Motivators, Barriers, and Facilitators to Weight Loss and Behavior Change Among African American Adults in Baltimore City: A Qualitative Analysis

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Abstract: Background: African American adults achieve smaller amounts of weight loss than their white counterparts when exposed to the same intervention and are more likely to regain weight during long-term follow-up.

Objective: To identify perceived motivators, barriers, and facilitators to weight loss and behavior change among African American adults.

Methods: Two focus groups were conducted between April and May 2015 at an urban community health center in Baltimore City, Maryland. A total of 13 participants took part in the discussions. Eligible participants were obese (BMI 30+) African American adults aged 21–70 who had at least one obesity-related comorbidity. Discussion questions were designed to identify the personal, social, and environmental factors that influence weight loss and behavior change among urban minority populations.

Results: Statements were first classified as a motivator, barrier, or facilitator, then divided further as a personal, social, or environmental factor influencing weight loss and behavior change. Among the findings, several novel motivators (reducing or eliminating medication, improving physical intimacy) and barriers (personal transportation, lack of access to scales) emerged that were not previously characterized in the existing literature.

Conclusions: This study was intended to provide preliminary evidence that may be used to guide the development of innovative and culturally relevant weight-loss interventions in the future. Results are applicable to similar urban minority populations.

Keywords: Weight loss■Obesity■Focus groups■African American

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INTRODUCTION

The rate of obesity among black/African American adults in Baltimore City, Maryland is more than twice that of white adults (38.49% versus 18.82%, respectively).[1] This far exceeds the racial disparity in obesity rates nationally (47.8% versus 33.4%, respectively),[2] and is accompanied by disproportionately higher rates of various obesity-related comorbidities, including hypertension, stroke, and diabetes.[1]

Wellness-promoting activities, such as healthy eating and regular physical activity, have been shown to promote weight loss[3] and lower the risk of obesity-related comorbidities.[4] Despite this, evidence from existing behavioral weight loss interventions suggest that African American adults achieve smaller amounts of weight loss than their white counterparts when exposed to the same intervention[5–11] and are more likely to regain weight during long-term follow-up.[7,10]

A number of lifestyle intervention trials have been designed specifically to encourage physical activity and weight loss among African American adults.[10,12,13] Unfortunately, long-term maintenance of behavior change specific to African American adults has not been reported.[10,14] These findings indicate that there continues to be a need for further development of culturally appropriate interventions that promote weight loss and behavior change among African American adults.

Qualitative research, including the use of focus groups, has been shown to be useful in intervention development[15,16] and understanding the factors that influence behavior change.[17] The purpose of this study is to conduct focus groups among African American men and women in Baltimore City to identify perceived motivators, barriers, and facilitators to weight loss and behavior change. Findings may be used to guide the development of innovative and culturally relevant weight-loss interventions for similar urban minority populations.

Table 1. Anthropometric data of study participants.

Characteristic	Mean (range)
Age (years)	
Total (n = 13)	42 (29–53)
Male (n = 6)	43 (34–53)
Female (n = 7)	41 (29–51)
Weight (pounds)	
Total (n = 13)	354 (220–549)
Male (n = 6)	387 (260–520)
Female (n = 7)	326 (220–549)
Body mass index (BMI)	
Total (n = 13)	52.5 (36.6–81.1)
Male (n = 6)	53.0 (36.6–71.8)
Female (n = 7)	52.0 (36.6–81.1)

METHODS

Participants

Eligible participants were obese (BMI 30+) African American adults between the ages of 21–70 who were actively receiving care at Total Health Care (THC) – one of Maryland's largest minority-run, nonprofit, tax-exempt community health centers. Participants also had at least one obesity-related comorbidity (e.g., hypertension, dyslipidemia, or type II diabetes mellitus) and spoke English as a primary language. Those who met the inclusion criteria were identified and informed of the study by clinicians at THC. Members of the research team contacted participants to confirm their participation and respond to any questions regarding the study. Ten men and ten women were initially contacted, ultimately resulting in the formation of two focus groups, one male and one female, each containing between 5 and 7 participants (see Table 1).

Focus group protocol

Prior to the focus groups, informed consent and permission to audio record the sessions were obtained. Participants were assured confidentiality and encouraged to participate in the discussion. Each session lasted about 1 h. Participants were provided with a meal and paid $10 USD for their time. Reimbursement was also provided for childcare and transportation.

Focus groups were held at THC. Trained moderators guided the discussion and probed for meaningful responses. An easel pad, visible to participants, was used by the moderators to document key points. Two note-takers were also present and recorded non-verbal expressions and identified key themes or patterns that arose during discussion. While moderators interacted closely with participants, note-takers were positioned behind the group to minimize distraction.

A semi-structured format with a standardized set of open-ended questions was used to stimulate discussion. Focus group questions were designed to identify perceived motivators, barriers, and facilitators to weight loss and behavior change. All procedures were approved by the Institutional Review Board at the Johns Hopkins Bloomberg School of Public Health.

Analysis

Following the focus groups, moderators and note-takers reviewed the audio recordings and shared their initial thoughts with the rest of the research team. Each audio recording was then transcribed verbatim twice independently and compared for accuracy. Transcripts were reviewed independently to identify major themes or patterns that arose during discussion using the social ecological model as a guide.[18] This model proposes a conceptual framework for understanding how individuals both influence and are influenced by various factors.

During the coding process, statements were first classified as a motivator, barrier, or facilitator, then divided further as reflecting personal, social, or environmental factors to weight loss and behavior change. In some cases, statements may have applied to more than one of the categories mentioned above. If this occurred, close attention was given to statement context and speaker intent. Joint revisions were made until a complete consensus was reached. Statements were then sorted according to their code, and results were characterized. Findings from the male and female focus groups were evaluated for notable similarities and differences, and the two coded transcripts were combined to create a single set of motivators, barriers, and facilitators.

RESULTS

Motivators

Across the male and female focus groups, key motivators included the desire to achieve good health, inner drive and self-determination, a concern for longevity and quality of life, and family. Male participants also stated that seeing results from weight loss efforts and the potential for improved physical intimacy were motivators to weight loss and behavior change.