine
612. Believes that a partner would be a great motivator for her to increase her PA
613. She believes that most older adults are not that motivated to exercise
614. Believes that the best way to motivate older AA women to participate in regular PA is to list potential benefits for them such as extremities will be more limber, weight loss would decrease pressure on LEs.
615. Perception that a role model (an older AA woman) who engages in regular PA and has obtained benefits of PA would be a positive motivator
616. Her aunt's constant encouragement to adopt healthier lifestyle behaviors is beginning to motivate the client to contemplate increasing her PA.
617. In order to motivate older AA women to increase their PA levels, they need to be informed that PA can help keep the body conditioned, improve circulation, and help them lose weight.
618. Health is the motivating factor for the client to maintain her walking schedule
619. Knows people younger than her that are not motivated to walk
620. Client always self-motivated herself to walk daily. She tries to encourage others to walk e.g. her daughters and friends because walking is a healthy activity to participate in but they refuse. Unsuccessful in convincing others (motivating) to engage in PA
621. Although she tries hard to motivate/ encourage her daughters to walk and take care of themselves, they did not start adhering to her encouragement until they started having problems with their own blood pressure and cholesterol
622. Provide the following information in order to motivate other older overweight AA women to participate in regular PA: eat a proper diet, eat in moderation, stop being sedentary, avoid fried foods, eat fruits and vegetables and walk 10-15 minutes a day
623. Believes that it is difficult to motivate others to participate in regular PA but good health should be a major motivator. Thinks AA women should be educated on a sedentary and an active lifestyle
624. She also believes that it is difficult to motivate some older AA women to walk just for pleasure.
625. An older Caucasian male motivated the client to continue to walk because he was older than her and he used a walker to ambulate

Movement

- 626. Movement is painful
- 627. She is unable to maneuver stairs because this causes severe LE pain, thus, PA is limited.
- 628. Limited mobility of LEs and hip replacement surgeries hinder certain changes in positions
- 629. Believes that when a person is overweight it is difficult for that person to perform some activities e.g. bending over or just decreased energy in general. When a person is normal weight, these activities are not difficult.
- 630. Believes that overweight people have a difficult time bending over to pick up things
- 631. Remaining physically active prevents stiffness and maintains mobility of limbs
- 632. Impaired leg movement/ motion interfere with PA.
- 633. Believes that the quality of sleep and one's ability to move and ambulate changes when a person gains weight
- 634. She has friends who are unable to bend or stoop over to pick up things because they have gained so much weight.
- 635. Believes that overweight people have difficulty performing ADLs.

Normal weight

- 636. If a person is normal weight, they are able to perform tasks and ambulate without difficulty.
- 637. It is better to be normal weight.
- 638. Perception of normal weight is higher than health care standards
- 639. Acknowledges that she is not in the normal weight category and that she needs to lose some weight
- 640. Normal weight is healthier for you and people would feel better if they were not overweight
- 641. Believes that women should weigh approximately 150 pounds or less to prevent being classified as overweight.
- 642. Being normal weight allowed the client to feel better, to have better mobility, and to be able to wear previous clothing; (did not have to purchase larger size clothing).

Overweight

- 643. Vows not to be overweight because it is not a good thing
- 644. Overweight status means decreased physical activity. Being overweight in addition to other health conditions would decrease one's ability to care for oneself
- 645. Refutes being overweight but is unaware that she is classified as obese. Believes that being overweight is unhealthy
- 646. Being overweight may be worse than other conditions; certainly it is not desirable

- 647. Does not consider herself overweight. Being overweight is worse for certain body types or body builds
- 648. Being overweight would interfere with self-care activities (the ability to care for oneself).
- 649. Being overweight threatens independence thus this is the impetus to refrain from becoming overweight
- 650. Being overweight limits what a person can do, how fast they can do things and where they can go
- 651. There is no difference between being classified as chubby or overweight
- 652. Believes that chubbiness is a precursor to being overweight
- 653. Being overweight makes the most mundane task difficult
- 654. Being overweight interferes with a person's ability to sleep and rest
- 655. Being overweight makes life difficult
- 656. Any illness can be exacerbated with overweight status
- 657. Being overweight makes it complicated to maneuver in and out of cars
- 658. Being overweight interferes with specific activities (i.e. maneuvering stairs)
- 659. Some AA older adults weigh too much
- 660. Overweight people are not concerned about their health
- 661. Overweight people do not look like human beings anymore
- 662. Believes that exercise programs help overweight people to become attractive. Being overweight is unhealthy
- 663. Believes that being overweight decreases a person's ability to engage in PA by causing pain and fatigue.
- 664. Does not perceive self to be overweight
- 665. Being overweight is not healthy
- 666. Perception that overweight people are satisfied with their weight
- 667. Overweight is associated with decreased energy and shortness of breath
- 668. Being overweight can decrease your ability to perform ordinary tasks
- 669. Being overweight can contribute to increased pressure on the joints of the lower extremities which can lead to joint damage
- 670. Believes there are a lot of overweight people in Alabama and some people are too large to sit in a standard chair
- 671. There are no advantages to being overweight. Client is knowledgeable that there are overweight/obesity related illnesses that can occur.
- 672. In her older age, she is aware of the health consequences of years of being overweight.
- 673. Believes that after the age 40, people who are overweight are at increased risk for diabetes, hypertension, joint pain.
- 674. Does not believe that there are any advantages to being overweight

- 675. Believes that overweight people experience shortness of breath with exertion and must have frequent rest periods with ambulation
- 676. Perceives that overweight people eat constantly
- 677. Perceives that people with a large body frame can be classified as overweight. People can carry adipose tissue on any area of the body such as the upper extremities
- 678. Her friend requires medical treatment for her constant LE pain because she is overweight
- 679. Believes that overweight people are overweight because they do not care about themselves.
- 680. Being overweight can run in families
- 681. Recognizes that being overweight may cause heart, respiratory, neurological or mobility problems.
- 682. Believes that there are no advantages to being overweight. She names examples of disadvantages, which are related to transportation and mobility (e.g. two seats on airplane).
- 683. Believes that if you weigh more, maybe you would be able to lift or carry more things.
- 684. No advantages to being overweight
- 685. Believes that some overweight people are able to lift or move heavy objects because they have more strength and endurance but this is not true for every overweight person.
- 686. Perceives being overweight was an advantage to her when she was providing care taker duties
- 687. Believes that overweight people have a difficult time functioning in society today. Also thinks that most overweight people are uncomfortable and become short of breath with exertion. But acknowledges that all overweight people do not experience discomforts or dyspnea.
- 688. Believes that a person is overweight if they sit down in the car and the car sinks or becomes low to the ground.
- 689. Overweight people should not be discriminated against in regard to flying on airplanes. Airlines should be required to make accommodations.
- 690. Believes that it is more difficult for overweight persons to recover from illness episodes
- 691. Being overweight causes a person to fatigue quickly with ambulation, clothes are too tight and must purchase new larger ones, and the person cannot walk for long periods of time.
- 692. Believes that being overweight is a problem for older AA women in the summer months. Believes that overweight people have a more difficult time remaining cool in the summer

693. Being overweight can cause increased pressure on the joints of the LEs, mobility status slows down, and decreased endurance (fatigues easier) performing even small tasks.

694. Does not believe that it is a good thing to be chubby.

Obesity

695. Believes that morbid obesity is unhealthy

696. Believes that obesity is greater among younger women than older women

697. Perceives that people who are obese should be able to look at themselves and see if they are overweight. No one should have to tell a person that they are overweight.

698. Because she was not having any health problems when she was younger, she did not believe that being overweight/ obese was affecting her health. But now she realizes the effects of obesity.

699. She does not think that obesity is a problem for the women in her building because they continue to be ambulatory

700. Able to verbalize that being overweight can cause a person to have ambulation problems, to be required to pay for two seats on an airplane, and that people may not want you to ride in their car if you are overweight

701. Has the perception that obesity would be a serious problem for her. Once weight gain begins, it can easily get out of control. Therefore, she plans to participate in activities that will prevent her from becoming overweight or obese

702. Believes that obesity is a serious problem in Alabama

703. Uses more adjectives that mean 'excessive' to describe the word obese.

Perceives obese as being worse than overweight; a higher degree of overweightness.

704. Obesity is viewed as an inconvenience.

705. Other perceived disadvantages of obesity include immobility, depression, and dyspnea

706. Believes that obese people who are admitted into the hospital have more complications and respiratory problems than normal weight patients

Pain

707. Lower extremity (LE) pain

708. Lower extremity pain due to circulation problems

709. Excessive weight causes pain and it is difficult for older adults to use exercise machines and to engage in exercise programs

710. Because of pain in LEs, it is difficult for her to use public transportation

711. Because of pain and swelling in LEs, one's own transportation would allow time to make frequent stops if needed

712. Pain management to maintain mobility

- 713. Use pain medication to aid in ambulation and sleep
- 714. Pain management to maintain mobility
- 715. Decreased endurance and mobility because of pain
- 716. Exacerbation of pain can lead to decrease mobility
- 717. Beliefs about knee treatment modalities for older adults and that the treatments do not last long
- 718. Exacerbation of knee pain lead to the need for medical intervention
- 719. Pain decreased mobility
- 720. History of receiving a corticosteroid injection for knee pain was distressing
- 721. Perceives pain and swelling of her LEs as what makes it difficult for mobility and attending social events
- 722. Keeping active is important for maintaining mobility. Recognizing and accepting the pain helps one to be active within the constraints of pain
- 723. History of LE pain and swelling for years that worsened with age
- 724. Exacerbation of pain and swelling occurred more with aging, which decreased mobility and functional status and led to retirement and social isolation because of inability to wear shoes and no transportation
- 725. Pain travels from one body part to another. Associates increased pain with increased BP.
- 726. Back pain is a barrier to participating in regular exercise. Denies that she received any benefits from attending physical therapy.
- 727. Back pain is a barrier to her performing exercise. Pain makes it too difficult to attempt exercise
- 728. Pain in back and upper extremities prevents her from performing exercise
- 729. Even though she experiences pain in her hands, she must continue to perform ADLs because she lives alone.
- 730. Back pain primarily interferes with her mobility now.
- 731. current back pain prevents her from performing the home exercises that were prescribed for her
- 732. Arthritic pain makes performing household chores and basic mobility difficult. Pain makes any activity difficult to perform but some days are better than others.
- 733. Despite family support and encouragement to perform regular PA, arthritic pain interferes with performing regular PA
- 734. Although she has arthritic pain in her knee joints, she does not let the pain interfere with her ADL. She works through her pain.
- 735. Believes that even though she is still able to ambulate, the exacerbation in her arthritic knee pain has interfered in her ambulation to a certain extent.
- 736. Has LE pain in her shin splint area
- 737. Complains of intermittent knee pain. She has received medical treatment (steroid injection) of the pain three years ago

- 738. She also believes that sexual activity may be painful
- 739. Despite the leg pain she experiences, she continues to ambulate throughout her building
- 740. Pain management strategy (e.g. analgesics) to aid in increasing her mobility status while exercising
- 741. Because of the arthritic pain she has in her knees and the lower back pain from a bulging disk, she is unable to stand for long periods of time or participate in regular PA.
- 742. Friends complain about knee pain as a barrier to walk.

Physical Activity

- 743. Believes that It is important to stay busy(active) daily
- 744. Even when sick/ill, a person should engage in day-to-day (routine) tasks. It is not good to stay in bed.
- 745. Believes that watering her flowers keeps her active
- 746. Activity is better than being immobile or inactive
- 747. A person should engage in whatever type or level of activity she can tolerate
- 748. Adopted watering flowers to include as much walking back and forth in order to get as much PA as possible from this task.
- 749. PA without rest periods can cause pain because pain increases with PA
- 750. Use PA as a pain management strategy. PA is a distracter and in this way helps to prevent the brain from interpreting the sensation of pain
- 751. Believes that keeping busy equals physical activity
- 752. When performing PA, it is okay to have rest periods because it is important to be independent as long as possible
- 753. Any physical activity that does not hurt you is good to perform on a regular basis
- 754. Believes that sexual activity is considered physical activity and older women do not have the added worry of pregnancy
- 755. Based on the examples she listed, she perceives PA to be a form of exercise or taking part in activities at a gym and or housework.
- 756. The place where she lives has long hallways where she has the opportunity to increase her PA.
- 757. Perceives riding in motorized wheelchair to different floors of her building as PA
- 758. Recognizes the incremental benefits of exercise, and that exercise becomes easier with time.
- 759. Decreased energy and pain are barriers to regular PA but some days are better than others.
- 760. Knowledgeable of the benefits of regular PA but unable to perform on a regular basis because of pain
- 761. Attempts to performs some PA because of the known benefits. She states that she feels better. Belief that PA makes one feel better and one has to work through the hard times of PA/ exercise.

- 762. Client loved to travel and she considered traveling PA
- 763. Questioning the interviewer whether climbing stairs increase her PA. She admits that she is not enthused about using the stairs but recognizes that using the stairs would increase her PA level
- 764. Believes that her health, age and lack of motivation are the barriers to her performing regular PA
- 765. Client loves to travel, which she considers PA. Limited income is a barrier to her ability to travel.
- 766. Although she considers sex as a form of PA, she is not interested in engaging in sexual activity anymore.
- 767. She and her walking partner attend different church activities on different days and therefore they would not be able to walk on those days. (Interferes with frequency of PA).
- 768. Was unable to walk everyday because of conflicts in scheduling between walking partner's and her schedules.
- 769. Recognizes that other people in her apartment building would benefit from more PA than they are getting
- 770. Living alone encourages more PA.
- 771. Believes that regular PA is an important aspect of her life and that all people should engage
- 772. Denies any lack of knowledge related to how to improve her PA level.
- 773. Currently very physically active. Perceives herself as being knowledgeable about an appropriate PA routine/ schedule program
- 774. Client enjoys working outside in her yard as well as others. She considers herself a workaholic and she doesn't mind working long hours. Overworking has some untoward effects, such as LE pain and soreness.
- 775. She loves working outside and performing yard work. She even does yard work for her daughter who lives out of town
- 776. Participant daughter's neighbor told the participant not to do all of the yard work in participant's daughter's yard but ironically, the neighbor wanted the client to work in the neighbor's yard.
- 777. Believes that living alone forces older adults to be more physically active
- 778. Believes that she is knowledgeable of everything she needs to know about increasing her PA because she attends PT and walks on a regular basis.
- 779. Participating in regular PA (mobility) is a coping mechanism
- 780. Increases her PA by watering her flowers and performing light yard work. She implies that these activities are a sufficient form of exercise.
- 781. Considers PA as strenuous activities such as yard work
- 782. Believes that laziness is a barrier to performing regular PA

- 783. Believes that PA includes activities that increase your heart rate such as walking and calisthenics
- 784. Perceives that her largest barrier to increasing her PA level is her inability to stand for long periods of time
- 785. Identifies that it is important keep active and not to remain sedentary because that can cause stiffness of joints and make ambulation difficult.
- 786. Believes that staying active by performing regular PA is important to prevent LE stiffness and pain
- 787. Her decreased ability to stand for long periods of time is a barrier to performing regular PA
- 788. Even though she was very active, she did not lose weight and her appetite remained the same.
- 789. Believes that her spinal cord problems are the barriers related to why she cannot stand or walk for long periods of time, which interferes with her PA level.
- 790. Believes that walking three times a week and climbing stairs in her home every day shows that she is active.
- 791. Because she is already very physically active, she believes that she knows everything about regular PA
- 792. Client is already very physically active, however, she would be willing to listen to additional suggestions on how to increase her PA

Physical Activity / Exercise Benefits

- 793. The benefits of regular PA includes better mobility, heart conditioning, BS control and lowering of one's cholesterol level
- 794. Believes that there are benefits to performing regular PA. The major benefit for the client is that her LEs are limber and have less discomfort
- 795. Believes that regular PA is good and it has many benefits.
- 796. Believes that participating in regular PA helps you to lose weight, improve mobility and to decrease fatigue.
- 797. Although there are many benefits to participating in PA, each person must gauge her own body as to how much she can engage in. Regular PA is important for longevity.
- 798. Client is more active now because she is retired and she has time to exercise and believes that it prevents illnesses
- 799. Believes that PA is important for older adults because it will enhance their mental and physical health as well as enhancing physical beauty/ attractiveness, and social behaviors
- 800. Believes that performing regular PA helps older adults to be able to be mobile and to perform ADLs without assistance
- 801. Believes that performing regular PA will improve all facets of a person's life that a person engages in and it keeps the body active and functioning without difficulty

- 802. Believes that if enough effort is put forth, the energy to engage in PA will occur.
- 803. PA helps people to maintain or achieve a healthy weight for their height and age
- 804. PA is important for good health and longevity but society inhibits people from participating in regular PA
- 805. Believes that PA is good for one's health especially if the person is able to perform the activity
- 806. Believes that PA is important to help keep your limbs mobile
- 807. Regular PA is essential to good health and it must be performed daily or else wasting or loss of movement / function occurs.
- 808. Knowledgeable of some of the benefits of regular PA. Recognizes the physical and mental benefits of exercise/ activity.
- 809. Perceives that there are benefits to regular PA, such as decreasing bone stiffness
- 810. Believes that regular PA may increase a person's energy level
- 811. Aware that regular PA is essential to good health even if you only perform a little at a time.
- 812. Regular activity makes you feel better
- 813. Keeping busy and physically active is important for good mental and physical health
- 814. PA promotes independence.
- 815. Physical activity is important to maintain ambulation without the use of assistive devices
- 816. Believes that she gains increased energy after performing PA
- 817. Increased PA may increase longevity.
- 818. Believes that walking is a healthy activity that even helps to promote and maintain your mental functioning
- 819. Confirms that regular PA is helpful to those who participate on a regular basis. She has observed people walking at the mall whose endurance improved with each week of walking.
- 820. Participating in regular PA makes you feel better, it decreases your pain intensity, it decreases your stress level, and it lowers your BP and your cholesterol level.

