Clinical Implications of Body Image Among Rural African-American Women

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OBJECTIVE: **To increase understanding of body image among rural, African-American women through open-ended interviews.**

DESIGN: **Individuals' perceptions of body image were investigated using open-ended, in-depth interviews that were tape-recorded, transcribed, and analyzed to identify common themes and to compare thematic data across three body mass index categories (obese, overweight, and normal).**

SETTING: **University-affiliated rural community health center.**

PARTICIPANTS: **Twenty-four African-American women, aged 21 to 47 years.**

MAIN RESULTS: **Respondents reported the following common themes: dissatisfaction with current weight; fluctuating levels of dissatisfaction (including periods of satisfaction); family and social pressure to be self-accepting; and social and physical barriers to weight loss. The interviews revealed ambivalence and conflicts with regard to body image and weight. Among these women, there was strong cultural pressure to be self-accepting of their physical shape, to "be happy with what God gave you," and to make the most of their appearance.**

CONCLUSIONS: **The pressure to be self-accepting often conflicted with these obese women's dissatisfaction with their own appearance and weight. Although the respondents believed they could lose weight "if [they] put [their] mind to it," those women wanting to lose weight found that they lacked the necessary social support and resources to do so. The conflicts stemming from social pressures and their own ambivalence may result in additional barriers to the prevention of obesity, and an understanding of these issues can help health care providers better address the needs of their patients.**

KEY WORDS: **obesity; African Americans; women; body image; weight loss.**
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Rates of overweight are increasing among all adult Americans,[1] although African-American women suffer from being overweight and from obesity at much higher rates than white women. Combined prevalence data from NHANES III (1988–1994) showed that 65.8% of black women over 20 years of age were obese or overweight compared with 49.2% of white women[2]; and 37% of black women were obese compared with 24% of their white counterparts.[3] Overweight black women are at increased risk of obesity-related diseases, such as type 2 diabetes and hypertension,[4] and are at higher risk of death from cardiovascular disease, diabetes, and cancer.[5–7]

Although weight loss has been shown to be effective in reducing the prevalence of these diseases,[8] black women's comparatively lower success at dieting[9] presents additional challenges to health care providers. Black women are as likely as white women to report that they are dieting,[10] yet their rates of weight loss are low.[11] Compared with white women, African-American women participate less often in weight-loss programs,[12] have higher dropout rates,[13] and lose less weight when they do participate.[6,14] Those who do lose weight are less likely to maintain the weight loss.[15]

Studies have found African-American women to be more self-accepting in terms of weight, body shape, and appearance than white women[16–27] and less likely to view themselves as overweight. As income and education levels decrease, the percentage who perceive themselves as overweight also decreases.[28] Although African-American women may be more accepting of their weight than white women, this tolerance puts them at increased risk of obesity.[7] Despite this tendency to be more self-accepting, several studies have shown that those who are overweight are often dissatisfied.[16,17,19,22,29,30]

Health professionals are often unfamiliar with the complex social and cultural beliefs surrounding weight and body image within the African-American culture, limiting providers' abilities to effectively help these women reduce obesity and its consequent health risks.[31] The recent National Institutes of Health (NIH) "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults—The Evidence Report" stresses exploring these cultural variations in attitudes and beliefs for each targeted population in order to increase treatment effectiveness.[2]

The highest rates of obesity in the United States have been found in Southern rural African-American women,[32,33] yet existing studies of attitudes toward weight have focused on urban, college-educated African-American women[16–18,22,34] or adolescent African-American women.[20,23] This study was conducted in response to a population-based survey that documented the prevalence of obesity to be 46% and overweight to be 22% among adult African-American women in two rural central Virginia counties.[35] The high prevalence of obesity in this population of rural,

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African-American women suggests that the beliefs concerning obesity among these women warrant examination. The purpose of this study was to explore attitudes and beliefs about body image and weight in rural African-American women in order to inform clinicians and to support the design of more appropriate interventions.