Physical Condition

- 821. LE Edema
- 822. Wears TED hose for LE edema
- 823. Justification that feet have always been big and large shoe size due to this not to feet being overweight
- 824. Nodular areas present on LEs
- 825. Edema in LEs resolving slowly
- 826. Currently has a ruptured disk which causes her pain
- 827. Leg length is a barrier to regular PA

828. Believes that her genu valgum is a contributing factor to her decreased mobility. She is considering an assistive device to use for ambulation.

Physical Therapy

- 829. Physical therapy was recommended to assist with knee pain and mobility
- 830. Unable to participate in regular physical therapy without transportation to get the clinic
- 831. Transportation and money are needed to participate in regular PT
- 832. Perceived that PT was not beneficial for her back pain nor her knee pain
- 833. Provided a description of what her PT was like when she attended. Formal PT included physical engagement in exercises along with teaching (knowledge building).
- 834. Believes that PT is helping her stress level and giving her energy to perform activities she had stop doing years ago.
- 835. Acknowledges that there are health benefits associated with attending PT
- 836. Does not experience angina after exercising now and the client contributes this to attending PT
- 837. Uses the stairs as a warm up period before her PT appointment
- 838. PT is a form of exercise that is supervised by medical personnel to verify technique and for treatment of specific health conditions.
- 839. Because the PT is allowing her to see results physically and mentally, she believes that she will continue with the program because it makes her feels better
- 840. After her surgery, she was prescribed PT and OT in order to strengthen her upper and lower extremities as well as hands and fine motor skills.
- 841. Believes that PT is going to the gym and attending exercise classes. History of attending PT after she had a broken leg.

Perception of Health:

- 842. Her health is not what it used to be
- 843. Perceives normal weight to be good health
- 844. Some conditions are within a person's control (overweight) while others are not (i.e. swelling)
- 845. Being overweight contributes to poor health
- 846. Overweight people are not healthy regardless of their age
- 847. Believes that excess weight is not good for knee joint health
- 848. Perceives someone who is underweight as not being healthy
- 849. Believes that underweight and overweight statuses are both unhealthy
- 850. When she compares herself to other people, she believes that her health is worse than others
- 851. Trying to accept health status and her current level of independence
- 852. Acknowledges that being overweight is not good for one's health

- 853. Believes that out of all her children, only one would be able to compete with her in regard to all of the activities she can perform in a day
- 854. Believes that being skinny is not healthy especially if the person is frail and lacks muscle tone. People can be too fat or too skinny both extremes are not healthy.
- 855. Believes that people can be obese or underweight and both conditions are not healthy.
- 856. Recognizes the importance of increasing the amount of ambulation and physical activity in order to be healthier
- 857. Being overweight makes a person more at risk for diabetes and other health problems
- 858. In the old days, people used to consider chubby children as healthy children but it is not healthy because there are complications that accompany an overweight status.
- 859. Believes that it is okay to be skinny as long as you are healthy. She has two grandchildren who are overweight and she recognizes that being overweight is not healthy for anyone.
- 860. Perceives that she does not have any health problems
- 861. Became offended when she was told that she was classified as obese based on her weight and height.
- 862. Perceives good health as the ability to ambulate, to drive, to be oriented, and to travel within the city regardless of weight status.
- 863. Believes that a person has good health when their BP is low, lose weight (if overweight), low stress level, no depression, and have the ability to socialize with others.

Safety:

- 864. Safety is a concern when getting in and out of the bath tub
- 865. Safety is important to her and her family because she is at increased risk for a fall.
- 866. Does not weigh on standing scales often because of a fear of falling . Weight has been stable over recent months.
- 867. Fear of falling is a barrier to performing regular PA
- 868. Believes that being overweight can cause you to be vulnerable to (violent) attacks
- 869. Safety is an issue at the place she goes for PA

Sedentary/Inactivity:

- 870. Even if a person is unable to work out side of the home it is important not to be sedentary
- 871. A sedentary lifestyle can lead to a decline in mobility. That's why it is essential to move your extremities
- 872. Long periods of inactivity can exacerbate mobility problems
- 873. Long periods of inactivity lead to leg pain and cramps
- 874. A sedentary lifestyle can lead to bone deterioration

- 875. Inactivity can lead to functional decline and then she would need assistance from other family members of which some have their own responsibilities and priorities and others are in the same condition as she.
- 876. A sedentary lifestyle will only worsen the changes that come with old age
- 877. Inactivity is not healthy.
- 878. A sedentary lifestyle is a barrier to good health. In order to get and benefit from exercise, the person has to exert some effort.
- 879. She appears to lead a very sedentary lifestyle
- 880. Believes that spending too much time in the bed is a barrier to PA
- 881. Believes that a sedentary lifestyle is not healthy and drains one's energy (makes one weak).
- 882. Perceives that the residents in her apartment building would not encourage her to participate in regular PA because they live a sedentary lifestyle
- 883. Believes that most of the older adults in her building live very sedentary lifestyles so much so that she would go around to check on them because weeks would go by without her seeing them.
- 884. Believes that hot temperatures in Alabama contribute to a more sedentary lifestyle among older adults.

Stress:

- 885. Stressful situations can lead to a decline in appetite
- 886. Going through cancer treatments led to a decline in appetite because this was stressful
- 887. Stress is not healthy; worry leads to stress
- 888. Attributes severe stress as reason for hospitalization
- 889. Attributes release of stress to PT
- 890. Believes that stress of caregiving was the cause of her losing weight but she realized that she had to get a handle on her stress because it was not healthy.
- 891. Participating in regular PA is a stress reliever and a coping mechanism.

Surgery

- 892. History of LE surgery
- 893. Surgery decreased LE edema
- 894. Realizes the need for surgery but refuses to consent to knee surgery despite knee problems.
- 895. Beliefs that knee surgery is not successful for everyone
- 896. History of attending physical therapy after knee surgery
- 897. History of multiple surgeries. Her decreased range of motion nor pain is a motivation to have another surgery

- 898. History of right hip replacement due to severe bone deterioration. Extremely knowledgeable about past surgeries.
- 899. Believes surgeries have contributed to decreased mobility and endurance and have made her weaker and in a sense has “handicapped” her.
- 900. Believes that the metal used in her body for hip and knee replacements have contributed to decreased mobility and ability to stand up for long periods of time.
- 901. History of carpal tunnel surgery and she attended PT post surgery
- 902. Believes that some overweight people have gastric bypass surgery for cosmetic reasons; but the surgery is not guaranteed to work for everyone.
- 903. History of stent replacement.
- 904. Status post neck surgery the client is unable to stand for long periods of time and she walks slow
- 905. Before the surgery, the client was in pain and, had a decreased appetite despite daughter cooking for her. She was unable to ambulate very well and she lost weight. After the surgery, she went back to her regular routine and she regained some of the weight back.
- 906. She is fearful of surgery so she has refused to have the bulging disk repaired

Transportation

- 907. Believes that own transportation would make her more independent
- 908. Her own transportation would equal more independence
- 909. Considers it a burden to have other people meet her transportation needs.
- 910. Not having her own transportation has lead to a decrease in independence
- 911. Having your own transportation allows a person to be independent with routine tasks
- 912. Not having her own transportation increases her financial burden because she is on a fixed income and she has to pay someone to take her places
- 913. Own transportation would decrease the need to rely on public transportation services
- 914. Own transportation would lead to being able to attend more social functions
- 915. Regrets not having her own transportation. She views no transportation as a obstacle to her independence
- 916. Without your own transportation, a person is dependent on others to get around
- 917. Pain and swelling in legs are barriers to her purchasing her own transportation
- 918. Pain and swelling in legs are barriers to driving a car
- 919. Transportation is perceived as a facilitator to participating in regular PT because she does not want to become dependent on assistive devices to ambulate.
- 920. Has a strong desire to obtain her own transportation but LE pain is a barrier.

921. Lack of transportation is a barrier to organized physical activity. She depends on others to carry her to water aerobics and she does not like to ask. She has more pain with walking and exercising now that she is older

922. Transportation is a barrier to her going to the senior citizen center for water aerobics because she hates asking family members to carry her.

Underweight/ Skinny

923. Believes that underweight people are unhealthy

924. Believes that it is not normal to be underweight

925. Underweight means your diet is inadequate and you are not healthy

926. Believes that underweight is not attractive nor healthy

927. Being underweight (skinny) is perceived to be that a person is sick, weak, and has difficult time doing things

928. Being underweight is not healthy

929. Believes that underweight people are fragile

930. Perception that some people with small body frames are underweight and they have difficulty gaining weight.

931. Client does not want to be classified as skinny. She believes that her current weight status normal.

932. Skinny people look like death or they could be on drugs which causes them to be skinny

933. Being too thin is not considered healthy

934. Believes that if a person is too skinny and that person becomes ill, [they will lose weight] and it will be more difficult for the person to overcome the illness.

935. Perceives that being underweight is the best. She has always had a weight problem and in her younger days she struggled with maintaining a normal weight

936. Does not believe that being skinny would cause any problems for a person. Denies ever being too skinny in her lifetime.

937. Believes that it is okay to be skinny if the person trying to become skinny by exercising but believes that it is an issue if the person is skinny because of poor health

938. Believes that a smaller older adult would have better mobility and get outside more.

939. Believes that it is bad for an older adult to be too skinny because they look ill and older than stated age when they are underweight.

Weight Changes/Status

940. People on TV bear witness that certain programs aid in wt loss and help them look and feel better.

941. Enjoys watching extreme weight loss shows on TV

- 942. Perceives that overweight/ obese people who lose weight feel better after they lose weight
- 943. States that her weight only fluctuates between 2-3 pounds
- 944. Client's weight only fluctuates 1-2 pounds and it has been this way for 20 years. Proud that her dress size has not changed in 20 years
- 945. Client is still able to wear clothes that were given to her years ago. She wears a size 20 in dresses.
- 946. Does not have an explanation for why her weight has basically remained the same over the past 20 years
- 947. She believes that in order for people to lose weight they only need to decrease the amount of food they eat
- 948. Has lost weight over the past 18 months
- 949. Decreased food intake and increased exercise amount
- 950. Believes that her weight lost occurred because of her utilization of the stairs
- 951. Believes that obese people would benefit from performing regular PA because it would aid in weight loss.
- 952. Uses her clothes size to monitor if she is gaining weight or not
- 953. Believes that all people, overweight or not should use their clothes to monitor their weight status . If you clothes become tight, that should indicate that weight loss is needed
- 954. She is concerned that her friend is gaining weight and that her friend loves to eat. She wants to help her lose the weight she gained
- 955. Client had walked so much that she lost weight, so she has stopped walking.
- 956. Client is aware of her height and weight [BMI] and she is knowledgeable of what she should weigh in order not to be classified as overweight.
- 957. Recognizes that when she gains weight, she fatigues easier and doesn't feel as well.
- 958. She has a history of weight gain but she realizes that she should never weigh more than 150 pounds because that would be excessive for her height
- 959. Believes that she lost weight because of the stress that accompanied her caretaking duties
- 960. Uses home scales to measure and monitor her weight status.
- 961. Client is aware that a person should weigh a certain amount according to their height (based on standard/published weight-to-height tables).
- 962. Attended a weight loss clinic in her younger years to help her loss weight
- 963. Client has purposely lost some weight by cutting calories and trying to eat healthier.
- 964. Weight loss is a benefit of regular PA, which results in less pressure on the LEs and her clothes fit better

965. She is aware that her weight should be aligned with her height according to standard ht-wt charts.
966. Realizes that she has weighed more than the ht-wt chart states she should weigh for years.
967. Looking in the mirror and weighing on the scales are two techniques to use to monitor whether you are overweight.
968. Client had lost weight unintentionally because she had a decreased appetite before her surgery but she gained the weight back after surgery (no more pain)
969. Believes that people should know if they are overweight by the way their clothes fit and how much they weigh on the scales
970. Believes that even though some older people do not eat in excess, it is difficult for some to lose weight.

Work Status

971. Worked until the age 66 but retired because of a history of falling on the job, and problems with mobility/ movement.
972. Worked at a church daycare where she fixed meals for children. The demands that accompany working with children became too difficult so she decided to retire
973. When she worked in the hospital, she was required to perform a lot of walking
974. Difficulty climbing up and down stairs was a catalyst for her to retire
975. The apartment building did sponsor activities for the tenants to participate in but the client would be unable to attend because she would be at work during the scheduled time
976. Being retired can lead to a sedentary lifestyle so that is why the client chooses to increase her PA
977. Believes that performing her job on concrete has contributed to her inability to stand for long periods of time.
978. History of walking for 20 years but decreased her walking frequency from 6 days to 3 days because she still works.
979. Her job does not require that she walks but she chooses to climb the stairs on her job.
980. Once she retires, she plans to start taking swimming lesson as a way to increase her PA.

STEP 4: List of 44 Theme Clusters

1. Seeking and receiving medical advice from Health Care Provider
2. Age related changes
3. Ambulation
4. Appearance/ Embarrassed
5. Assistive Device
6. Beliefs or perception
7. Chronic Illness
8. Control
9. Definition of obesity/overweight
10. Definition of PA/Exercise/PT
11. Dependent
12. Desire:
13. Energy/endurance
14. Exercise
15. Family –Friend Support/ influence
16. Faith or Spirituality
17. Finances
18. Grief or depression
19. Health care provider mistrust
20. Incontinence
21. Independence
22. Lifestyle habits:
23. Meal preparation/ Eating habits
24. Medication/ alternative treatment
25. Mobility
26. Motivation
27. Movement
28. Normal Weight
29. Overweight
30. Obesity
31. Pain
32. Physical Activity
33. Physical Activity / Exercise Benefits
34. Physical condition
35. Physical Therapy
36. Perception of Health
37. Safety:
38. Sedentary/inactivity
39. Stress

- 40. Surgery
- 41. Transportation
- 42. Underweight/ skinny
- 43. Weight Changes/status
- 44. Work Status

STEP 4 (part-b): List of 13 Similarly Grouped Categories

(Note this was a reduction from 44 categories to 13 similar categories)

Category 1

- Seeking and receiving medical advice from healthcare provider
- Medication/ alternative treatment

Category 2

- Age related changes

Category 3

- Ambulation:
- Assistive Device
- Mobility
- Movement

Category 4

- Beliefs or perception
- Perception of Health:

Category 5

- Chronic Illness
- Pain
- Physical condition
- Incontinence
- Surgery

Category 6

- Control
- Desire:
- Motivation:

Category 7

- Definition of obesity/overweight
- Definition of PA/Exercise/PT

- Normal Weight
- Overweight
- Obesity
- Underweight/ skinny
- Weight Changes/status

Category 8

- Appearance/ Embarrassed:
- Grief or depression
- Health care provider mistrust
- Stress:

Category 9

- Dependent
- Energy/endurance
- Exercise
- Independence

Category 10

- Family –Friend Support/ influence
- Faith or Spirituality

Category 11

- Finances
- Transportation
- Work Status
- Safety:

Category 12

- Lifestyle habits:
- Meal preparation/ Eating habits

Category 13

- Physical Activity
- Physical Activity / Exercise Benefits
- Physical Therapy
- Sedentary/inactivity

STEP 4 (part-c) Thirteen Categories with Selected Formulated Meanings

(Note: these selected formulated meanings were derived from the participant's significant statements)

CATEGORY 1

Seeking and receiving medical advice from Health Care Provider

1. Believes that it is important to maintain a sense of control over health by keeping medical appointments
2. Because of breast cancer diagnosis, it is important to maintain her regular mammogram appointments
3. Maintains mammogram schedule and regular medical follow-up visits in order to monitor current health status
4. Healthcare provider beliefs about treatment in older adults appears to be that pain management does not always work
5. Keeping medical appointments is a way of managing health
6. Even though she was informed by medical personnel that she was overweight, she failed to change her diet and eating habits
7. Failed to follow medical advice to lose weight and eat healthy because she was not having any adverse effects from her weight at the time.
8. She now knows firsthand the consequences of being overweight because the risk factors that she was advised of years ago have come to fruition. She did not translate information into behavior modification in her younger years.
9. She acknowledges some of the benefits of regular PA because her doctor made her aware. However, she still states that is difficult for her to engage in PA/exercise because of her current health status.
10. Although her doctor recommended dietary changes because of her diagnoses of high cholesterol and HTN, she does not follow the recommended diet.
11. Although she does not adhere to her diet, she states that she does take her medications as prescribed. She does not appear to understand that both treatment complement each other
12. Her healthcare provider encouraged her to participate in sexual activity but she does not have a partner and does not want a partner
13. At one time she was advised to eat more protein in order to gain some weight
14. She has an upcoming doctor's appointment so she is adhering to her diet in an attempt to have normal lab results
15. Perceives that obesity may be a contraindication to some medical treatments
16. Believes that obese persons may not be able to perform activities (e.g. exercise programs) recommended by physicians.
17. Some medical interventions require the obese person to lose weight first but the person was too obese to exercise in order to aid in weight loss. There needs to be different weight loss strategies for different people
18. With PT, the therapist provides the patients with home exercises that should be performed at the frequency prescribed.

19. She adheres to exercise regime and medications but her weakness is eating sweets.
20. Her healthcare provider encouraged her to continue her current PA level because her test results were normal and better than most people of similar age.
21. Healthcare professionals have been discussing an appropriate weight for her height with client.
22. The client and the doctor negotiated a weight range that was acceptable to both. Client realizes that carrying excess weight is not good for her heart.
23. She has been informed by her healthcare professional that she has arthritis all over her body.
24. Her insurance company representative encouraged her not to regain all of her weight back.
25. Television doctor stated that people need to walk/exercise for at least one hour a day but it was okay to start at 30 minutes and then build up to an hour.
26. An example of a disadvantage of being overweight was described as when some obese people depending on their illness must lose weight first before they can receive treatment. She believes that it is harder for an overweight person to heal than a smaller person. Believes it is more difficult for health care providers to treat obese people when they are ill.