METHODS

Initial interview topics were identified during a group discussion with 9 African-American women members of the Alliance of Black Churches.[36] The Alliance is 1 of 2 coalitions developed in association with the University of Virginia to implement health-related programs in 2 nearby rural counties with similar demographics and high African-American populations. Following pilot interviews with 4 women, additional respondents were identified through the community health center that had worked closely with the second county church coalition. A center health educator asked clients (who were not generally coalition members) to identify friends and family members who would be willing to be interviewed. On the 5 days of scheduled interviews, the project investigators traveled to the health center and conducted open-ended, in-depth interviews over a 3-month period. Interviews were between 40 and 60 minutes in length, and respondents were paid $20 for their participation. The number of interviews totaled 24 and was determined by a criterion of redundancy.[37] That is, responses were categorized during data collection; redundancy occurred in the interviews when no new categories were generated.

As stated previously, the goal of the study was to explore body image and weight among this population, not obesity specifically, and this is how the research was described to participants. This is also why we interviewed women of all body sizes. The interview protocol used broad "grand tour questions" as suggested by Spradley,[38] and interviewers elicited more detail in follow-up questions. Participants discussed topics including weight history, satisfaction with their current weight, perceptions and attitudes of others about their weight, the relation between weight and health, the relation between weight and attractiveness, their desire and ability to lose weight, reasons for wanting to change their weight, and perceived barriers to weight change. Interviews were tape-recorded and transcribed verbatim. Interviewers also took notes, and the notes were compared by the interviewers with the transcripts to ensure accuracy.

For the purposes of this study, obesity (body mass index [BMI] $\geq$ 30 kg/m^2) and overweight (BMI = 25 to 29.9 kg/m^2) were defined to correspond with the recent NIH clinical guidelines on obesity.[2]

Data from the interview transcripts were analyzed using a modification of Spradley's taxonomic analysis.[38] After a preliminary review of these data, primary themes became the initial domains for analysis. These themes closely mirrored the questions asked in the interview protocol. All interview data were categorized into these initial domains and then reanalyzed into subdomains and emergent categories. Data were considered as a whole and also separated for comparison by body size using the obese, overweight, and normal BMI ranges described above.

RESULTS

Respondent Characteristics

Characteristics of the participants are presented in Table 1. In general, these women were in their 20s and early 30s, unmarried, with children, and without college degrees. Twenty-one of the 24 had lived their entire life in this rural county (583 square miles, population 12,800). Based on self-reported weight and height, 50% of respondents were obese; 37.5% were overweight; and 12.5% were normal weight.

These 24 women were compared with 97 women between the ages of 21 and 32 years who had participated in a population-based survey we conducted in the same county.[35] There were more obese women in the current study group (50% vs 33%), but this difference was not statistically significant (P = .18). Even in the population-based study, 72% of the women of these ages were overweight or obese. There were no significant differences between the groups in any of the variables listed in Table 1, except the 24 current interviewees were more affluent. In

Table 1. Characteristics of the Study Participants (n = 24)

Characteristic	%	(n)
Age, y		
21–26	54.2	(13)
27–32	41.7	(10)
>33	4.2	(1)
Body mass index, kg/m^2		
≤24	12.5	(3)
25–29.9	37.5	(9)
≥30	50.0	(12)
Education		
Some high school	20.8	(5)
High school graduate	50.0	(12)
Some college or more	29.2	(7)
Household income per year		
<$10,000	37.5	(9)
$10,000–$35,000	33.3	(8)
$35,000–$50,000	29.2	(7)
Marital status		
Single	58.3	(14)
Married/living as married	20.8	(5)
Divorced/widowed	20.8	(5)
Children		
None	29.2	(7)
One or more	70.8	(17)
Length of residency in county, y		
2–5	8.3	(2)
10–20	4.2	(1)
Entire life	87.5	(21)

the prior survey, 35% of the women had an income less than $10,000 per year, 57% had an income of $10,000 to $35,000 per year, and 8% had an income of $35,000 to $50,000 per year ($P = .01$ by χ^2 analysis).