Medication/ alternative treatment

1. Treatment (corticosteroid injection) relieved knee pain and made ambulation easy and comfortable
2. The corticosteroid injection therapeutic effect was short term
3. Pain treatment modalities do not work for everyone
4. An alternative pain treatment (salve) modality used to decrease pain and swelling
5. A home remedy method (soak in a hot tub) to decrease pain in LEs
6. Pain management strategies to decrease discomfort and to make it easier to ambulate
7. Uses pain management strategies to keep active and perform light household chores.
8. Belief that taking multiple medications may be effecting appetite
9. After receiving the steroid injection, she denies having any exacerbation of knee pain that would cause her to seek medical treatment
10. Perceives that birth control pills are also contributing to her niece's weight gain
11. PT is used by persons who have a chronic medical condition that requires massages or injections for treatment
12. There are no quick fixes like pills that will accomplish long-term results
13. Client suffers from back and LE pain but she takes medication for the pain which helps with her mobility

14. Uses hot water (moist heat) as a pain management strategy for knee and back arthritic pain
15. Uses topical pain medicine for arthritic pain
16. Went to a chiropractor for her back pain because standing is painful and obtained some relief
17. Pain management strategies were used to decrease pain and increase mobility.

CATEGORY 2

Age related changes

1. Believes that weight loss occurs normally with aging
2. Weight loss occurs with aging regardless of whether a person is ill
3. Believes that weight loss occurs with aging because the fat deteriorates.
4. Loss of appetite may occur with aging, but not for everyone
5. Believes that with aging comes the deterioration of bones so It is important to stay busy/active to prevent further decline
6. Perceives that her mobility has declined with age
7. Mobility pace has declined with age and arthritis
8. Anticipating that one day, she will not be able to maintain housework, but not yet.
9. Appears to anticipate a decline in ambulation and the future need for an assistive device
10. Believes that activity level decreases with age and this change is irreversible.
11. Perceives functional decline occurs with aging ; body and physical changes that come with aging are permanent
12. Aging changes one's ability to be physically active
13. Anticipates physical and health decline with aging and she expects family to assist her if and when the time comes
14. Belief that declining health occurs with age, but it does not occur at the same rate or degree for all people
15. Acceptance of old age is necessary for making the needed lifestyle changes
16. Older adults will eventually regret not making necessary lifestyle changes
17. Believes that older overweight women in their 70s and 80s eventually develop HTN or diabetes
18. Decreased appetite with aging
19. Has noticed a decline in mobility and functional status in her older age, which she associates with the changes in the condition of her body
20. Decline in mobility and functional status has occurred with aging. However, arthritis has also contributed to limiting her activity level. In her younger days, she participated in several recreational physical activities.
21. Tries to accept the fact that her mobility is not what it used to be when she was younger. There is some remorse regarding her decline in mobility.
22. Believes that her functional status and mobility decline d with age and that she will never regain the independence she had during her youth. Envious of other's independence

23. Believes that one's ability to perform usual/routine tasks/activities decline with age
24. Believes that her activity level is less now that she's older.
25. Believes that physical abilities and mobility decreases with age
26. Increased satiety occurs with aging
27. Leg discomfort, which has increased with age, prevents the performance of regular PA
28. Also believes that PA automatically decreases with age
29. Moved into a one-level home prior to older adulthood. One-level allow for easier access with assistive devices in future years and /or as mobility / ambulation becomes impaired. Has made some modifications to home so that she only uses a few rooms during the winter months. (This cuts down on heating cost).
30. Being an older adult does not have to inhibit a person from performing ADL. God has provided everyone with the necessary tools to take care of one's own personal needs.
31. Client has the perception that as people get older, they need to have some fat reserve just in case they get sick or to prevent looking sick
32. The pain intensity of the arthritis increases with age.
33. Has difficulty with walking and running and these activities become even more slower with aging.
34. Client has become less active with age. She is unable to perform activities that she has performed for years such as maintaining a garden and cutting her own grass
35. Believes that weight loss can occur with aging because older adults tend to eat less
36. As she aged, she decreased her walking frequency because of age, work schedule, and church activities on Sundays.

CATEGORY 3

Ambulation:

1. Ambulating up and down stairs is a hindrance because it is difficult to ambulate and stabilize self.
2. Now that the client is older, she moved from her home because she was having difficulty climbing up and down stairs on a daily basis.
3. Client has a history of walking in her former community but stopped walking because her ambulation became slower
4. Knows that some overweight people do not have problems with ambulation while others fatigue easily and requires frequent rest periods.
5. Her musician is overweight but she is able to ambulate without difficulty or dyspnea. The client considers her musician a "healthy fat person" because she does not experience these problems.
6. Believes that walking is a healthy activity that makes you feel better

7. When people become short of breath with ambulation and unable to walk for long distances then the person should know that they are overweight.
8. Realizes that she is able to ambulate better and her mobility is better when she loses some weight.
9. Decreased ability to walk or stand for long periods of time. However, she tries to perform these activities any way to prevent further decline.

Assistive Device

1. Weak bladder requires bedside commode at night
2. Without BSC, incontinence would soil clothes and home
3. Requires assistive devices to ambulate
4. Adaptive devices are required outside the home but inside can hold onto things
5. Must hold on to walls and furniture to support ambulation
6. Must use assistive devices when ambulating outside of her home
7. Has been using assistive devices to ambulate for 12 years
8. Requires an assistive device to bathe
9. Maintain ambulation independence as long as possible. Try to put off the use of assistive ambulation devices as long as possible.
10. Anticipating the potential need for ambulation assistive devices in the future but wants to delay the need as long as possible. Start off by using the minimum supportive assistive device
11. Functional Assistive device (back brace) is needed to perform routine house work
12. She uses a walker for ambulation and the building does have elevators
13. Requires an assistive device to maintain some independence and for mobility around her home.
14. Believes that everything (assistive devices) that she needs to increase her PA is available in her home, but has to be motivated and “feel” like engaging in PA .
15. Believes that her PA level would increase if she did not have to use an assistive device (a cane) to ambulate.
16. Client has seen many other older adults start off walking with assistive devices but they eventually become more independent and do not require such devices.

Mobility

1. Mobility is limited and difficult
2. Mobility only with assistive device
3. Mobility is limited
4. Mobility is slow and it takes time to prepare for outings, so she has to get up several hours before appointment time.
5. Worked in a hospital as one of the cooks
6. Being overweight can decrease your mobility.

7. Decreased mobility has lead to decreased PA with aging
8. Being overweight/ obese leads to a decrease in mobility status.
9. There no advantages to being overweight. Being overweight slows down your mobility status
10. Decreased mobility and endurance when performing ADL such as cooking
11. Being overweight decreases a person's ability to ambulate, perform yard work, LE joints become stiffer, and fatigues sooner
12. Obese people have difficulty with their mobility
13. Does not believe that all overweight older AA women have problems with mobility or traveling because of her 90 –year- old aunt who was overweight and did not experience any problems with mobility or functional status.

Movement

1. Movement is painful
2. She is unable to maneuver stairs because this causes severe LE pain, thus, PA is limited.
3. Limited mobility of LEs and hip replacement surgeries hinder certain changes in positions
4. Believes that when a person is overweight it is difficult for that person to perform some activities e.g. bending over or just decreased energy in general. When a person is normal weight, these activities are not difficult.
5. Believes that overweight people have a difficult time bending over to pick up things
6. Remaining physically active prevents stiffness and maintains mobility of limbs
7. Impaired leg movement/ motion interfere with PA.
8. Believes that the quality of sleep and one's ability to move and ambulate changes when a person gains weight
9. She has friends who are unable to bend or stoop over to pick up things because they have gained so much weight.
10. Believes that overweight people have difficulty performing ADLs.

CATEGORY 4

Beliefs or perception

1. Belief or perception that a person should not become overweight
2. Believes that being overweight can decrease a person's mobility
3. Believes that weight gain was related to pregnancies not to amount of food intake
4. Believes past weight loss has put weight at a "good place"
5. Perceives weight to be "fine". Does not want to be overweight.
6. No difference between obesity and overweight

7. Perceives that she has a large body frame
8. Believes that overweight people have fat accumulation around their heart, which is unhealthy
9. Believes that people should weigh a certain amount
10. Perceives that extreme underweight and overweight are both unhealthy statuses but believes that obesity is the worse out of the two conditions
11. Does not believe that there is a problem with obesity among older AA women in Alabama. Appears to base this reasoning on one of her neighbors who weighs 120 pounds and is very active.
12. Perceives herself to be “a little obese” but not overweight
13. Believes that a person can look in the mirror and know if they are overweight or obese
14. She is aware that being overweight may affect a person’s blood pressure, cholesterol, and endurance
15. There are no health advantages that accompany being overweight
16. Does not think that there is an overweight problem among older AAW just in Alabama. She thinks that there is a problem in the U.S.
17. Acknowledges that there are a small number of older AA women who are overweight and lives in her building.
18. Believes that PA involves helping others and she wishes that she was able to help others more
19. Appears to be proud that she does not have to take any medication for any condition. She bases her perceptions on comparing her health status to other older women in her building.
20. She realizes that a person’s weight distribution varies based on height
21. Believes that increased height can increase a person’s weight on the scales
22. Believes that her body frame is small in comparison to her younger friend whose body frame is large
23. Believes that her niece will eat food even if she has just eaten
24. Being overweight means that the person does not care about themselves
25. Perceives older women in her building to just being a “little heavy” but not really overweight or obese.
26. Believes that PA is healthy for a person to perform
27. She informed her choir member that she was too young to be obese and that she needed to decrease her food intake.
28. Perceives that some of her neighbors are envious of her ability to ambulate and of her functional status
29. Recognizes that the height of a person can change the perception of that person’s weight status
30. Good health and being active are important to client

31. This client has never had a weight problem and she does not know the role that “overweight” plays with “obesity”. She believes that people who are overweight or obese are that way because of genetics.
32. Believes that many obese people cannot bathe themselves, which results in skin breakdown. Perceives that being obese makes a person more apt to perspire quickly and develop body odor
33. Only parks close to the store if she has her husband with her who has difficulty with ambulation. She views the handicapped sticker as a stigma.
34. There are no advantages to being overweight. She does not like to be overweight
35. Client perceives herself to be more active. She travels, performs ADLS and perceives herself as being a busy person.

Perception of Health:

1. Her health is not what it used to be
2. Perceives normal weight to be good health
3. Some conditions are within a person’s control (overweight) while others are not (i.e. swelling)
4. Being overweight contributes to poor health
5. Overweight people are not healthy regardless of their age
6. Believes that excess weight is not good for knee joint health
7. Perceives someone who is underweight as not being healthy
8. Believes that underweight and overweight statuses are both unhealthy
9. When she compares herself to other people, she believes that her health is worse than others
10. Trying to accept health status and her current level of independence
11. Acknowledges that being overweight is not good for one’s health
12. Believes that out of all her children, only one would be able to compete with her in regard to all of the activities she can perform in a day
13. Believes that being skinny is not healthy especially if the person is frail and lacks muscle tone. People can be too fat or too skinny both extremes are not healthy.
14. Believes that people can be obese or underweight and both conditions are not healthy.
15. Recognizes the importance of increasing the amount of ambulation and physical activity in order to be healthier
16. Being overweight makes a person more at risk for diabetes and other health problems
17. In the old days, people used to consider chubby children as healthy children but it is not healthy because there are complications that accompany an overweight status.

18. Believes that it is okay to be skinny as long as you are healthy. She has two grandchildren who are overweight and she recognizes that being overweight is not healthy for anyone.
19. Perceives that she does not have any health problems
20. Became offended when she was told that she was classified as obese based on her weight and height.
21. Perceives good health as the ability to ambulate, to drive, to be oriented, and to travel within the city regardless of weight status.
22. Believes that a person has good health when their BP is low, lose weight (if overweight), low stress level, no depression, and have the ability to socialize with others.

CATEGORY 5

Chronic Illness

1. Cancer did not spread to lymph nodes so chemotherapy was not necessary
2. After her cancer went into remission, her appetite slowly returned and she began to slowly regain the weight lost.
3. Knee joint (cartilage) health has declined
4. Family history of arthritis but her sister has transportation to get to therapy
5. She is aware of several obesity-related illnesses
6. Believes that her health problems (DM, HTN, Joint pain) started when she was younger but she was unaware of the problems at the time
7. Recognizes that diabetes is a serious condition that can affect her eyes and kidneys; aware of the downward trajectory of diabetes.
8. Joint health is an integral part of one's mobility and the cartilage in her joints has deteriorated, which causes her pain
9. Accepted arthritic condition of extremities and refuses to have anymore surgeries
10. Experiences shortness of breath now that she is overweight
11. Realizes that being overweight increases the amount of pressure exerted on her weight bearing joints and exacerbates arthritis
12. Gout is a form of arthritis that may cause extreme pain and edema in the joints of the body especially the big toe. Knowledgeable about gout and takes medication to control gout.
13. Her health condition prevents her from performing regular PA
14. Diminished eye sight may be a contributing factor to regular PA
15. Has been experiencing intermittent weakness and dizziness after working out in the yard. She knows to check her BS and BP. Engaging in strenuous activities (like yard work) before eating leads to extreme hunger and weakness.
16. The only time the client is not active is when she experiences dizziness or light-headedness

17. Attributes re-occurrence of her heart disease to husband's illness
18. Has a 25 year diagnosis history of arthritis
19. Being overweight can cause HTN, knee and back pain
20. Belief that overweight is harmful to skeletal system.
21. If she developed diabetes that would be a stressor for her because of the changes she would have to make in order to manage the disease. She believes that she would have to have more assistance from others to manage the disease.
22. Has a history of scoliosis
23. Realizes that hyperglycemia can cause damage to the blood vessels of the eyes. She does not want to experience eye problems related to DM but she is still does not adhere to her diet.
24. Believes that she has arthritis because several members of her family have arthritis.
25. Was interested in knowing the cause of arthritis because she knows many people with the condition.

Pain

1. Lower extremity pain
2. Lower extremity pain due to circulation problems
3. Excessive weight causes pain and it is difficult for older adults to use exercise machines and to engage in exercise programs
4. Because of pain in lower extremity, it is difficult for her to use public transportation
5. Because of pain and swelling in lower extremity, one's own transportation would allow time to make frequent stops if needed
6. Pain management to maintain mobility
7. Use pain medication to aid in ambulation and sleep
8. Pain management to maintain mobility
9. Decreased endurance and mobility because of pain
10. Exacerbation of pain can lead to decrease mobility
11. Beliefs about knee treatment modalities for older adults and that the treatments do not last long
12. Exacerbation of knee pain lead to the need for medical intervention
13. Pain decreased mobility
14. History of receiving a corticosteroid injection for knee pain was distressing
15. Perceives pain and swelling of her lower extremity as what makes it difficult for mobility and attending social events
16. Keeping active is important for maintaining mobility. Recognizing and accepting the pain helps one to be active within the constraints of pain
17. History of lower extremity pain and swelling for years that worsened with age
18. Exacerbation of pain and swelling occurred more with aging, which decreased mobility and functional status and led to retirement and social isolation because of inability to wear shoes and no transportation

19. Pain travels from one body part to another. Associates increased pain with increased blood pressure.
20. Back pain is a barrier to participating in regular exercise. Denies that she received any benefits from attending physical therapy.
21. Back pain is a barrier to her performing exercise. Pain makes it too difficult to attempt exercise
22. Pain in back and upper extremities prevents her from performing exercise
23. Even though she experiences pain in her hands, she must continue to perform ADLs because she lives alone.
24. Back pain primarily interferes with her mobility now.
25. current back pain prevents her from performing the home exercises that were prescribed for her
26. Arthritic pain makes performing household chores and basic mobility difficult. Pain makes any activity difficult to perform but some days are better than others.
27. Despite family support and encouragement to perform regular PA, arthritic pain interferes with performing regular PA
28. Although she has arthritic pain in her knee joints, she does not let the pain interfere with her ADL. She works through her pain.
29. Believes that even though she is still able to ambulate, the exacerbation in her arthritic knee pain has interfered in her ambulation to a certain extent.
30. Has LE pain in her shin splint area
31. Complains of intermittent knee pain. She has received medical treatment (steroid injection) of the pain three years ago
32. She also believes that sexual activity may be painful
33. Despite the leg pain she experiences, she continues to ambulate throughout her building
34. Pain management strategy (e.g. analgesics) to aid in increasing her mobility status while exercising
35. Because of the arthritic pain she has in her knees and the lower back pain from a bulging disk, she is unable to stand for long periods of time or participate in regular PA.
36. Friends complain about knee pain as a barrier to walk.

Physical condition

1. Lower extremity Edema
2. Wears TED hose for lower extremity edema
3. Justification that feet have always been big and large shoe size due to this not to feet being overweight
4. Nodular areas present on lower extremity
5. Edema in lower extremity resolving slowly
6. Currently has a ruptured disk which causes her pain
7. Leg length is a barrier to regular PA

8. Believes that her genu valgum is a contributing factor to her decreased mobility. She is considering an assistive device to use for ambulation.