Thematic Analysis

Dissatisfaction with Weight. The majority of respondents initially expressed some degree of dissatisfaction with their weight or body size. Of the 24 women interviewed, 17 (71%) stated clearly that they would like to lose weight. Only 1 woman was content with her weight at the time of the interview; 3 women were content with their weight but wanted smaller stomachs; 1 thin woman wanted to gain weight; and 2 women expressed ambivalence throughout the interview. Those who wished to lose weight cited either their ideal weight or the number of pounds they would like to lose, ranging from "a little bit" of weight to over 200 pounds. Many women stated that they would like to return to the weights they were before pregnancy. Wanting to lose weight was related to an individual's body mass index (BMI): 11 (92%) of the 12 obese women wanted to lose weight versus 6 (50%) of the 12 overweight and normal weight women.

In explaining why they wanted to lose weight, the women gave responses that fell into four major categories. The first was dissatisfaction with clothing (discomfort, unavailability of attractive, larger-size fashions); the second reason was that they did not feel attractive and believed that they were perceived negatively by others. Although very few women wanted to lose weight to please a significant other, many of them felt that losing weight would improve their self-esteem. Third, women were often unhappy because their weight inhibited them from doing things they enjoyed: taking beach vacations, playing with their children, shopping for clothes, and being intimate with their husband or boyfriend.

Finally, all respondents, and obese women in particular, discussed health implications of obesity that often fueled their interest in losing weight. These health-related reasons for losing weight ranged from simply not feeling "quite as healthy as I did when I was lighter" to more serious worries about health issues such as blood pressure, cholesterol, and diabetes. Some currently felt tired or experienced shortness of breath, and others were worried about future medical problems. "Because in my family," one woman (5′8″, 235 pounds) said, there are "a lot of health problems that are from being overweight—hypertension, strokes ..."

Fluctuating Satisfaction Levels. During the interviews, it became clear that satisfaction with weight fluctuated for these women, depending on a variety of circumstances. Few women expressed total dissatisfaction. Of the 17 who wanted to lose weight, 10 also voiced a level of satisfaction with their weight or appearance at some point during the interview.

Again, clothing issues determined women's satisfaction or dissatisfaction with their weight. There was a belief that anyone could look good, depending on the clothes she wore.

In some cases, satisfaction with weight depended on the relative sizes of others. A woman (5′5″, 345 pounds) who felt she weighed too much for her age said, "I feel uncomfortable around, you know, other people, you know, that are smaller than I am." Another woman (5′7″, 185 pounds) said that she no longer felt as attractive as she did before her first baby was born; however, "most of the girls I see now [are] just as big as I am, that's why I don't feel bad ... I look at them and feel better."

Perceptions of others also affected women's own satisfaction. One woman (5′5″, 250 pounds) felt people were more positive toward her when she was slimmer. "Other people liked ... the way my clothes fit on me and paid a lot more attention." For some women, satisfaction increased as a result of others' perceptions, even though their weight had not changed. One woman (5′1′, 275 pounds) said that she used to feel very unattractive; but now she had a boyfriend and felt attractive to other men who "don't care how big I am."

One respondent (5′9″, 250 pounds) expressed varying levels of dissatisfaction with her weight throughout the interview. However, when asked how important weight had been in her life, she said:

> *Not important at all. On a scale of 1 to 10, I'd say maybe a 2 or 3. Because I get disgusted sometimes when I can't find a certain thing [clothing] that I'm looking for. But other than that, I'm fine.*

Like many of the women, her dissatisfaction was tempered with feelings of self-acceptance.