Incontinence

1. Pt has intermittent incontinence
2. Has trouble holding her urine and this result in intermittent incontinence.
3. Intermittent urge incontinence especially after drinking a large amount of liquids
4. Has tried different techniques to control urinary intermittent incontinence
5. Urge incontinence without pain
6. (A natural disaster interfered with MD appointment and remembering to reschedule appointment. Incontinence is embarrassing and it is often difficult for women to talk with healthcare providers about this issue).
7. History of increased urinary frequency contributes to her increased homebound status.
8. Concerned about how others regarding perceive her urinary frequency

Surgery

1. History of lower extremity surgery
2. Surgery decreased lower extremity edema
3. Realizes the need for surgery but refuses to consent to knee surgery despite knee problems.
4. Beliefs that knee surgery is not successful for everyone
5. History of attending physical therapy after knee surgery
6. History of multiple surgeries. Her decreased range of motion nor pain is a motivation to have another surgery
7. History of right hip replacement due to severe bone deterioration. Extremely knowledgeable about past surgeries.
8. Believes surgeries have contributed to decreased mobility and endurance and have made her weaker and in a sense has “handicapped” her.
9. Believes that the metal used in her body for hip and knee replacements have contributed to decreased mobility and ability to stand up for long periods of time.
10. History of carpal tunnel surgery and she attended PT post surgery
11. Believes that some overweight people have gastric bypass surgery for cosmetic reasons; but the surgery is not guaranteed to work for everyone.
12. History of stent replacement.
13. Status post neck surgery the client is unable to stand for long periods of time and she walks slow

14. Before the surgery, the client was in pain and, had a decreased appetite despite daughter cooking for her. She was unable to ambulate very well and she lost weight. After the surgery, she went back to her regular routine and she regained some of the weight back.
15. She is fearful of surgery so she has refused to have the bulging disk repaired

CATEGORY 6

Control

1. She also believes that some people can control their weight gain and others cannot.
2. Believes that she can control her medical diagnoses with lifestyle behavior modifications
3. Believes that purchasing expensive shoes that are more supportive will prevent damage occurring to her feet

Desire:

1. If she could physically perform more activities she would do it. The desire to be active remains; but the reality is her body cannot perform as it did prior to old age.
2. Desire to be active is stronger than the desire to be inactive
3. Yearns for the ability to perform some of the same activities she did when she was younger such as gardening. She does not believe that she will ever be able to garden again because of her health
4. The loss of her independence causes episodes of depression. Desires to be more independent in the care of her home and doing things outside the home.
5. Does not have a rationale for why her weight virtually remains the same. She desires to lose weight because of her hypertension and she denies having a large food intake.
6. Verbalizes understanding that walking would be beneficial to her health if she would engage but she has not committed to walking with him yet.
7. Admits she is capable of engaging in physical activity but frequently does not have the desire to engage.
8. Occasionally the desire to engage in PA is absent.
9. Recognizes that sexual activity would be one way to increase PA level but she does not have a desire to have sex
10. Admits to having the desire to engage in sexual activity but does not want to participate anymore. Believes that some older women who engage in sexual activity with younger men are paying the men for their services.

11. Because she has sympathy for overweight persons, she has a desire to assist them with weight loss through exercise and diet
12. Client is currently very active. Only wishes she could add swimming to her list of activities

Motivation:

1. Believes that if overweight people could read her information they would be motivated to increase their PA
2. Motivated to repot flowers because they are a memorial to her son despite decreased energy level
3. Would be motivated to participate in social activities that she is interested in. Personal interests lead to motivation.
4. Current illnesses and the fear of new illnesses are motivation to adopt a healthier lifestyle, such as increasing exercise and eating a healthy diet
5. Believes that people will be motivated to participate in regular PA if people are informed of the benefits of regular PA
6. Belief that encouraging women to find exercise partners and to seek support from others would be a motivator for PA.
7. Teaching women the consequences of PA (that it promotes a healthy life) is a motivator.
8. To motivate, emphasize that there will be problems and hurdles in life but PA is necessary even during these times.
9. Her brother's health condition is what motivates him to walk on a regular basis but his condition has not motivated the client. Although she is aware of the benefits and consequences for participating and not participating in regular PA, knowledge does not translate into behavior modification.
10. Believes that if you tell people the benefits of regular PA, they will be motivated to engage
11. Longevity is a motivator to engage in regular PA
12. Needs ideas on how to motivate herself to increase engagement in PA.
13. She motivates some of her neighbors to walk
14. Believes that some tenants would participate in exercise classes and some people would not be motivated despite the incentive
15. Believes that food would motivate people in her building to exercise
16. Having energy and being healthy are motivating factors for this client to participate in regular PA
17. Believes that food and games would motivate some of the older adults in her building to participate in PA

18. Client believes that she would want to participate in an intervention study because she would want to help overweight people lose weight but she does not want to hurt anyone's feelings.
19. Believes that it is important to work with obese people to help them with strategies to lose weight instead of focusing on cosmetics
20. Because of her physical education background, she tries to encourage family members not to become overweight or obese. When she chastises others about gaining weight, she meets resentment.
21. Does not understand how an overweight person could look at themselves and not be motivated to lose weight on their own
22. Tries to encourage others to walk. Believes that it is important for people to be self motivated when it comes to participating in PA
23. Client is self-motivated when it comes to performing PA. Working in her yard is therapeutic to her and a time to meditate on God, and provides her with a sense of peacefulness.
24. Believes that her neighbors are motivated to participate in yard work as regular PA because of her example and the presentation of her yard
25. Believes that using herself as an example (to illustrate all of the things she is able to do at her age would be a motivational technique for other older AA women.
26. Recommends an informal structure without use of a pulpits or podiums.
Recommends informing women about an appropriate routine or schedule of physical activities and the need to incorporate breaks/ rest periods
27. Self-directed/ motivated to obtain information on her chronic illnesses and health promotion
28. When people see that she has lost weight they ask her about the strategies she uses
29. She tries to motivate other older AA women to participate in regular PA by example. She lets them know what she is doing to lose weight and become healthier.
30. Believes that showing older AA women before and after pictures of herself would motivate them to want to participate in regular PA
31. Because she has been attending an exercise program where she has been taught about proper diet and exercise, she is motivated to adapt her lifestyle based on what she has learned
32. Her motivating factor to participate in regular PA is her overall health and the fact that she does not want to add any additional medications to her daily routine
33. Believes that a partner would be a great motivator for her to increase her PA
34. She believes that most older adults are not that motivated to exercise

35. Believes that the best way to motivate older AA women to participate in regular PA is to list potential benefits for them such as extremities will be more limber, weight loss would decrease pressure on lower extremity.
36. Perception that a role model (an older AA woman) who engages in regular PA and has obtained benefits of PA would be a positive motivator
37. Her aunt's constant encouragement to adopt healthier lifestyle behaviors is beginning to motivate the client to contemplate increasing her PA.
38. In order to motivate older AA women to increase their PA levels, they need to be informed that PA can help keep the body conditioned, improve circulation, and help them lose weight.
39. Health is the motivating factor for the client to maintain her walking schedule
40. Knows people younger than her that are not motivated to walk
41. Client always self-motivated herself to walk daily. She tries to encourage others to walk e.g. her daughters and friends because walking is a healthy activity to participate in but they refuse. Unsuccessful in convincing others (motivating) to engage in PA
42. Although she tries hard to motivate/ encourage her daughters to walk and take care of themselves, they did not start adhering to her encouragement until they started having problems with their own blood pressure and cholesterol
43. Provide the following information in order to motivate other older overweight AA women to participate in regular PA: eat a proper diet, eat in moderation, stop being sedentary, avoid fried foods, eat fruits and vegetables and walk 10-15 minutes a day
44. Believes that it is difficult to motivate others to participate in regular PA but good health should be a major motivator. Thinks AA women should be educated on a sedentary and an active lifestyle
45. She also believes that it is difficult to motivate some older AA women to walk just for pleasure.
46. An older Caucasian male motivated the client to continue to walk because he was older than her and he used a walker to ambulate

CATEGORY 7

Definition of obesity/overweight

1. Perceives morbid obesity as seen on television as what is considered overweight.
2. Defines overweight as a person who carries excess weight and pressure on the joints of their extremities.
3. Considers the term obesity and overweight as having the same meaning, being too fat. Perceives no differences between what the terms mean
4. Believes that morbid obesity as seen on television represents overweight people in general

5. Denies knowing whether she is overweight; unable to determine whether she is overweight
6. Provides an illustration of overweight as a person who requires two chairs in order to sit down in the waiting room of a hospital.
7. Believes that obesity and overweight are in the categories. Does not or cannot discern between obesity and overweight.
8. Belief that anyone over 200 pounds is fat/obese. Believes that the classification of obesity occurs when a person weighs 200 pounds or greater
9. Believes the word obese means the same as the word overweight
10. Defines obesity as fat
11. Defines overweight as fat
12. Believes that obesity and overweight means the same thing. There is no difference in the two terms
13. Perceives someone who is overweight as being fat. Just a change in terminology only
14. Believes that the word stout is just another way of saying overweight
15. Believes people are considered obese if they weigh 300-400 pounds
16. Believes that people who weigh 200 pounds are considered overweight. States that her weight is almost at the 200 mark but she is planning to prevent herself from reaching 200 pounds
17. Believes that there is no difference in the meaning of the words “chubby” and “obese”
18. When she was younger, people perceived chubby children as healthy and happy children.
19. Believes that obesity means fat. Although she has never had problems with being overweight, she has sympathy for their plight
20. Defines the word obesity as fat but also states that a person who is obese is overweight. She uses all of the terms interchangeably
21. Defines overweight as the person is “a little larger” than normal weight
22. Does not believe that there is a difference between being obese or overweight
23. Overweight means you are too fat
24. Believes that overweight and obesity means the same thing.
25. There is no difference between the words obese and overweight. Believes that the word overweight does not have as much stigma as the word obese.
26. Believes that overweight means that you are too large and that you can pinch an inch or more abdominal fat
27. Believes that obesity and overweight mean the same.
28. Believes that there is a difference in the terms obesity and obese but was adamant to state that she was not obese
29. Associates obesity with people who weigh between 180-300 pounds.

30. Obesity and overweight are considered to have the same meaning
31. Defines the word obese as very overweight
32. Was unable to provide a definition for overweight
33. Obesity and overweight are different words but they have the same meanings.
34. People use the word overweight instead of obese because it is perceived to be less offensive
35. States AAs like to use the term “big-bone” instead of using the term overweight or obese.
36. Believes that obesity is a condition where the person has gained too much weight. She does not consider herself obese or overweight.

Definition of Physical Activity (PA)/Exercise/ Physical Therapy (PT)

1. PA, PT and exercise mean the same thing. There is no difference in meanings
2. PA and exercise are considered to have the same meaning based on the examples provided.
3. (meet people, piece of mind) Examples of the benefits of regular PA
4. Client is not sure how to define PA and she was asking the interviewer to confirm her answer
5. Client described household chores as PA
6. Stated that jogging, walking and exercising were forms of PA
7. When asked what was exercise, she changed and stated that jogging and walking were exercise but eventually stated that exercising and PA had the same meaning.
8. Believes that PT involves medical personnel working with clients to exercise their extremities
9. Believes that PA is a form of exercise that involves any movements of the body
10. PA is a form of exercise
11. Believes that PT is when a health care provider/ personnel teaches you about exercise and the benefits
12. Believes that PA and exercise mean the same. Both involve moving your body.
13. Believes that PT is a technique used to get people to exercise their extremities to prevent stiffness and to help with the restoration of independent ambulation
14. Believes that PA includes walking, cleaning, and climbing stairs

Normal Weight

1. If a person is normal weight, they are able to perform tasks and ambulate without difficulty.
2. It is better to be normal weight.
3. Perception of normal weight is higher than health care standards

4. Acknowledges that she is not in the normal weight category and that she needs to lose some weight
5. Normal weight is healthier for you and people would feel better if they were not overweight
6. Believes that women should weigh approximately 150 pounds or less to prevent being classified as overweight.
7. Being normal weight allowed the client to feel better, to have better mobility, and to be able to wear previous clothing; (did not have to purchase larger size clothing).

Overweight

1. Vows not to be overweight because it is not a good thing
2. Overweight status means decreased physical activity. Being overweight in addition to other health conditions would decrease one's ability to care for oneself
3. Refutes being overweight but is unaware that she is classified as obese. Believes that being overweight is unhealthy
4. Being overweight may be worse than other conditions; certainly it is not desirable
5. Does not consider herself overweight. Being overweight is worse for certain body types or body builds
6. Being overweight would interfere with self-care activities (the ability to care for oneself).
7. Being overweight threatens independence thus this is the impetus to refrain from becoming overweight
8. Being overweight limits what a person can do, how fast they can do things and where they can go
9. There is no difference between being classified as chubby or overweight
10. Believes that chubbiness is a precursor to being overweight
11. Being overweight makes the most mundane task difficult
12. Being overweight interferes with a person's ability to sleep and rest
13. Being overweight makes life difficult
14. Any illness can be exacerbated with overweight status
15. Being overweight makes it complicated to maneuver in and out of cars
16. Being overweight interferes with specific activities (i.e. maneuvering stairs)
17. Some AA older adults weigh too much
18. Overweight people are not concerned about their health
19. Overweight people do not look like human beings anymore
20. Believes that exercise programs help overweight people to become attractive. Being overweight is unhealthy
21. Believes that being overweight decreases a person's ability to engage in PA by causing pain and fatigue.
22. Does not perceive self to be overweight
23. Being overweight is not healthy
24. Perception that overweight people are satisfied with their weight
25. Overweight is associated with decreased energy and shortness of breath
26. Being overweight can decrease your ability to perform ordinary tasks

27. Being overweight can contribute to increased pressure on the joints of the lower extremities which can lead to joint damage
28. Believes there are a lot of overweight people in Alabama and some people are too large to sit in a standard chair
29. There are no advantages to being overweight. Client is knowledgeable that there are overweight/obesity related illnesses that can occur.
30. In her older age, she is aware of the health consequences of years of being overweight.
31. Believes that after the age 40, people who are overweight are at increased risk for diabetes, HTN, joint pain.
32. Does not believe that there are any advantages to being overweight
33. Believes that overweight people experience shortness of breath with exertion and must have frequent rest periods with ambulation
34. Perceives that overweight people eat constantly
35. Perceives that people with a large body frame can be classified as overweight. People can carry adipose tissue on any area of the body such as the upper extremities
36. Her friend requires medical treatment for her constant LE pain because she is overweight
37. Believes that overweight people are overweight because they do not care about themselves.
38. Being overweight can run in families
39. Recognizes that being overweight may cause heart, respiratory, neurological or mobility problems.
40. Believes that there are no advantages to being overweight. She names examples of disadvantages, which are related to transportation and mobility (e.g. two seats on airplane).
41. Believes that if you weigh more, maybe you would be able to lift or carry more things.
42. No advantages to being overweight
43. Believes that some overweight people are able to lift or move heavy objects because they have more strength and endurance but this is not true for every overweight person.
44. Perceives being overweight was an advantage to her when she was providing care taker duties
45. Believes that overweight people have a difficult time functioning in society today. Also thinks that most overweight people are uncomfortable and become short of breath with exertion. But acknowledges that all overweight people do not experience discomforts or dyspnea.
46. Believes that a person is overweight if they sit down in the car and the car sinks or becomes low to the ground.
47. Overweight people should not be discriminated against in regard to flying on airplanes. Airlines should be required to make accommodations.
48. Believes that it is more difficult for overweight persons to recover from illness episodes

49. Being overweight causes a person to fatigue quickly with ambulation, clothes are too tight and must purchase new larger ones, and the person cannot walk for long periods of time.
50. Believes that being overweight is a problem for older AA women in the summer months. Believes that overweight people have a more difficult time remaining cool in the summer
51. Being overweight can cause increased pressure on the joints of the LEs, mobility status slows down, and decreased endurance (fatigues easier) performing even small tasks.
52. Does not believe that it is a good thing to be chubby.

Obesity

8. Believes that morbid obesity is unhealthy
9. Believes that obesity is greater among younger women than older women
10. Perceives that people who are obese should be able to look at themselves and see if they are overweight. No one should have to tell a person that they are overweight.
11. Because she was not having any health problems when she was younger, she did not believe that being overweight/ obese was affecting her health. But now she realizes the effects of obesity.
12. She does not think that obesity is a problem for the women in her building because they continue to be ambulatory
13. Able to verbalize that being overweight can cause a person to have ambulation problems, to be required to pay for two seats on an airplane, and that people may not want you to ride in their car if you are overweight
14. Has the perception that obesity would be a serious problem for her. Once weight gain begins, it can easily get out of control. Therefore, she plans to participate in activities that will prevent her from becoming overweight or obese
15. Believes that obesity is a serious problem in Alabama
16. Uses more adjectives that mean ‘excessive’ to describe the word obese. Perceives obese as being worse than overweight; a higher degree of overweightness.
17. Obesity is viewed as an inconvenience.
18. Other perceived disadvantages of obesity include immobility, depression, and dyspnea
19. Believes that obese people who are admitted into the hospital have more complications and respiratory problems than normal weight patients

Underweight/ skinny

1. Believes that underweight people are unhealthy

2. Believes that it is not normal to be underweight
3. Underweight means your diet is inadequate and you are not healthy
4. Believes that underweight is not attractive nor healthy
5. Being underweight (skinny) is perceived to be that a person is sick, weak, and has difficult time doing things
6. Being underweight is not healthy
7. Believes that underweight people are fragile
8. Perception that some people with small body frames are underweight and they have difficulty gaining weight.
9. Client does not want to be classified as skinny. She believes that her current weight status normal.
10. Skinny people look like death or they could be on drugs which causes them to be skinny
11. Being too thin is not considered healthy
12. Believes that if a person is too skinny and that person becomes ill, [they will lose weight] and it will be more difficult for the person to overcome the illness.
13. Perceives that being underweight is the best. She has always had a weight problem and in her younger days she struggled with maintaining a normal weight
14. Does not believe that being skinny would cause any problems for a person. Denies ever being too skinny in her lifetime.
15. Believes that it is okay to be skinny if the person trying to become skinny by exercising but believes that it is an issue if the person is skinny because of poor health
16. Believes that a smaller older adult would have better mobility and get outside more.
17. Believes that it is bad for an older adult to be too skinny because they look ill and older than stated age when they are underweight.

Weight Changes/Status

1. People on TV bear witness that certain programs aid in wt loss and help them look and feel better.
2. Enjoys watching extreme weight loss shows on TV
3. Perceives that overweight/ obese people who lose weight feel better after they lose weight
4. States that her weight only fluctuates between 2-3 pounds
5. Client's weight only fluctuates 1-2 pounds and it has been this way for 20 years. Proud that her dress size has not changed in 20 years
6. Client is still able to wear clothes that were given to her years ago. She wears a size 20 in dresses.
7. Does not have an explanation for why her weight has basically remained the same over the past 20 years

8. She believes that in order for people to lose weight they only need to decrease the amount of food they eat
9. Has lost weight over the past 18 months
10. Decreased food intake and increased exercise amount
11. Believes that her weight loss occurred because of her utilization of the stairs
12. Believes that obese people would benefit from performing regular PA because it would aid in weight loss.
13. Uses her clothes size to monitor if she is gaining weight or not
14. Believes that all people, overweight or not should use their clothes to monitor their weight status. If you clothes become tight, that should indicate that weight loss is needed
15. She is concerned that her friend is gaining weight and that her friend loves to eat. She wants to help her lose the weight she gained
16. Client had walked so much that she lost weight, so she has stopped walking.
17. Client is aware of her height and weight [BMI] and she is knowledgeable of what she should weigh in order not to be classified as overweight.
18. Recognizes that when she gains weight, she fatigues easier and doesn't feel as well.
19. She has a history of weight gain but she realizes that she should never weigh more than 150 pounds because that would be excessive for her height
20. Believes that she lost weight because of the stress that accompanied her caretaking duties
21. Uses home scales to measure and monitor her weight status.
22. Client is aware that a person should weigh a certain amount according to their height (based on standard/published weight-to-height tables).
23. Attended a weight loss clinic in her younger years to help her lose weight
24. Client has purposely lost some weight by cutting calories and trying to eat healthier.
25. Weight loss is a benefit of regular PA, which results in less pressure on the LEs and her clothes fit better
26. She is aware that her weight should be aligned with her height according to standard ht-wt charts.
27. Realizes that she has weighed more than the ht-wt chart states she should weigh for years.
28. Looking in the mirror and weighing on the scales are two techniques to use to monitor whether you are overweight.
29. Client had lost weight unintentionally because she had a decreased appetite before her surgery but she gained the weight back after surgery (no more pain)
30. Believes that people should know if they are overweight by the way their clothes fit and how much they weigh on the scales
31. Believes that even though some older people do not eat in excess, it is difficult for some to lose weight.

CATEGORY 8

Appearance/ Embarrassed:

1. She is embarrassed about her feet edema and the inability to wear acceptable/ appropriate dress shoes to church
2. How she looks and dresses is important to her. Her appearance is so important that she limits her social outings because of swelling in her feet.
3. Believes that overweight/ obesity is unattractive to look at
4. Acknowledges that she has gained some weight and she attributes her arm flabbiness to weight gain and not the loss of muscle tone.
5. Perceives that being Overweight or chubby is not attractive
6. Acknowledges that she has a history of some abdominal weight gain
7. Perceives flabbiness of arms to be unattractive so she covers them with clothing
8. Perception that in younger years she could disguise her overweight appearance
9. Perception in her younger days was that she looked good but her perception now is that thinner is healthier
10. Perceives that “chubby” or having curves is okay or is attractive but more obvious physical changes are indicative of being obese or overweight.
11. Attractiveness of her shoes was an issue for her when she first started wearing the platform shoe; but now she does not let the look of the shoe bother her anymore. She has accepted her prosthetic-raised shoe
12. Believes that being too skinny is not attractive and that skinny person’s are unhealthy
13. Perceives her overweight status as attractive
14. Believes that people with abdominal obesity should not wear certain clothing items
15. Perceives that her niece is classified as obese but not her. Some styles of clothing/ fashion are unattractive when worn by obese women
16. Does not consider being skinny an attractive weight status. Also considers a skinny person to be malnourished and sickly.
17. Believes that older women who are overweight simply do not care about their appearance but denies that there is a serious obesity problem among older AA women
18. Older AA women tend to take care of themselves and their appearance better than younger AA women
19. Believes that older women do not want to be classified as overweight or obese. Older women have decreased physical attributes to compete for companionship Being normal weight or not being overweight is one of the few things older women have going for them
20. Believes that older women take pride in their appearance
21. Believes that overweight people (especially younger people) are not concerned about their weight but older adults do care about their appearance

22. Believes that the overweight women in her apartment building care about their appearance but believes that there are no obese people in her building because the older adults care about their appearance.
23. Believes that cosmetics are used to hide physical flaws but if obese people lose weight they would be in better shape
24. Being beautiful on the outside is not as important as being physically healthy
25. Client has increasing awareness that a person does not have to look fat to be classified as obese
26. Believes that there are medical issues related to being overweight but there are no cosmetic issues. There are some beautiful overweight people. Skinny people do not translate to beautiful people.
27. When your clothes have become too tight then the person should know that they are overweight because they have gained weight
28. Believes that a person can look in the mirror and see if they are overweight or not.
29. Client did not like the way she looked after weight loss so she decided to gain some of her weight back because she believed that she looked sick.
30. Believes that her appearance was much better after she regained some of the weight she lost. She looked ill to herself.
31. Believes that her daughter would not have told her that she looked ill but she was not happy with her appearance after her weight loss so she regained some of her weight and she feels comfortable with her appearance.
32. Believes that overweight people should be able to look at themselves in the mirror and know if they are overweight or not.
33. Clothes do not fit anymore because the person has gained weight.
34. Client does want to be taller because she perceives that taller people look better in their clothes.

Grief or depression

1. Believes that after her grief resolved her appetite returned
2. Grief can lead to a decreased appetite
3. There are different levels of grief which can cause various effects on one's appetite
4. Grief because of the death of a loved one can cause a person to lose one's appetite
5. Grief has also contributed to decreased participation in activities that use to be considered fun
6. Recalling the activities of her youth brings to light her current limitation; this causes a great deal of sadness
7. Becomes depressed when she thinks about her current health status
8. She has periods of depression
9. Does admit that when she does perform regular PA she feels better. Important not to give in to sadness/ depression or feeling sorry for one's self.

10. Realizes that although she moves slower now than she did during her youth, she needs to stop feeling sorry for herself because she can still perform some activities just at a slower pace
11. Becomes depressed in the winter months. Recognizes depression may be responsible for a decreased appetite. Depression in winter months causes increased social isolation.
12. During the winter months the client stops participating in outdoor activities, which is a major component of her life. She becomes depressed and this leads to a decreased appetite. Depression and social isolation led to infrequent church attendance (a change from the usual).
13. Believes that obese people suffer with depression

Health care provider mistrust

1. Believes that Caucasians classify AAs as having weight problems. Believes that other races have problems with weight and she is not going to accept the obesity classification for AAs.
2. Finds it offensive that AAs are classified with so many health disparities.
3. Believes that AA women are classified with so many diseases because healthcare providers interpret the test incorrectly for AAs. Does not know if the same is occurring among AA men because they typically do not go to the doctor.

Stress:

1. Stressful situations can lead to a decline in appetite
2. Going through cancer treatments led to a decline in appetite because this was stressful
3. Stress is not healthy; worry leads to stress
4. Attributes severe stress as reason for hospitalization
5. Attributes release of stress to PT
6. Believes that stress of caregiving was the cause of her losing weight but she realized that she had to get a handle on her stress because it was not healthy.
7. Participating in regular PA is a stress reliever and a coping mechanism.

CATEGORY 9

Dependent

1. Without her own transportation, she is more dependent on others to get to medical appointments and the taxi service is not reliable.
2. Belief that one should not depend on others unless absolutely necessary.
3. Believes that overweight people are lazy and that they like being dependent on others for their needs and that's why they do not participate in regular PA

4. It is acceptable to be dependent on others only when a person is not cable of performing certain tasks for him/herself
5. Loss of independence would occur with surgery because she would need major assistance from others post surgery
6. Lacks independence in regards to gardening. Pain makes it difficult to garden outside in the yard.
7. Regrets the loss of Independence which was very important to her during her youth. Now she has to rely on others to do ordinary things such as walk outside her home by herself. Concern of family members is irritating to her.
8. Recognizes that many older adults her age are no longer able to perform many ADLs without assistance from others
9. Believes that obese people are dependent on others for assistance.
10. Believes that obese people cannot perform ADL without the assistance of others

Energy/endurance

1. It does not matter whether an overweight person has energy because their size limits their physical abilities
2. Decreased energy level can cause decreases in physical activity level. Attributes low PA level to her decreased level of energy.
3. Decreased energy leads to decreased PA and the need to conserve energy
4. Decreased energy leads to decreased participation in activities.
5. Tried vitamins to increase energy level
6. Decreased energy leads to decreased participation in activities
7. Cooking style now appears to be a way to preserve energy.
8. Regardless of information that would be provided about PA, decreased energy is her plays a major role in her functional limitations
9. Decreased energy reduces her ability to performing household chores and it increases her functional limitations regardless of the family support
10. Difficult to shop because she does not have the energy to walk around large stores.
11. Decreased energy is a barrier to PA
12. Knowledgeable of the benefits of regular PA but does not have the energy everyday to perform regular PA.
13. Decreased energy is a barrier to performing daily PA
14. Client has decreased endurance with standing activities such as when cooking. This has caused her not to cook as much as she used to.
15. Experiences shortness of breath when she performs ADL but she compensates by resting between activities before continuing her activities.
16. Does not let shortness of breath with activities deter her from performing needed activities. She rests between activities.
17. She admits that she had to have rest periods in order to complete her walk.
18. Decreased ability to walk or stand for long periods of time. Feet will swell if she stands for long periods of time
19. Shortness of breath with activity appears to be her major barrier to performing regular PA

20. Started experiencing an exacerbation of shortness of breath within the last year and this caused her PA level to decrease more
21. Older adults should use frequent, small rest periods to complete tasks and activities. Suggests standing rest periods because sitting decreases motivation to continue with activity
22. Knows that some overweight people do not have problems with ambulation while others fatigue easily and requires frequent rest periods.
23. Paces herself when performing household chores. This keeps her from becoming too fatigued
24. She has decreased endurance with performing household chores. She becomes fatigued much faster than she used to. She has to sit down to wash, iron or fold clothes or wash dishes.
25. Overweight people fatigue easily with activity.
26. There are no advantages to being overweight. Some overweight people have to sit down to perform some ADLs or have frequent rest periods to complete ADLs. She classified herself as obese but stated that her ability to climb up and down stairs is not impaired.

Exercise

1. Exercise programs are good for overweight people to participate in because it helps them lose weight
2. Believes that it is difficult for older adults to use exercise machines
3. Considers watering her flowers a form of exercise
4. Considers yard work to be a form of exercise
5. Performs light yard work on regular basis and she considers this exercise
6. The perceived benefit of regular exercise is that it makes a person feels better
7. Engaging in light yard work is equivalent a form of exercise for her
8. Exercise is more difficult for overweight people but it is good for them.
9. Believes that if obese people perform regular exercise this will lead to extreme weight loss
10. Believes that participating in regular exercise will lead to weight loss and it will relieve stress on the knee and hip joints
11. Knowledgeable of some upper extremity exercises even though she does not perform them on a regular basis
12. History of exercise classes at her apartment complex. They would perform arm exercises without free weights
13. Recognizes walking as a form of exercise
14. Knowledgeable of some upper extremity exercises with hand weights even though she does not perform regular upper extremity exercises. She no longer does upper extremity exercises with free weights because it causes are pain and soreness.
15. Post exercise soreness became a barrier to performing regular upper extremity exercise
16. Perceived post exercise soreness as an abnormal result and therefore she discontinued performing regular upper extremity exercise
17. Exercise group and convenient location for exercise was discontinued from her apartment building
18. She had access to a weight room at the community center but she did not use it.

19. Knowledge is not enough to overcome perceived difficulties with mobility to increase participation in regular exercise
20. Range of motion (ROM) of upper and lower extremities is essential to functional status and mobility and she has limited ROM in all four extremities.
21. (running, walking, swimming) Examples of exercise
22. Stated that PT was a form of exercise
23. Knowledgeable of the benefits of regular PA and she tries to perform upper extremity exercises in order to improve upper extremity ROM
24. Recognizes that exercise is important and that she needs to participate
25. Demonstrating what exercise is to her by standing up and forward flexing
26. Demonstrating other forms of exercise by extending and flexing her knees and ROM of shoulders. She realized that exercise helps the extremities of the body remain mobile
27. Believes that push-ups is a form of exercise that she would not be able to perform
28. Believes that PT is a form of exercise designed to work out a person's extremities
29. Client mostly walked once a week prior to retirement because she was working through the week
30. Believes that walking would help improve her arthritic pain and her decreased endurance. Also realizes that a sedentary lifestyle is not good for one's health.
31. Understands that walking can improve arthritic pain
32. Believes that walking the hallways of her apartment helps her maintain her current weight status.
33. Walks intermittently and short distances with one of her neighbors
34. swimming and walking are good activities for the body because they tone and condition the extremities and the body in general so that the person can ambulate and function without difficulty
35. Believes that exercise involves a person using all body parts. Because ADLs requires the use of all (or most) body parts, ADLs are a form of exercise.
36. Recognizes to lose weight in a healthy manner, exercise is an essential component
37. Exercise consist of performing activities that tones the body and it will aid in obtaining longevity
38. Performs regular exercise six days a week unless she is sick
39. Believes that exercise is the key to her overall good health, but especially for her heart disease and diabetes
40. Performs upper and lower extremity exercises in her bed at infrequent intervals. Believes that she is performing adequate amounts of exercise.
41. Considers exercise to be activities such as aerobic dance because the person is moving the body in different directions. Also considers walking, riding a bike, and working in the yard as exercise.
42. Changed the form of exercise she was using from riding a stationary bike to attending water aerobics
43. Water aerobics exerts less pressure on joints but she does not attend water aerobics in the wintertime because she does not like getting out of the water into the cold air.

44. People who cannot walk should perform upper extremity exercises and lower extremity exercises while sitting in a chair. There is some form of exercise any person can perform
45. Believes that if she had additional information about back/ upper body strengthening exercises and range of motion exercises for the upper and lower extremities, she would participate in more PA.
46. Contemplating the start of a walking regime in her neighborhood or just walking up and down her driveway.
47. Client thought that she was obtaining adequate amounts of exercise when she was performing yard work in her younger days, therefore she did not think that she needed to increase her walking.
48. She thought that because she was working everyday and cutting the lawn in two yards, she was getting adequate exercise.
49. Believes that exercise is staying busy, [walking running, cooking and jogging] and includes formal activities as well as household chores.
50. Believes that walking is a healthy activity even though she started walking because she was bored.
51. Walking improves blood flow and mental functioning. Walking for long periods of time may cause lower extremities pain or discomfort
52. The timing of the water aerobics class was a barrier to her participation but now that she knows that there are some alternative times, she plans to attend.

Independence

1. Independence is important so she tries to stay busy
2. Being overweight worsens one's condition and leads to a loss of independence
3. Remaining independent is important and this is accomplished by performing her own routine tasks at home
4. She is still capable of performing her own housework without outside assistance
5. She is still capable of putting on her own clothes without assistance
6. Believes that it is important to be able to maneuver around her house and care for herself without assistance.
7. Believes that keeping active is important to her independence but regrets the inability to attend church regularly because of edema in her feet.
8. Independence is important to her. She does not want to become dependent on others.
9. Believes that even though physical functioning can decline with aging, it is important to accept the changes that come with aging, but at the same time to stay independent as much as possible. Don't become dependent
10. One's own independence is important because other people have their own responsibilities which makes it more difficult to get assistance from others especially if they work

11. Independence is important. Believes that God will help you to remain independent if you keep active and help others
12. Self-Independence is important to her. As long as she can perform all of her ADLs and IADLs she is happy
13. Performing her own household tasks and not depending on others is important to her
14. Refused to allow poor health to force dependence on others
15. Not having her own transportation is a barrier to her social independence. Continues to perform ADLs and light housekeeping without help from others. Not at the point of dependence.
16. Believes that older adults should maintain independence as long as possible
17. Lives alone with intermittent outside help. Perceives that she would not have anyone to assist her full time if she consented to have the surgery
18. She paces herself when performing household chores. This method helps her to remain self-sufficient
19. Able to live in assistive living complex and maintain some independence with assistance which is available free of cost
20. Maintaining independence is important. Whenever her pain is under control, she tries to do all of her household chores in one day but the next day she will be in a lot of pain because she would have overworked her body. Has not learned how to pace her activities to prevent pain and fatigue
21. She used to shop for herself before she retired
22. Living alone helps older adults remain independent.
23. Prides herself on being able to perform all of her yard work without any assistance from her children
24. Does not want to be dependent on anyone for anything. She likes to perform activities as she deems necessary. Is willing to help others with activities and chores.
25. She is proud that she is able to perform household chores with asking for assistance from others. Many of the household chores she undertakes are very strenuous activities.
26. People need to rely on themselves for as long as they can.
27. Client is able to perform ADLs without assistance at this time.

CATEGORY 10

Family –Friend Support/ influence

1. Son doesn't understand the importance of PA and the implications related to decreased activity

2. Son thinks that resting and elevating her lower extremities will improve the pain and swelling but he doesn't understand the risks associated with decreased activity
3. Family members can contribute to or hinder diet compliance because they do the shopping for the client
4. A family member suggested surgery as a quick fix verses a lifestyle change of regular exercise but client did not agree with that suggestion
5. Others make it convenient for this client to increase her homebound status and decrease her social outings. Church attendance has decreased but church members deliver sacrament to her at her home.
6. Grandson tries to encourage her to increase her walking but although pain is a barrier, she tries to increase her walking
7. Family members perform instrumental ADLs because she is unable.
8. there appears to be a self imposed barrier because she feels rushed when she goes to the store with people other than her son who died
9. Mobility is limited and she requires moderate assistance from others. She feels that she is a burden to her grandson because he has to help her with mobility issues such as traveling in the car.
10. Independent with small tasks in the home and has sufficient help and support from adult children.
11. Pain makes PA difficult despite family member encouragement. She gets upset with her grandson because he does not understand how she feels but she does not say anything
12. She also allows her family members to shop for her because they are able to walk faster than her, but this decreases her PA. passed on shopping duties to family members because they are more proficient at it; shopping has become difficult for her and she moves about the store very slowly.
13. She chooses to let her grandchildren perform her grocery shopping instead of doing it herself.
14. Acknowledges that letting her kids shop for her has caused her not to even attempt to shop for herself. It is easier to let the kids shop for her.
15. Has no motivation to shop for herself now that she has retired and she has family members who are willing to shop for her, so there is no need for her to go.
16. Her brother constantly tries to encourage her to participate in regular PA
17. Some family members believe that the client is too sedentary and she needs to increase her PA level.
18. Her brother uses walking as a stress reliever and to improve his overall health
19. Does not have any family who would encourage her to participate in regular PA
20. Believes that older adults with children or grandchildren make them get things for them instead of getting up themselves, which would be PA.
21. Believes that some family members encourage older adults to lead a more sedentary lifestyle because the family members do many activities that the older person could do for themselves. Family members are at fault for causing/ encouraging premature dependency.