The Importance of Self-Acceptance. When women were asked if they would trade bodies with anyone in the world, 14 (58%) of 24 said that they would not. Even women who had previously expressed dissatisfaction with their own bodies—women who were mildly to extremely dissatisfied—said that they would not make the switch, or that they could not think of anyone with whom to trade. The themes of self-acceptance, making the best of what you have, and valuing character above appearance were all reflected in responses to this question.

One respondent (5′4″, 200 pounds) told the interviewer that she wanted to change her weight and "body figure" because she hated shopping, she was physically uncomfortable, and she struggled just to climb the stairs. "We never go to the beach," she said, "because I feel so insecure about myself. I feel so unattractive, it's terrible. I go to sleep thinking about my weight, and I wake up thinking about my weight." Yet when asked if she would trade bodies with anyone else in the world, she said:

> *No, I think I'd rather just keep my regular body and just work on that. I wouldn't want to trade with anybody ... I say, "God made me, let me keep me." You know, I don't want to be like somebody else. I just want to be me. I'm satisfied with this body.*

The Importance of Acceptance by Others. Respondents' discussion of what others thought about their weight generally focused on significant male partners, family members, friends, and coworkers. At one extreme, respondents said that some family members, particularly fathers, husbands, or boyfriends, encouraged them *not* to lose weight. One woman said her boyfriend did not like "bony women," and another's liked her weight because there was "more for him to hold onto." One respondent, a petite young woman, said her father implored her not to diet, telling her, "If you get sick, you won't have anything to fall back on." Respondents frequently mentioned the importance of having a "healthy weight" in case of illness.

At the other extreme, half of the obese and 2 of the overweight women had been criticized by others for their weight gain. However, this was not common. Negative comments came from work or community acquaintances or distant relatives, not from close friends or family members. Between these two extremes—encouraging weight gain and criticism—lay either silence or supportiveness. Half of the obese and one third of the overweight respondents reported that their husbands or boyfriends did not say anything about their weight. Another third of the overweight women said their male partners complimented them on their figures.

Any criticisms that came from loved ones were framed in a supportive manner. Some women said a boyfriend might mention their weight gain, but "he doesn't hound me about the weight" or "he only mentions it now and then." Family members were also, for the most part, silent. One woman (5′2″, 145 pounds) stated, "My family, they gonna try to cheer you up the most they can. They're not gonna tell you the truth. My mother says I look all right. It's just me [that's not satisfied]."

Family members did express concern about respondents' health. "My mom tells me to diet," explained one woman (5′3″, 210 pounds), "not to hurt [my] feelings, but because she's worried about my health." Two women had sisters that suggested they lose weight, but their comments came with offers of support, either empathy or a willingness to exercise together.

The pervasive attitude of others in these women's lives was acceptance. The women wanted to lose weight so that they would feel better about themselves, not because of the prejudices, preferences, or nagging of others. If others' attitudes had any influence on their desire to lose weight, it was because the women wanted to please uncomplaining husbands or to ease parent's health concerns.

Perceived Ability to Lose Weight. The women discussed barriers to weight loss and their perceived ability to lose weight. The numerous barriers these women faced contrasted with their startling optimism that they could lose weight if they wanted to do so.

When asked to explain why they weighed what they did, respondents gave explanations for their current weight that generally reflected a sense of resignation and inevitability. Women primarily attributed their heaviness to God, family history, weight retained from pregnancy, stress, aging, and the types of food available in their homes and workplaces. "I guess just because I was meant to be this size," suggested one (5′9″, 250). "Maybe this is just the way God wanted me to be." Many women believed that they would weigh even more as they grew older because it was a family tendency. Even relatively thin women believed that they would become overweight as they aged.

Women in the study were asked to discuss what would help them to lose weight and what factors might prevent them from successfully losing weight. All women were knowledgeable about lifestyle changes they would have to make in order to lose weight, although several believed that skipping meals was an appropriate dieting strategy.