22. Family members promote sedentary lifestyles of older adults
23. No one would encourage her to increase her PA but one of her grandsons. She believes that other people would tell her to stop doing as much as she is currently doing.
24. Grandson is the only person who does not discourage her from performing regular PA
25. People important to her would try to discourage her from walking because they believe that she is over exerting herself.
26. Friends who have limited mobility and overall functional status are trying to discourage the client from performing regular PA.
27. Her friends do not understand why it is so important for the client to engage in regular PA before socializing
28. Family does not adhere to eating foods that are healthy. Client is making changes in her diet in order to eat healthier despite her family's disapproval
29. Family members do not encourage client to participate in regular PA. All of her encouragement comes from medical personnel
30. She remembered that her son who lives out of town was proud of her PA routine and he encourages her to continue with her daily routine.
31. She is attempting to find her an exercise partner because she believes that would motivate her to do more.
32. Family member encourages her to perform regular PA but she believes laziness is a barrier.
33. She realizes that her family member only encourages her to increase her PA in order to help her mobility and overall health. Attempts to hide amount of time spent lying down from family.
34. Her grandson also encourages her to increase her PA.
35. She has a family member who is a strong proponent of healthy lifestyle behaviors. This family member tries to encourage her to adopt a healthy lifestyle of diet and exercise.
36. Believes that her family members would be happy if she would engage in regular PA. Some members would even be willing to walk with her.
37. In the past, she has tried to encourage her daughters to lose weight but she met a lot of resentment from them so she stopped. She realizes that there are health related illnesses that accompany obesity and she does not want her daughters to experience these problems.
38. Client stopped walking with a partner because she walked at a faster pace than her walking partner
39. Her friends give her reasons for not participating in regular PA such as knee pain.
40. Her daughters tell her that it is good that she exercises but they are not going to exercise
41. One daughter lives close to a nice walking track but she does not take advantage of this amenity. The client is concerned about her daughter's health and weight status. She yearns to participate in PA (e.g. walking) with her daughter but is waiting for an invitation.

Faith or Spirituality

1. Perceives self as blessed
2. She chooses to believe in God to help her cope with knee pain.
3. Expresses thankfulness to God that she is her current size
4. Faith in God is an important coping mechanism to use when you have an illness
5. She feels grateful to God that she is able to perform as well as she does because there are other older adults whose health conditions are worse than hers.
6. She is grateful to God that her health is as well as it is because it could be worse.
7. Spirituality is an important to help her deal with LE pain that she experiences. She refuses to contemplate knee surgery
8. She uses her religion as an important coping mechanism to help her stay physically active. Staying active helps keep the mind and brain intact.
9. Uses prayer to give thanks to God for her family and her current health
10. Believes that she has been blessed by God because she was not sickly the majority of her life. Perception that her poor health was caused by aging not other conditions
11. Belief in the serenity prayer. Accepts her pain and believes that God will help her endure and cope with pain.
12. Believes that God will help the person accomplish goals if she put forth an effort.
13. Believes that family members do not understand that she does not walk more with her walker because of LE pain
14. Perception that family members would be happy if she had more independence. Family members wish for a better state of health for her.
15. She described an overweight woman who was older than her but was able to ambulate better than her. She considers this neighbor as being blessed because she is oriented and appropriate at 95 years old.
16. She uses prayer to help her cope with leg pain . She considers herself to be a spry person.
17. She believes that she is blessed by God to be able to perform the activities that her friends cannot
18. At first she felt like people were using her to help them but now she feels that she is blessed to be able to help others who cannot perform all of their ADLs
19. Believes God purposefully designed her body to withstand work even in old age.
20. Believes that God will give a person the strength to perform any activities that they need to perform. The person just has to make the effort and not complain
21. Although she is 74 years old, her health is still a priority for her. She is thankful to God that she has lived this long but she wants to continue living a healthy life
22. Tries to encourage family members to eat healthy but they do not want to make any changes so now she prepares two different meals.
23. She thanks God for being able to perform ADLs alone

CATEGORY 11

Finances

1. Being overweight can cause a financial burden because you have to purchase new clothes
2. Notion that bigger things (i.e. clothes and shoes) cost more money
3. Not having one's own transportation and the increased co-pay for doctor visits is an increased burden because she previously did not have to pay anything for transportation. Money is attributed to doctor or PT visits, not transportation
4. Money is limited among some older adults because they are on a fixed income. They have to prioritize their spending because of financial restraints.
5. Limited income is perceived as a barrier to performing regular PA because she believes you need to go "somewhere" to participate
6. Unable to go to the YMCA as desired because she has to work to pay her bills.
7. Consider it a blessing from God that you can afford to purchase certain materials, but do not misuse blessings to pay someone to do the actual job (work) for you.
8. Understands that a lack of finances prevents some people from buying foods that are healthier.
9. Believes that people today are trying to cook healthier but there are obese people who probably lack adequate finances to purchase healthy foods
10. Believes that community gardens would be one strategy to assist people with inadequate finances to obtain healthy foods

Transportation

1. Believes that own transportation would make her more independent
2. Her own transportation would equal more independence
3. Considers it a burden to have other people meet her transportation needs.
4. Not having her own transportation has lead to a decrease in independence
5. Having your own transportation allows a person to be independent with routine tasks
6. Not having her own transportation increases her financial burden because she is on a fixed income and she has to pay someone to take her places
7. Own transportation would decrease the need to rely on public transportation services
8. Own transportation would lead to being able to attend more social functions
9. Regrets not having her own transportation. She views no transportation as a obstacle to her independence
10. Without your own transportation, a person is dependent on others to get around

11. Pain and swelling in legs are barriers to her purchasing her own transportation
12. Pain and swelling in legs are barriers to driving a car
13. Transportation is perceived as a facilitator to participating in regular PT because she does not want to become dependent on assistive devices to ambulate.
14. Has a strong desire to obtain her own transportation but LE pain is a barrier.
15. Lack of transportation is a barrier to organized physical activity. She depends on others to carry her to water aerobics and she does not like to ask. She has more pain with walking and exercising now that she is older
16. Transportation is a barrier to her going to the senior citizen center for water aerobics because she hates asking family members to carry her.

Work Status

1. Worked until the age 66 but retired because of a history of falling on the job, and problems with mobility/ movement.
2. Worked at a church daycare where she fixed meals for children. The demands that accompany working with children became too difficult so she decided to retire
3. When she worked in the hospital, she was required to perform a lot of walking
4. Difficulty climbing up and down stairs was a catalyst for her to retire
5. The apartment building did sponsor activities for the tenants to participate in but the client would be unable to attend because she would be at work during the scheduled time
6. Being retired can lead to a sedentary lifestyle so that is why the client chooses to increase her PA
7. Believes that performing her job on concrete has contributed to her inability to stand for long periods of time.
8. History of walking for 20 years but decreased her walking frequency from 6 days to 3 days because she still works.
9. Her job does not require that she walks but she chooses to climb the stairs on her job.
10. Once she retires, she plans to start taking swimming lesson as a way to increase her PA.

Safety:

1. Safety is a concern when getting in and out of the bath tub
2. Safety is important to her and her family because she is at increased risk for a fall.
3. Does not weigh on standing scales often because of a fear of falling. Weight has been stable over recent months.
4. Fear of falling is a barrier to performing regular PA
5. Believes that being overweight can cause you to be vulnerable to (violent) attacks
6. Safety is an issue at the place she goes for PA

CATEGORY 12

Lifestyle habits:

1. Lifestyle habits are routine and very hard to break. She keeps this schedule regardless of planned activities.
2. She has had this daily routine for years so it is difficult for her to change.
3. Realizes that she didn't make the best lifestyle choices when she was younger.
4. She chose to buy larger clothing sizes rather than to modify her life-style behaviors.
5. Knowledge of obesity related illnesses still did not translate into lifestyle behavior modification
6. Knowledge of the importance of performing PA and exercise does not necessarily translate into behavior modification. She mostly uses her motorized wheelchair to get around her home.
7. Considers herself as always being an active person but she is more active as an older adult because her residential building is more suitable for PA.
8. She uses the stairs in order to increase her daily activity level
9. She has always been active but the type of activities she participates in now are different from her younger days. However, she perceives that she is more active now than when she was younger.
10. Believes that she is the most active person in her apartment building
11. She perceives herself as a leader for the rest of the tenants in her apartment building
12. There was a person who provided exercise classes for the tenants but the client believes that because she did not attend, others in the building would not attend
13. Believes that people who do not adopt a healthy lifestyle do not care about their health
14. Perceives her activity level to be the same as in her younger years.
15. Client has a difficult time sitting still for long periods of time. Her mind is constantly thinking of activities for her to do around the house.
16. She is not only active at her home, she will help someone at their home if they are working on a project
17. Has always been a very active person since childhood
18. Contributes her active lifestyle to her childhood responsibilities. She was responsible for helping her mother care for her sick brother.
19. Had a very strong curiosity for anything that would keep her busy and physically active
20. She does not like exercise equipment. She prefers to perform yard work or walk outside where she can commune with nature.
21. Client has been active all of her life. If she ever gets to the point where she would not be able to perform yard work or take care of her own housework, she would be ready to die instead of having to depend on others.
22. Understands that in order to lose weight, there needs to be lifestyle changes in regard to eating and exercise.

23. She has made a lifestyle change regarding her diet despite her family's refusal to change.
24. Although years ago people ate foods high in fat, they walked more and lead more active lifestyles than people do today
25. She has since learned that it is difficult to get adults to make changes in their lifestyle so she has decided not to worry about her family making changes anymore.
26. She feels proud of her accomplishment and her ability to be active at her age.
27. Believes that older overweight people stay indoors more so than younger overweight people, who are more visible.
28. No matter what the season, in Alabama older overweight adults stay indoors because their mobility is slow.
29. Follows a very strict walking schedule regardless of the weather or the planned events of the day

Meal preparation/ Eating habits

1. Believes that overweight people eat excessive amounts of food
2. Believes that overweight people partake of too much of traditional southern AA foods, which is perceived as unhealthy diet
3. Overweight people consume too much food and it is not equivalent to the amount of energy they expend.
4. Perceives that most overweight people eat too much and they have sedentary lifestyles
5. Perceives that older people have early satiety
6. Devised methods to cook and store large amounts of food for one person
7. Her eating and cooking habits have changed now that she is older
8. Does not routinely eat a regular well-balanced meal; eats according to how she feels and what she craves.
9. Does not eat breakfast in the early morning hours
10. Appears to use coffee as a appetite suppressant
11. Appears to skip breakfast and just wait until lunch to eat.
12. Does not have a regular scheduled time for any of her meals. She only eats when she "feels" hungry
13. Overweight people and those with diabetes should follow a special (low calorie, low fat) diet especially when purchasing and preparing food and a history of diabetes
14. Possesses the knowledge about what is appropriate to eat based on her medical history of diabetes but she does not always adhere to diabetic diet
15. Even though she knows that some foods she eats are not appropriate for her medical condition she attempts to limit the intake amount of that inappropriate food. However, she should eat the no sugar added ice cream
16. Believes that the southern, traditional "soul food" diet of AA's contributes to AA weight gain
17. Believes that Caucasians do not purchase or eat the southern, traditional "soul foods" that some AA's eat.

18. Believes that Caucasians have a better diet or food choices than most Southern older AAs
19. Believes that AAs eat a lot of pork which contributes to overweight status
20. AA food choices lead to many AA being overweight
21. Believes that eating a healthy diet prevents people from becoming overweight
22. Believes that decreasing food intake has contributed to her weight loss. Does not appear to eat a well balanced diet
23. Eating habits have changed. Appears to have become bored with her food choices which leads to a decreased food intake.
24. Food intake decreased because of boredom with food choices. Has difficulty selecting new/ different menus/ foods cook.
25. Some of her food choices are congruent with what she previously stated AAs eat
26. Perceives that obese people eat in excess and continuously
27. She enjoyed eating traditional southern "soul food" despite the knowledge that this type of food was contributing to her overweight status.
28. Appetite fluctuates and it decreases with exacerbations of sinus flare-ups
29. Belief that weight has remained stable because she routinely eats the same amount and does not overeat.
30. She appears to eat meals on a regular basis. Tries to be adhere to medical advice regarding meals.
31. Appears to eat at regular meal times but likes to eat potato chips. She is aware that potato chips are high in fat and calories
32. She eats regular potato chips by the handful. She does not eat the baked or low fat versions and she realizes that this is not a healthy food choice.
33. She is knowledgeable of some foods to avoid that can increase cholesterol. Her family has stopped eating beef and pork but she still likes to indulge every once in a while.
34. She is trying to make some healthier diet choices by using ground turkey instead of ground beef
35. She does not consider herself to be a big eater and that's why she believes she is not overweight
36. Believes that eating a meal and immediately laying down after the meal contributes to a person gaining weight. Therefore it is important to find something to do after a meal other than going to bed
37. Having mental or physical problems can also contribute to overeating
38. Likes to cook southern "soul food" and share it with others
39. Uses pig tails to season greens and cabbage and believes that these vegetables will not taste good if they are not cooked with pig tails
40. Perceives herself as being able to eat in moderation. Her meals do not appear to be balanced meals (meals appear to be deficient).
41. When she observes large amounts of food being prepared and people eating, that sight temporarily diminishes her appetite
42. Participant eats only a small amount of food but her friend will eat whatever the participant doesn't eat.

43. She has problems eating meat other than chicken. She can only eat half of a chicken breast but that would count as two servings for her. She likes to eat vegetables instead of meat.
44. Although she is aware that she should not eat sweets, she continues to eat sweets but she attempts to burn the calories by performing yard work
45. Loves to eat watermelon because it suppresses her appetite and it doesn't raise her blood sugar the next day
46. Likes to eat junk food but knows that it is not good for her
47. Concerned that she gets involved in daily activities before eating breakfast and as a result, her BP and BS become elevated. Concerned that she gets involved in daily activities before eating breakfast and as a result, her BP and BS become elevated.
48. She is aware of the correct foods to eat but she often eats foods (like sweets) that are not part of a diabetic diet
49. Knowledgeable of alternative choices to eating sweets but refuses to use them because of the potential side effects.
50. Has learned to read food labels and what foods to avoid.
51. Decreased appetite was also related to her husband's food choices. He wanted fast-food and she did not. But her husband is now better and she thanks God for bringing her through that stressful situation.
52. Loves to eat but she is trying to eat in moderation because it is healthier
53. Eating regular serving sizes now
54. Decreased intake of sweets and eating more normal serving sizes contributed to her losing weight
55. Client does not adhere to her ADA diet even though she has a history of diabetes. Knowledge does not always translate into behavior modification. It's difficult to change long term eating habits
56. Believes that if she drinks only water that will counter balance the sweets that she eats. She is aware that she should not be drinking regular sodas or eating sweets but she regularly indulges in these.
57. Monitors blood sugar more frequently when she is eating something that she should not be eating.
58. Believes that older Alabamians overeat on foods that are high in fat because this is what they were raised on when they were children.
59. Cooking preferences include cooking most vegetables with ham hocks or the like
60. Older adults cook food the way their parents cooked food (traditional southern cooking)
61. Believes that her weight has decreased because she is eating healthier, decreased her sweet intake, and caloric intake/ serving size(s).

CATEGORY 13

Physical Activity

1. Believes that It is important to stay busy(active) daily

2. Even when sick/ill, a person should engage in day-to-day (routine) tasks. It is not good to stay in bed.
3. Believes that watering her flowers keeps her active
4. Activity is better than being immobile or inactive
5. A person should engage in whatever type or level of activity she can tolerate
6. Adopted watering flowers to include as much walking back and forth in order to get as much PA as possible from this task.
7. PA without rest periods can cause pain because pain increases with PA
8. Use PA as a pain management strategy. PA is a distracter and in this way helps to prevent the brain from interpreting the sensation of pain
9. Believes that keeping busy equals physical activity
10. When performing PA, it is okay to have rest periods because it is important to be independent as long as possible
11. Any physical activity that does not hurt you is good to perform on a regular basis
12. Believes that sexual activity is considered physical activity and older women do not have the added worry of pregnancy
13. Based on the examples she listed, she perceives PA to be a form of exercise or taking part in activities at a gym and or housework.
14. The place where she lives has long hallways where she has the opportunity to increase her PA.
15. Perceives riding in motorized wheelchair to different floors of her building as PA
16. Recognizes the incremental benefits of exercise, and that exercise becomes easier with time.
17. Decreased energy and pain are barriers to regular PA but some days are better than others.
18. Knowledgeable of the benefits of regular PA but unable to perform on a regular basis because of pain
19. Attempts to performs some PA because of the known benefits. She states that she feels better. Belief that PA makes one feel better and one has to work through the hard times of PA/ exercise.
20. Client loved to travel and she considered traveling PA
21. Questioning the interviewer whether climbing stairs increase her PA. She admits that she is not enthused about using the stairs but recognizes that using the stairs would increase her PA level
22. Believes that her health, age and lack of motivation are the barriers to her performing regular PA
23. Client loves to travel, which she considers PA. Limited income is a barrier to her ability to travel.
24. Although she considers sex as a form of PA, she is not interested in engaging in sexual activity anymore.
25. She and her walking partner attend different church activities on different days and therefore they would not be able to walk on those days. (Interferes with frequency of PA).
26. Was unable to walk everyday because of conflicts in scheduling between walking partner's and her schedules.

27. Recognizes that other people in her apartment building would benefit from more PA than they are getting
28. Living alone encourages more PA.
29. Believes that regular PA is an important aspect of her life and that all people should engage
30. Denies any lack of knowledge related to how to improve her PA level.
31. Currently very physically active. Perceives herself as being knowledgeable about an appropriate PA routine/ schedule program
32. Client enjoys working outside in her yard as well as others. She considers herself a workaholic and she doesn't mind working long hours. Overworking has some untoward effects, such as LE pain and soreness.
33. She loves working outside and performing yard work. She even does yard work for her daughter who lives out of town
34. Participant daughter's neighbor told the participant not to do all of the yard work in participant's daughter's yard but ironically, the neighbor wanted the client to work in the neighbor's yard.
35. Believes that living alone forces older adults to be more physically active
36. Believes that she is knowledgeable of everything she needs to know about increasing her PA because she attends PT and walks on a regular basis.
37. Participating in regular PA (mobility) is a coping mechanism
38. Increases her PA by watering her flowers and performing light yard work. She implies that these activities are a sufficient form of exercise.
39. Considers PA as strenuous activities such as yard work
40. Believes that laziness is a barrier to performing regular PA
41. Believes that PA includes activities that increase your heart rate such as walking and calisthenics
42. Perceives that her largest barrier to increasing her PA level is her inability to stand for long periods of time
43. Identifies that it is important keep active and not to remain sedentary because that can cause stiffness of joints and make ambulation difficult.
44. Believes that staying active by performing regular PA is important to prevent LE stiffness and pain
45. Her decreased ability to stand for long periods of time is a barrier to performing regular PA
46. Even though she was very active, she did not lose weight and her appetite remained the same.
47. Believes that her spinal cord problems are the barriers related to why she cannot stand or walk for long periods of time, which interferes with her PA level.
48. Believes that walking three times a week and climbing stairs in her home every day shows that she is active.
49. Because she is already very physically active, she believes that she knows everything about regular PA
50. Client is already very physically active, however, she would be willing to listen to additional suggestions on how to increase her PA

Physical Activity / Exercise Benefits

1. The benefits of regular PA includes better mobility, heart conditioning, BS control and lowering of one's cholesterol level
2. Believes that there are benefits to performing regular PA. The major benefit for the client is that her LEs are limber and have less discomfort
3. Believes that regular PA is good and it has many benefits.
4. Believes that participating in regular PA helps you to lose weight, improve mobility and to decrease fatigue.
5. Although there are many benefits to participating in PA, each person must gauge her own body as to how much she can engage in. Regular PA is important for longevity.
6. Client is more active now because she is retired and she has time to exercise and believes that it prevents illnesses
7. Believes that PA is important for older adults because it will enhance their mental and physical health as well as enhancing physical beauty/ attractiveness, and social behaviors
8. Believes that performing regular PA helps older adults to be able to be mobile and to perform ADLs without assistance
9. Believes that performing regular PA will improve all facets of a person's life that a person engages in and it keeps the body active and functioning without difficulty
10. Believes that if enough effort is put forth, the energy to engage in PA will occur.
11. PA helps people to maintain or achieve a healthy weight for their height and age
12. PA is important for good health and longevity but society inhibits people from participating in regular PA
13. Believes that PA is good for one's health especially if the person is able to perform the activity
14. Believes that PA is important to help keep your limbs mobile
15. Regular PA is essential to good health and it must be performed daily or else wasting or loss of movement / function occurs.
16. Knowledgeable of some of the benefits of regular PA. Recognizes the physical and mental benefits of exercise/ activity.
17. Perceives that there are benefits to regular PA, such as decreasing bone stiffness
18. Believes that regular PA may increase a person's energy level
19. Aware that regular PA is essential to good health even if you only perform a little at a time.
20. Regular activity makes you feel better
21. Keeping busy and physically active is important for good mental and physical health
22. PA promotes independence.
23. Physical activity is important to maintain ambulation without the use of assistive devices
24. Believes that she gains increased energy after performing PA

25. Increased PA may increase longevity.
26. Believes that walking is a healthy activity that even helps to promote and maintain your mental functioning
27. Confirms that regular PA is helpful to those who participate on a regular basis. She has observed people walking at the mall whose endurance improved with each week of walking.
28. Participating in regular PA makes you feel better, it decreases your pain intensity, it decreases your stress level, and it lowers your BP and your cholesterol level.

Physical Therapy

1. Physical therapy was recommended to assist with knee pain and mobility
2. Unable to participate in regular physical therapy without transportation to get the clinic
3. Transportation and money are needed to participate in regular PT
4. Perceived that PT was not beneficial for her back pain nor her knee pain
5. Provided a description of what her PT was like when she attended. Formal PT included physical engagement in exercises along with teaching (knowledge building).
6. Believes that PT is helping her stress level and giving her energy to perform activities she had stop doing years ago.
7. Acknowledges that there are health benefits associated with attending PT
8. Does not experience angina after exercising now and the client contributes this to attending PT
9. Uses the stairs as a warm up period before her PT appointment
10. PT is a form of exercise that is supervised by medical personnel to verify technique and for treatment of specific health conditions.
11. Because the PT is allowing her to see results physically and mentally, she believes that she will continue with the program because it makes her feels better
12. After her surgery, she was prescribed PT and OT in order to strengthen her upper and lower extremities as well as hands and fine motor skills.
13. Believes that PT is going to the gym and attending exercise classes. History of attending PT after she had a broken leg.

Sedentary/inactivity:

1. Even if a person is unable to work out side of the home it is important not to be sedentary
2. A sedentary lifestyle can lead to a decline in mobility. That's why it is essential to move your extremities
3. Long periods of inactivity can exacerbate mobility problems
4. Long periods of inactivity lead to leg pain and cramps
5. A sedentary lifestyle can lead to bone deterioration

6. Inactivity can lead to functional decline and then she would need assistance from other family members of which some have their own responsibilities and priorities and others are in the same condition as she.
7. A sedentary lifestyle will only worsen the changes that come with old age
8. Inactivity is not healthy.
9. A sedentary lifestyle is a barrier to good health. In order to get and benefit from exercise, the person has to exert some effort.
10. She appears to lead a very sedentary lifestyle
11. Believes that spending too much time in the bed is a barrier to PA
12. Believes that a sedentary lifestyle is not healthy and drains one's energy (makes one weak).
13. Perceives that the residents in her apartment building would not encourage her to participate in regular PA because they live a sedentary lifestyle
14. Believes that most of the older adults in her building live very sedentary lifestyles so much so that she would go around to check on them because weeks would go by without her seeing them.
15. Believes that hot temperatures in Alabama contribute to a more sedentary lifestyle among older adults.

STEP 4 (part d): Reduction to Eight Phenomena Based-CategoriesCategory 1

- Seeking and receiving medical advice from Healthcare provider
- Medication/ alternative treatment

Category 3

- Ambulation
- Assistive Device
- Mobility
- Movement

Category 4

- Beliefs or perception
- Perception of Health:

Category 5

- Chronic Illness
- Pain
- Physical condition
- Incontinence
- Surgery

Category 6

- Control
- Desire:
- Motivation

Category 7

- Definition of obesity/overweight
- Definition of PA/Exercise/PT
- Normal Weight
- Overweight
- Obesity
- Underweight/ skinny
- Weight Changes/status

Category 9

- Dependent
- Energy/endurance
- Exercise
- Independence

Category 13

- Physical Activity
- Physical Activity / Exercise Benefits
- Physical Therapy
- Sedentary/inactivity

Eight Category Tables

(Note: these tables illustrate the process from formulated meanings, to categories, to sub-themes)

Category 1: Health Status

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>1. Believes that it is important to maintain a sense of control over health by keeping medical appointments</p> <p>2. Because of breast cancer diagnosis, it is important to maintain her regular mammogram appointments</p> <p>3. Maintains mammogram schedule and regular medical follow-up visits in order to monitor current health status</p> <p>5. Keeping medical appointments is a way of managing health</p> <p>6. Even though she was informed by medical personnel that she was overweight, she failed to change her diet and eating habits</p> <p>7. Failed to follow medical advice to lose weight and eat healthy because she</p>	<p>Seeking and receiving medical advice from health care providers</p>	<p>Maintains a sense of control over one's own health through routine and regular health care provider visits</p> <p>Recognizes that managing health is the responsibility of the individual</p> <p>Acknowledges that, if followed, advice and instructions from health care providers will lead to better health outcomes, however, women often do not adhere to such regimes</p>	<p>Good health is valued but maintenance is ultimately the women's responsibility.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>was not having any adverse effects from her weight at the time</p> <p>8. She now knows firsthand the consequences of being overweight because the risk factors that she was advised of years ago have come to fruition.</p> <p>9. She did not translate information into behavior modification in her younger years. She acknowledges some of the benefits of regular physical activity because her doctor made her aware. 10. However, she still states that is difficult for her to engage in physical activity/exercise because of her current health status.</p> <p>11. Although her doctor recommended dietary changes because of her diagnoses of high cholesterol and hypertension, she does not follow the recommended diet.</p> <p>12. Although she does not adhere to her diet, she states that she does take her medications as prescribed. She does</p>		<p>Awareness that non-adherence to regime prescribed by health care providers and failure to modify lifestyle behaviors may result in negative health consequences</p>	

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
not appear to understand that both treatments complement each other			

Category 3: Function

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>63. Ambulating up and down stairs is a hindrance because it is difficult to ambulate and stabilize self. 64. Now that the client is older, she moved from her home because she was having difficulty climbing up and down stairs on a daily basis. 69. When people become short of breath with ambulation and unable to walk for long distances then the person should know that they are overweight. 71. Decreased ability to walk or stand for long periods of time. However, she tries to perform these activities any way to prevent further decline.</p> <p>108. Requires assistive devices to ambulate. 110. Must hold on to walls and furniture to</p>	<p>Ambulation</p> <p>Assistive Device</p>	<p>Acknowledges that ambulation is essential to maintain independence with household responsibilities.</p> <p>Understands people may have some difficulty with ambulation, preservation of ambulation is crucial to prevent further decline and manage weight status.</p> <p>Awareness that assistive devices allows people to be mobile and ensures their safety with</p>	<p>Ambulation promotes independence and good health consequences</p> <p>Assistive devices ensure safety and mobility</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>support ambulation. 113. Requires an assistive device to bathe. 115. Anticipating the potential need for ambulation assistive devices in the future but wants to delay the need as long as possible. Start off by using the minimum supportive assistive device. 118. Requires an assistive device to maintain some independence and for mobility around her home. 120. Believes that her physical activity level would increase if she did not have to use an assistive device (a cane) to ambulate.</p>		<p>activities of daily living, especially ambulation.</p>	
<p>570. Mobility is slow and it takes time to prepare for outings, so she has to get up several hours before appointment time. 573. Decreased mobility has lead</p>	Mobility	<p>Recognizes that mobility tends to decrease with aging and that being overweight/ obese negatively affects an individual ability to perform any physical activity.</p>	<p>Overweight/obesity negatively exacerbates age related changes in mobility.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>to decreased physical activity with aging. 575. There no advantages to being overweight. Being overweight slows down your mobility status. 577. Being overweight decreases a person's ability to ambulate, perform yard work, lower extremities joints become stiffer, and fatigues sooner. 578. Obese people have difficulty with their mobility</p> <p>626. Movement is painful. 629. Believes that when a person is overweight it is difficult for that person to perform some activities e.g. bending over or just decreased energy in general. When a person is normal weight, these activities are not difficult. 631. Remaining physically active prevents stiffness and maintains</p>	Movement	<p>Identifies that overweight leads to decreased overall physical activity, which results in decreased range of motion of extremities, mobility, and endurance.</p>	<p>Overweight status is a barrier to overall mobility and movement</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
mobility of limbs. 634. She has friends who are unable to bend or stoop over to pick up things because they have gained so much weight.			

Category 4: Awareness

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>131. Perceives that extreme underweight and overweight are both unhealthy statuses but believes that obesity is the worse out of the two conditions. 133. Perceives herself to be “a little obese” but not overweight. 137. Does not think that there is an overweight problem among older AA women just in Alabama. She thinks that there is a problem in the U.S. 152. This client has never had a weight problem and she does not know the role that “overweight” plays with “obesity”. She believes that people who are overweight or obese are that way because of genetics. 153. Believes that many obese people cannot bathe themselves, which results in skin breakdown. Perceives that being obese makes a person more apt to perspire quickly</p>	Beliefs or perception	<p>Realizes that genetics plays a role in underweight and overweight statuses</p> <p>Views overweight/obesity as more severe national health problem</p> <p>Obesity is a barrier to maintaining self care activities</p>	<p>Heredity influences weight status but obesity is a public health concern</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>and develop body odor</p> <p>845. Being overweight contributes to poor health. 848. Perceives someone who is underweight as not being healthy. 854. Believes that being skinny is not healthy especially if the person is frail and lacks muscle tone. People can be too fat or too skinny both extremes are not healthy. 858. In the old days, people used to consider chubby children as healthy children but it is not healthy because there are complications that accompany an overweight status. 862. Perceives good health as the ability to ambulate, to drive, to be oriented, and to travel within the city regardless of weight status.</p>	Perception of Health	<p>Recognizes that either extreme of the weight continuum (skinny or obese) is not healthy and should be avoided.</p> <p>Acknowledges that society opinions about overweight/ obese children have changed because it is no longer considered a sign of good health</p> <p>Views good health as having the ability to perform activities of daily living without any restrictions.</p>	Individuals with normal weight and mobility are in good health.

Category 5: Impact on health

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>159. Knee joint (cartilage) health has declined. 162. Believes that her health problems (diabetes, hypertension, Joint pain) started when she was younger but she was unaware of the problems at the time. 164. Joint health is an integral part of one's mobility and the cartilage in her joints has deteriorated, which causes her pain. 166. Experiences shortness of breath now that she is overweight. 175. Being overweight can cause HTN, knee and back pain. 177. If she developed diabetes that would be a stressor for her because of the changes she would have to make in order to manage the disease. She believes that she would have to have more assistance from others to manage the disease.</p> <p>709. Excessive weight causes pain</p>	<p>Chronic Illness</p>	<p>Acknowledges that obesity exacerbate chronic illnesses and mobility problems, which can cause dependency on others to manage illnesses.</p>	<p>Management of obesity and chronic illnesses prevents dependency on others.</p>
	<p>Pain</p>	<p>Recognizes that obesity can</p>	<p>Musculoskeletal pain is intensified</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>and it is difficult for older adults to use exercise machines and to engage in exercise programs.</p> <p>715. Decreased endurance and mobility because of pain. 722. Keeping active is important for maintaining mobility. Recognizing and accepting the pain helps one to be active within the constraints of pain.</p> <p>724. Exacerbation of pain and swelling occurred more with aging, which decreased mobility and functional status and led to retirement and social isolation because of inability to wear shoes and no transportation. 732. Arthritic pain makes performing household chores and basic mobility difficult. Pain makes any activity difficult to perform but some days are better than others.</p>		<p>exacerbate pain and inhibit an individual's ability to engage in physical activity.</p> <p>Acknowledges that some musculoskeletal pain occurs with aging</p> <p>Realizes the importance for older adults to engage in physical activity despite the pain in order to prevent declines in mobility and ambulation.</p>	by obesity, with aging, and it is a barrier to regular physical activity

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>822. Wears TED hose for lower extremity edema.</p> <p>826. Currently has a ruptured disk, which causes her pain.</p> <p>827. Leg length is a barrier to regular physical activity.</p> <p>828. Believes that her genu valgum is a contributing factor to her decreased mobility. She is considering an assistive device to use for ambulation.</p>	Physical condition	Recognizes that musculoskeletal problems can be a barrier to engaging in regular physical activity and maintaining adequate mobility.	Existing physical health conditions inhibit regular mobility and physical activities
<p>425. Pt has intermittent incontinence. 426. Has trouble holding her urine and this results in intermittent incontinence. 431. History of increased urinary frequency contributes to her increased homebound status.</p> <p>432. Concerned about how others regarding perceive her urinary frequency.</p>	Incontinence	<p>Aware that urinary incontinence and urinary frequency can cause older adults to limit their outside social engagements because of other's perceptions and fear of urinary accidents.</p> <p>Recognizes that surgery does not guarantee permanent repair of any physical</p>	<p>Older women have less control over urinary incontinence and frequency, which influence physical activity engagement.</p> <p>Surgery risks outweigh potential benefits of surgery despite pain.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>895. Beliefs that knee surgery is not successful for everyone. 897. History of multiple surgeries. Her decreased range of motion nor pain is a motivation to have another surgery.</p> <p>899. Believes surgeries have contributed to decreased mobility and endurance and have made her weaker and in a sense has “handicapped” her.</p> <p>900. Believes that the metal used in her body for hip and knee replacements have contributed to decreased mobility and ability to stand up for long periods of time. 906. She is fearful of surgery so she has refused to have the bulging disk repaired</p>	Surgery	<p>Recognizes that surgery does not guarantee permanent repair of any physical conditions.</p> <p>Realizes that an individual must contemplate the risks of harmful or potentially fatal consequences that can occur with any surgery.</p>	Surgery risks outweigh potential benefits of surgery despite pain.