Within their homes, women felt bound to the cooking and dietary habits of their families. "They like to eat more fried foods" was a typical description of their families' tastes. One woman (5′4″, 200 pounds) described what she faced at home by saying, "I am eating cakes and pies and stuff all the time. To us, there is no big dinner for Christmas because we eat like that 7 days a week."

Women who were interested in exercise programs expressed frustration at the lack of classes and facilities in or near their community. In order to attend structured programs they would have to travel at least 40 minutes each way, a tremendous barrier given that lack of time and energy were already barriers. One woman had no transportation, and several women needed babysitters. "Not having someone to do it with me" was expressed as a barrier to weight loss, but the unavailability of local programs was an even greater one.

Despite these barriers to weight loss and a general sense of inevitability about being overweight, 18 of the 19 women who wanted to lose weight or reduce their stomach size stated that they definitely had the ability to do so. "If I set my mind to it, I can" was typical of the most frequent response. One woman (5′7″, 200 pounds) who expressed frustration over having tried numerous diets with no success insisted that, "I can do it. I can change my eating habits, watch my fat intake, and the calories. I really think I can do it." Of these 19 women, only 5 had ever tried dieting in the past; all of these reported that they had some success but then gained the weight back. Only one woman said "maybe" she could lose weight, but she felt that if she joined a weight loss program she would be successful.

DISCUSSION

What emerged in these narratives were dual voices within each woman—a voice that conveyed her own dissatisfaction with her weight and appearance and another voice that expressed self-acceptance. These voices are ambivalent, presenting each woman with a conflict between satisfying her desire to look and feel better and accepting herself as she is.

Self-acceptance appears to be very important among these women. If given the chance, they indicated that they would not trade bodies with other women; rather, they wanted to make the most of what they have. In addition, the women described a social environment in which many other women are heavy and immediate family and friends are supportive. Being overweight was attributed to factors beyond their control, such as family weight histories, traditional eating habits, and the dearth of exercise programs or facilities in their communities. Although women believed that to some degree their weights were determined by their own behavior, their physical and cultural environment presented barriers to changing their diet or activity levels. Thus, while dissatisfied with their own size, these women were frequently not under pressure from themselves or others to change. Their own dissatisfaction was in conflict with a cultural message of self-acceptance.

Previous studies of body image and attitudes about weight in African-American women have focused on urban and more educated women and adolescents, but the findings are similar. While dissatisfaction with weight has been identified, many studies found mitigating circumstances or attitudes that diminished the importance of weight loss that were similar to those found in this study. For example, in the study by Parker et al.,[23] African-American adolescents were found to have a concept of beauty that centered on "using what you got"; in another, 40% of overweight African-American women considered themselves attractive[22]; "looking good" and being well dressed were identified as important components of attractiveness in another group of African-American women[17]; in another study, what bothered African-American women most about being overweight was not looking good and not being able to wear nice clothes[39]; and, in yet another, overweight African-American women described the acceptability of being overweight and described themselves as "cute," "looked good," etc.[18]

Other studies have also identified an African-American cultural norm of self-acceptance and a lack of pressure from family and friends for weight loss.[17,22,39,40] In fact, some of these researchers report an African-American male preference for heavy women.[17,18,20,22,23]

This study has a number of potential limitations. First, the sample size was small. This is an inherent problem with qualitative studies, in which a deeper understanding of the relevant issues is the goal rather than an effort to determine more superficial norms for a broader sample. The women we interviewed were fairly representative of the population of the county studied, and we continued interviewing women until we achieved redundancy. However, determining whether or not our findings are truly generalizable will require validation with a larger sample size. Second, although we conducted in-depth interviews with these women, we only interviewed them on a single occasion. Other beliefs may have been elicited if we had talked with them on multiple occasions and had developed even greater rapport.

The recent NIH guidelines for treating obesity stress the importance of assessing a patient's motivation to lose weight, as well as the need to adapt weight loss programs to meet the needs of diverse patient populations. The guidelines suggest that clinicians evaluate the following factors in determining an individual's motivation to lose weight: reasons and motivation for weight loss; previous history of successful and unsuccessful weight loss attempts; family, friends, and work-site support; the patient's understanding of overweight and obesity and how it contributes to obesity-associated diseases; attitude toward physical activity; time availability; barriers; and financial considerations. The diversity guidelines add specific adaptations of the program's setting and staffing, consideration of assumptions about the type of patient, and program flexibility based on patient feedback.[2]

Although these guidelines are both concrete and comprehensive, given the findings in this and other studies, adherence to the steps outlined might not lead to successful weight loss in this population. In other words, isolated clinical interventions probably would not be effective without addressing the ambivalence that African-American women face about their weight and body image.

Ambivalence is a normal, yet complex, element in any individual's decision to change a harmful behavior such as overeating. Miller and Rollnick define ambivalence as "a state of mind in which a person has coexisting but conflicting feelings about something."[41] They discuss the impact of ambivalence on individuals' motivation to change, causing them to often recognize the costs and risks of a behavior while simultaneously feeling attached or attracted to that behavior. A woman may want to lose weight but not want to lose her individuality or reject the body God gave her. To complicate matters further, specific ambivalent feelings are unique to each individual as well as variable across cultures.[41]

The African-American women in the study wanted to keep their own bodies, regardless of their size, they wanted to please their husbands, boyfriends, and significant others, and they wanted to feel better and be healthier. These potentially conflicting views need to be reconciled if they are to pursue activities that will lead to weight loss. Clinicians can help women resolve conflicting views by first helping them understand that they exist. Making these conflicts explicit can help with moving an individual through the stages of change.[41] The pros and cons of change have been referred to as a decisional balance—the more the balance is tipped toward the pros, the more likely an individual is to change her behavior.[42] A key concept in the motivational interviewing approach to behavior change is to develop discrepancy—help individuals see the difference between their current behavior and long-term goals.[41] In the case of these women, their ambivalence can be reflected back, as in the case of the woman who struggled just to climb stairs yet was satisfied with her body. Although she did not want to change bodies with anyone else, she might still be more satisfied with her own body if she lost weight.

A second integral factor in behavior change is self-efficacy—an individual's belief that she can lose weight.[41] These women indicated that they could lose weight if they only put their mind to it. Clinicians can help foster this belief through positive reinforcement and feedback concerning any appropriate behavior change or weight loss.

Finally, specific dietary and exercise recommendations can be made in the context of these findings. Presumably, the continuing increase in the prevalence of obesity in this country is the result of energy intake increasing as energy expenditure remains stable or declines.[43] Simple dietary guidelines can be consistently conveyed to decrease energy intake, especially with regard to avoiding high-fat and high-sugar, calorie-intense foods while maintaining food preferences. Although there are many barriers to engaging in organized exercise activities for these women, regular walking for even 10 to 15 minutes a day can lead to positive health benefits and should be encouraged.[2]

Weight control programs outside one-on-one interactions with health care providers may also play an important role in high-risk populations such as we studied. Kumanyika has observed that lower success rates among black women compared with white women in weight loss may have more to do with program content or delivery than with participant characteristics.[31,44] Although they do not explicitly address the ambivalence found in this study, promising community-based programs exist for urban African-American women,[45,46] which use culturally appropriate materials, interactive and learner-centered approaches, and African-American staff. Using these types of programs as models, long-term, low-cost, and accessible programs should be developed to meet the needs of rural women. Most importantly, these programs should directly address the ambivalent feelings that prevent African-American women from choosing healthier lifestyles.

Ultimately, the prevention of obesity may be more successful than its treatment.[47] This will be a difficult task given the increasing prevalence in this country and the ambivalent beliefs about weight that we elicited. Just as with cigarette smoking, changes in public perceptions and attitudes may ultimately lead to the appropriate changes in behavior. Continuing to develop a better understanding of these underlying beliefs, especially those of the groups at highest risk, will be crucial to this effort.

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