Category 6: Motivation or Desire

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>182. She also believes that some people can control their weight gain and others cannot. 183. Believes that she can control her medical diagnoses with lifestyle behavior modifications. 184. Believes that purchasing expensive shoes that are more supportive will prevent damage occurring to her feet.</p>	Control	<p>Recognizes that what can be controlled varies across individuals.</p> <p>Control may exist for all persons in the choices they make about their individual health.</p>	Women have some control over health choices but the desire to engage in physical activity is impacted by factors outside of their control.
<p>245. If she could physically perform more activities she would do it. The desire to be active remains; but the reality is her body cannot perform as it did prior to old age. 247. Yearns for the ability to perform some of the same activities she did when she was younger such as gardening. She does not believe that she will ever be able to garden again because of her health. 251. Admits she is capable of engaging in physical activity but frequently does not have the desire to engage. 253.</p>	Desire	<p>Awareness that even though one may have the desire to engage in physical activity, illnesses and declines in health and function may prevent one's ability to participate in regular physical activity.</p>	

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>Recognizes that sexual activity would be one way to increase physical activity level but she does not have a desire to have sex.</p> <p>582. Would be motivated to participate in social activities that she is interested in. Personal interests lead to motivation. 583. Current illnesses and the fear of new illnesses are motivation to adopt a healthier lifestyle, such as increasing exercise and eating a healthy diet. 590. Longevity is a motivator to engage in regular physical activity. 594. Believes that food would motivate people in her building to exercise. 600. Does not understand how an overweight person could look at themselves and not be motivated to lose weight on their own. 604. Believes that using herself as an example (to illustrate all of the things she is able to do at her age would be a motivational</p>	Motivation	<p>Motivation comes from within women and is dependent on their interests (e.g., likes and dislikes).</p> <p>Recognizes that peers, who are similar to themselves, can serve as role models or motivators to change behavior.</p>	<p>Motivation is individual, yet it can be internal or external and is influential.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>technique for other older AA women. 609. Believes that showing older AA women before and after pictures of herself would motivate them to want to participate in regular physical activity. 612. Believes that a partner would be a great motivator for her to increase her physical activity 614. Believes that the best way to motivate older AA women to participate in regular physical activity is to list potential benefits for them such as extremities will be more limber, weight loss would decrease pressure on lower extremities. 617. In order to motivate older AA women to increase their physical activity levels, they need to be informed that physical activity can help keep the body conditioned, improve circulation, and help them lose weight. 618. Health is the motivating factor for the client to maintain her walking schedule. 620. Client always self-motivated herself to walk daily.</p>		<p>Realizes that maintaining good health is a strong motivator.</p>	

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>She tries to encourage others to walk e.g. her daughters and friends because walking is a healthy activity to participate in but they refuse. Unsuccessful in convincing others (motivating) to engage in physical activity.</p> <p>624. She also believes that it is difficult to motivate some older AA women to walk just for pleasure.</p>			

Category 7: Terminology

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>185. Perceives morbid obesity as seen on TV as what is considered overweight. 190. Provides an illustration of overweight as a person who requires two chairs in order to sit down in the waiting room of a hospital. 199. Believes people are considered obese if they weigh 300-400 pounds. 213. Associates obesity with people who weigh between 180-300 pounds.</p> <p>204. Defines the word obesity as fat but also states that a person who is obese is overweight. She uses all of the terms interchangeably. 209. There is no difference between the words obese and overweight. Believes that the word overweight does not have as much stigma as the word obese.</p>	Overweight/ Obesity	<p>Recognizes that morbid obesity is a public health issue.</p> <p>Acknowledges that there is a stigma associated with the term obesity and that people prefer to use terms that are less offensive in society to describe obesity.</p>	Obesity is challenging and it has a negative connotation

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>219. States AAs like to use the term “big-bone” instead of using the term overweight or obese.</p> <p>220. Physical activity, physical therapy and exercise mean the same thing. There is no difference in meanings. 225. Client described household chores as PA. 229. Believes that physical activity is a form of exercise that involves any movements of the body. 233. Believes that physical therapy is a technique used to get people to exercise their extremities to prevent stiffness and to help with the restoration of independent ambulation. 227. When asked what was exercise, she changed and stated that jogging and walking were exercise but eventually stated that exercising and physical therapy had</p>	<p>Definition of physical activity /Exercise/physical therapy</p>	<p>There is difficulty in differentiating the terms physical activity, physical therapy, and exercise.</p>	<p>Barriers to appropriate activity participation</p>

<i>Selected Formulated Meanings</i>	<i>Category Labels</i>	<i>Theme Cluster</i>	<i>Sub-Theme</i>
<p>is unaware that she is classified as obese. Believes that being overweight is unhealthy. 648. Being overweight would interfere with self-care activities (the ability to care for oneself). 653. Being overweight makes the most mundane task difficult. 671. There are no advantages to being overweight. Client is knowledgeable that there are overweight/obesity related illnesses that can occur. 675. Believes that overweight people experience shortness of breath with exertion and must have frequent rest periods with ambulation. 679. Believes that overweight people are overweight because they do not care about themselves. 676. Perceives that overweight people eat constantly. 687. Believes that overweight people have a difficult time functioning in society today. Also thinks</p>		<p>Women hold negative and stigmatizing views of persons who are overweight.</p> <p>Society stigmatizes persons who are overweight and subjects them to prejudicial practices.</p> <p>.</p> <p>Acknowledges that being overweight in today's society is a barrier in itself.</p>	

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>that most overweight people are uncomfortable and become short of breath with exertion. But acknowledges that all overweight people do not experience discomforts or dyspnea. 689. Overweight people should not be discriminated against in regard to flying on airplanes. Airlines should be required to make accommodations.</p> <p>691. Being overweight causes a person to fatigue quickly with ambulation, clothes are too tight and must purchase new larger ones, and the person cannot walk for long periods of time.</p> <p>695. Believes that morbid obesity is unhealthy. 698. Because she was not having any health problems when she was younger, she did not believe that being</p>	Obesity	<p>Realizes that obesity is a preventable risk factor for many chronic illnesses and comprehends the severity of</p>	<p>Obesity is a modifiable risk factor that has various degrees of severity.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>overweight/ obese was affecting her health. But now she realizes the effects of obesity.703. Uses more adjectives that mean ‘excessive’ to describe the word obese. Perceives obese as being worse than overweight; a higher degree of overweightness. 704. Obesity is viewed as an inconvenience.</p>		<p>higher degrees of obesity.</p>	
<p>923. Believes that underweight people are unhealthy. 925. Underweight means your diet is in adequate and you are not healthy. 927. Being underweight (skinny) is perceived to be that a person is sick, weak, and has difficult time doing things. 932. Skinny people look like death or they could be on drugs which causes them to be skinny. 939. Believes that it is bad for an older adult to be too skinny because they look ill and older</p>	<p>Underweight/ Skinny</p>	<p>Perceives individuals who are underweight to be unhealthy, unattractive, and frail.</p>	<p>Underweight status is undesirable</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>than stated age when they are underweight.</p> <p>942. Perceives that overweight/ obese people who lose weight feel better after they lose weight. 947. She believes that in order for people to lose weight they only need to decrease the amount of food they eat. 951. Believes that obese people would benefit from performing regular physical activity because it would aid in weight loss. 952. Uses her clothes size to monitor if she is gaining weight or not. 957. Recognizes that when she gains weight, she fatigues easier and doesn't feel as well. 960. Uses home scales to measure and monitor her weight status. 963. Client has purposely lost some weight by cutting calories and trying to eat healthier. 964.</p>	Weight Changes/status	Awareness that there are several techniques available for people to lose weight and to monitor their weight status.	Supervising weight status is the woman's responsibility

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
Weight loss is a benefit of regular physical activity, which results in less pressure on the LEs and her clothes fit better. 967. Looking in the mirror and weighing on the scales are two techniques to use to monitor whether you are overweight. 970. Believes that even though some older people do not eat in excess, it is difficult for some to lose weight.			

Category 9: Level of Dependence

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>235. Without her own transportation, she is more dependent on others to get to medical appointments and the taxi service is not reliable. 237. Believes that overweight people are lazy and that they like being dependent on others for their needs and that's why they do not participate in regular physical activity. 238. It is acceptable to be dependent on others only when a person is not capable of performing certain tasks for him/herself. 241. Regrets the loss of Independence which was very important to her during her youth. Now she has to rely on others to do ordinary things such as walk outside her home by herself. Concern of family members is irritating to her. 242. Recognizes that many older adults her age are no longer able to perform many</p>	Dependent	<p>Recognizes that having one's own transportation is an important factor in maintaining independence.</p> <p>Acknowledges that dependence on others may occur with aging but one should not abuse or misuse assistance from others if it is not essential.</p>	Dependence is only acceptable when it is vital for survival

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>activity of daily living without assistance from others . 244.</p> <p>Believes that obese people cannot perform activity of daily living without the assistance of others.</p> <p>258. Decreased energy level can cause decreases in physical activity level. Attributes low physical activity level to her decreased level of energy. 260.</p> <p>Decreased energy leads to decreased participation in activities. 264.</p> <p>Regardless of information that would be provided about physical activity, decreased energy is her plays a major role in her functional limitations. 268.</p> <p>Knowledgeable of the benefits of regular physical activity but does not have the energy everyday to perform regular physical activity. 277. Older adults should use frequent, small rest</p>	Energy/ Endurance	<p>Awareness that one's energy level is an important factor in performing daily physical activities</p> <p>Recognizes the benefits of performing regular physical activity but a decreased energy level is a major barrier among older adults.</p>	<p>Knowledge of physical activity benefits does not translate to adequate energy levels needed to perform activities</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>periods to complete tasks and activities. Suggests standing rest periods because sitting decreases motivation to continue with activity.</p> <p>435. Remaining independent is important and this is accomplished by performing her own routine tasks at home. 438. Believes that it is important to be able to maneuver around her house and care for herself without assistance. 440. Independence is important to her. She does not want to become dependent on others. 441. Believes that even though physical functioning can decline with aging, it is important to accept the changes that come with aging, but at the same time to stay independent as much as possible. Don't become dependent. 444. Self-Independence is important to her.</p>	Independent	<p>Maintaining independence is an essential component for an individual's perceived quality of life.</p>	<p>Independence is valued as a measure of control over one's own state of affairs.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>As long as she can perform all of her activities of daily living and instrumental activities of daily living she is happy.</p> <p>454. Living alone helps older adults remain independent.</p> <p>456. Does not want to be dependent on anyone for anything. She likes to perform activities as she deems necessary. Is willing to help others with activities and chores.</p>			

Category 13: Level of Activity

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>744. Even when sick/ill, a person should engage in day-to-day (routine) tasks. It is not good to stay in bed. 746. Activity is better than being immobile or inactive. 747. A person should engage in whatever type or level of activity she can tolerate. 752. When performing physical activity, it is okay to have rest periods because it is important to be independent as long as possible. 761. Attempts to performs some physical activity because of the known benefits. She states that she feels better. Belief that physical activity makes one feel better and one has to work through the hard times of physical activity/exercise. 777. Believes that living alone forces</p>	Physical Activity	Acknowledges that performing regular physical activity at any tolerable level reaps positive health benefits and independence.	Engaging in any endurable, regular physical activity is beneficial to one's overall health

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>older adults to be more physically active. 780. Increases her physical activity by watering her flowers and performing light yard work. She implies that these activities are a sufficient form of exercise. 785. Identifies that it is important keep active and not to remain sedentary because that can cause stiffness of joints and make ambulation difficult.</p> <p>793. The benefits of regular physical activity includes better mobility, heart conditioning, BS control and lowering of one's cholesterol level. 799. Believes that physical activity is important for older adults because it will enhance their mental and physical health as well as enhancing physical beauty/ attractiveness, and</p>	<p>Physical Activity with Exercise Benefits</p>	<p>Recognizes that physical and mental health benefits occur with the performance of regular physical activity</p>	<p>Physical and mental health benefits of physical activity are incentives to engage regularly</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>social behaviors.</p> <p>804. Physical activity is important for good health and longevity but society inhibits people from participating in regular physical activity. 807. Regular physical activity is essential to good health and it must be performed daily or else wasting or loss of movement / function occurs.</p> <p>813. Keeping busy and physically active is important for good mental and physical health.</p> <p>829. Physical therapy was recommended to assist with knee pain and mobility.</p> <p>832. Perceived that physical therapy was not beneficial for her back pain nor her knee pain. 838. Physical therapy is a form of exercise that is supervised by medical personnel to verify</p>	Physical Therapy	<p>Understands that physical therapy is used to restore, manage, and prevent future or progression of mobility conditions.</p>	<p>Physical therapy is a form of supervised restorative treatment used after surgery or an injury.</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>technique and for treatment of specific health conditions. 840. After her surgery, she was prescribed physical therapy and occupational therapy in order to strengthen her upper and lower extremities as well as hands and fine motor skills. 841. Believes that physical therapy is going to the gym and attending exercise classes. History of attending physical therapy after she had a broken leg.</p>			
<p>871. A sedentary lifestyle can lead to a decline in mobility. That's why it is essential to move your extremities. 873. Long periods of</p>	Sedentary/Inactivity	Acknowledges that living a sedentary lifestyle has negative health consequences (decreased mobility, decreased	Inactivity promotes declines in physical health and mobility.

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>inactivity lead to leg pain and cramps. 876. A sedentary lifestyle will only worsen the changes that come with old age. 877. Inactivity is not healthy. 878. A sedentary lifestyle is a barrier to good health. In order to get and benefit from exercise, the person has to exert some effort. 881. Believes that a sedentary lifestyle is not healthy and drains one's energy (makes one weak). 884. Believes that hot temperatures in Alabama contribute to a more sedentary lifestyle among older adults.</p> <p>283. Exercise programs are good for overweight people to participate in because it helps them lose weight. 286. Considers yard work to be a form of exercise. 292. Believes that participating in</p>	Exercise	<p>endurance, and lower extremity pain).</p> <p>Recognizes that participating in regular exercise will promote positive health benefits that outweigh any negative results such as soreness.</p>	<p>Exercise promotes obesity reduction and mobility maintenance if regularly performed</p>

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>regular exercise will lead to weight loss and it will relieve stress on the knee and hip joints. 298.</p> <p>Perceived post exercise soreness as an abnormal result and therefore she discontinued performing regular upper extremity exercise. 301.</p> <p>Knowledge is not enough to overcome perceived difficulties with mobility to increase participation in regular exercise. 306.</p> <p>Recognizes that exercise is important and that she needs to participate. 312.</p> <p>Believes that walking would help improve her arthritic pain and her decreased endurance. Also realizes that a sedentary lifestyle is not good for one's health.</p> <p>Considers exercise to be activities such as aerobic dance because the</p>		<p>Knowledge of positive benefits of performing regular exercise does not translate into actual change in behavior of the individual.</p>	

<i>Selected Formulated Meanings</i>	Category Labels	Theme Cluster	Sub-Theme
<p>person is moving the body in different directions. Also considers walking, riding a bike, and working in the yard as exercise.331.</p> <p>Believes that exercise is staying busy, [walking running, cooking and jogging] and includes formal activities as well as household chores.</p>			

STEP 5: Final Reduction of Emergent Sub-Themes *from all Categories*

Comprehensive List of 16 Emergent Sub-Themes (exhaustive description of the lived experiences)	Creation of Meta-Themes (Final Reduction of Emergent Themes)
<ol style="list-style-type: none"> 1. Good health is valued but maintenance is ultimately the women's responsibility. (CAT 1) 2. Preservation of ambulation, even with assistive devices, promotes independence and good health consequences. (CAT 3) 3. Being overweight or obese impairs movement and negatively exacerbates age related changes in mobility. (CAT 3) 4. Heredity influences weight status but obesity is a public health concern (CAT 4) 5. Normal weight and the ability to care for oneself are markers for good health. (CAT 4) 6. Obesity influences the development of chronic illnesses and impacts the severity of musculoskeletal pain, but older adults need to engage in physical activity in spite of the pain. (CAT 5) 7. Existing physical health conditions impact women's abilities to remain mobile, participate in physical activity, and sustain social interests. (CAT 5) 8. Despite pain, the risks of surgery outweigh its potential benefits. (CAT 5) 9. Women have some control over health choices but the desire to engage in physical activity is impacted by factors outside of their 	<ol style="list-style-type: none"> 1. Responsibility for controlling health and weight 2. Preservation of function and mobility 3. Beliefs and attitudes 4. Impact of health conditions 5. Motivation and desire 6. Understanding of beneficial activities and treatments

<p>control. (CAT 6)</p> <p>10. Motivation is individual, yet it can be internal or external and is influential. (CAT 6)</p> <p>11. Persons who are overweight or obese are exposed to stigmas and prejudicial attitudes. (CAT 7)</p> <p>12. Women are responsible for monitoring and controlling their weight thereby reducing the risk factors of obesity (CAT 7)</p> <p>13. Knowledge of physical activity benefits does not translate to adequate energy levels needed to perform activities (CAT 9)</p> <p>14. Independence is valued and gives women control over their lives, whereas dependence is acceptable only when vital for survival (CAT 9)</p> <p>15. Engaging in regular physical activity or exercise is beneficial to women's physical and mental health, while inactivity leads to declines in health and mobility. (CAT 13)</p> <p>16. Women recognize the restorative nature of physical therapy; otherwise, there is little differentiation in their understanding of physical activity, physical therapy, and exercise. (CAT 13)</p>	

STEP 6: Meta-themes with Corresponding Sub- Themes

Meta-Theme	Sub- Theme
1. Responsibility for controlling health and weight	<ul style="list-style-type: none"> a. Good health is valued but maintenance is ultimately the women's responsibility. (CAT 1) b. Normal weight and the ability to care for oneself are markers for good health. (CAT 4) c. Women are responsible for monitoring and controlling their weight thereby reducing the risk factors of obesity (CAT 7) d. Independence is valued and gives women control over their lives, whereas dependence is acceptable only when vital for survival (CAT 9)
2. Preservation of function and mobility	<ul style="list-style-type: none"> a. Preservation of ambulation, even with assistive devices, promotes independence and good health consequences. (CAT 3) b. Being overweight or obese impairs movement and negatively exacerbates age related changes in mobility. (CAT 3)
3. Beliefs and attitudes	<ul style="list-style-type: none"> a. Heredity influences weight status but obesity is a public health concern (CAT 4) b. Persons who are overweight or obese are exposed to stigmas and prejudicial attitudes. (CAT 7)
4. Impact of health conditions	<ul style="list-style-type: none"> a. Obesity influences the development of chronic illnesses and impacts the severity of musculoskeletal pain, but older adults need to engage in physical activity in spite of the pain. (CAT 5) b. Existing physical health conditions impact women's abilities to remain mobile, participate in physical activity,

	and sustain social interests. (CAT 5)
5. Control over Health Choices	<p>a. Women have some control over health choices but the desire to engage in physical activity is impacted by factors outside of their control. (CAT 6)</p> <p>b. Motivation is individual, yet it can be internal or external and is influential. (CAT 6)</p>
6. Understanding of beneficial activities and treatments	<p>a. Despite pain, the risks of surgery outweigh its potential benefits. (CAT 5)</p> <p>b. Knowledge of physical activity benefits does not translate to adequate energy levels needed to perform activities (CAT 9)</p> <p>c. Engaging in regular physical activity or exercise is beneficial to women's physical and mental health, while inactivity leads to declines in health and mobility. (CAT 13)</p> <p>d. Women recognize the restorative nature of physical therapy; otherwise, there is little differentiation in their understanding of physical activity, physical therapy, and exercise. (CAT 13)</p>