To the Graduate Council:

I am submitting herewith a dissertation written by Serena Reese entitled "The Sedentary Relapse Experiences of African American Women." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Education.

Craig A. Wrisberg, Ph.D. Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Associate Vice Chancellor and
Dean of the Graduate School

THE SEDENTARY RELAPSE EXPERIENCES OF AFRICAN AMERICAN WOMEN

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Serena Reese

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ABSTRACT

Much of the physiological decline associated with aging is due to a sedentary lifestyle. Many people exercise for some time and then stop. Sedentary relapse is defined as exercising continuously for three to six months, then stopping for at least three months (Dishman, 1994). A sedentary lifestyle has been related to increases in cardiovascular disease risk factors such as diabetes, hypertension, and osteoporosis. Physically in-active women have an increased risk of diabetes that is prevalent among the African American population.

The purpose of this study was to examine the sedentary relapse experiences of 10 African-American women, ages 35-54. Since the perceptions of the women were the basis for this study, semi-structured interviews were conducted with each participant. Following each audiotaped interview, the data were transcribed and analyzed.

Themes common to all interviews were identified and a general thematic structure was derived. The four themes that emerged from these women's experiences of sedentary relapse included: 1)Barriers/Motivators; 2) Self-Image/Current Body Weight; 3) Unrealistic Expectations; and 4) Lifestyle Change. The first theme, Barriers/Motivators, described the crucial role that the women's families played in their physical inactivity. The second theme, Self-Image/Current Body Weight described attempts to harmonize personal perceptions with

societal expectations. The third theme, Unrealistic Expectations reflected the participants' views and personal experiences of wanting quick weight loss. The fourth theme, Lifestyle Change emerged from the participants' specific needs regarding interest and motivation to exercise. These four themes, implicit in all the interviews, comprised the basic structure of the experience these women had with sedentary relapse.

The results are discussed in relation to the existing literature on sedentary relapse. Discussion of the results centered on issues of women's health and wellness and on some possible ways to reduce the incidence of sedentary relapse among African American women. Recommendations for health care practitioners are discussed and suggestions are made regarding future research.

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CHAPTER 1

INTRODUCTION

People are becoming increasingly aware of the importance of physical activity in health maintenance and the negative factors associated with sedentary living. There is a growing number of individuals who habitually exercise three times a week for at least 20 minutes each session (Dishman, 1994). However, in spite of the increasing knowledge of the multiple health benefits of exercise, more than 50% of individuals who begin an exercise program drop out entirely within the first six months or continue to exercise on an irregular basis (Dishman, 1994). The high dropout rate has led researchers to study factors associated with adherence to an exercise program.

Lapses are expected slips, mistakes or events that are part of the process of developing a new healthy lifestyle (Brownell, Marlatt, Lichenstein & Wilson, 1986). Habits and attitudes include: a) perceived barriers to exercise; b) adherence (i.e., three exercise/physical activity days per week, 20 minutes per session, and at least six months of continuous participation in exercise/physical activities); c) type of physical activities; d) location of activities; e) motivational factors; and f) past activity in an exercise program. A relapse happens when lapses repeatedly occur (Cotton & Ekeroth, 1996).

One focus of relapse research has been self-efficacy. Bandura (1977) defined self-efficacy as the confidence in one's ability to perform a given behavior in a specific situation. Using Bandura's definition, self-efficacy has been studied in relation to exercise adherence (Buxton, Wyse & Mercer, 1996). Some research has revealed that self-efficacy is the strongest correlate and predictor of both present and future exercise behavior (McAuley, 1992; McAuley & Courneya, 1993).

Researchers have tended to categorize individuals as either active/exercisers or inactive/non-exercisers (Buxton et al., 1996). This all-or-none dichotomy ignores the different transitions individuals experience in adopting and maintaining exercise (Dishman, 1988). Marcus, Selby, Niaura and Rossi (1992) studied exercise self-efficacy ratings of 1063 government employees and 429 hospital employees. They found exercise self-efficacy scores were significantly differentiated for individuals at different stages of exercise behavior.

Unfortunately, according to Yancey and Walden (1994) none of the recent landmark studies on fitness have included significant numbers of African American, Hispanic, or Asian women in their samples. This has resulted in a limited understanding of possible racial/ethnic variance in preventive health behavior (Yancey & Walden, 1994).

The motivation for changing exercise habits often is related to the discrepancy between reality and the ideal image a person has of herself

(Yancey & Walden, 1994). Hughes and Demo (1989) reported low self-efficacy among African American women. In their review of the Hughes and Demo (1989) study, Yancey and Walden (1994) recommended that images of women in media and research include women of color who are actively involved in exercise lifestyle changes. Anderson, Janes, Ziemer and Phillips (1997) suggested that positive images of women of color may influence the attitudes and beliefs of others that may lead to increased involvement in health-related habits (also see Braithwaite & Lythcott, 1989). According to these researchers, respecting the culture of the target community promotes health-related habits. These habits tend to be correlated. For example, Hayes and Ross (1987) found significant correlations between healthy eating habits and participation in individual exercise programs; however, the sample size of African American women in their study was too small to provide meaningful statistical comparisons between African American, Caucasian, and other non-White women.

Numerous studies have indicated a relationship between adherence to a corporate fitness program and work attitude, reduced absenteeism, and job performance (Dishman, 1994; King, 1991). Rudman (1987) reported a positive relationship between adherence to a health and fitness program and employees' positive attitudes toward their work environment. Many corporations have included exercise

programs as a part of their employee health programs (King, 1991). Unfortunately, it appears that African American and Hispanic women may be recruited to worksite health programs at a lower rate than Caucasian women (Brill, Kohl and Blair, 1992). Farrell, Kohl, and Knadler (1987) also found the fitness levels of African American female participants in a worksite program to be lower than those of Hispanic and Caucasian women. Furthermore, there are few exercise interventions that target African American women (Yancey & Walden, 1994).

Farrell, Kohl, and Knadler (1987) noted that specific strategies to recruit more women of color need to be incorporated into worksite programs to enhance adherence. According to Dishman (1994), these strategies should be specifically designed to meet the individual needs of the participants in such programs. Moreover, exercise intervention strategies must include factors that may affect public health, particularly those associated with social and cultural forces which play a role in determining exercise habits.

Yancey and Harrell (1993) described four reasons women of color may be reluctant to engage in regular exercise: 1) unawareness of the ethnically-specific benefits of exercise (e.g., reducing hypertension and depression among African American women); 2) distrust of the medical establishment that stems from historical exploitation of communities of color by researchers; 3) lack of inclusiveness of African American, Asian,

Hispanic and Native American women in commercial media portrayals and in exercise health promotions; and 4) lack of ethnically-relevant role models at all levels of the fitness industry.

The benefits of participating in an exercise program increasingly have become a part of community medicine and public health policy. However, supervised exercise programs such as aerobic dance have not been successful in attracting large numbers of people who do not exercise (Dishman, 1994).

Statement of the Problem

The potential effects of a woman's situational factors (e.g., family, relationships) on her exercise experience has been recognized. Relapses may result from personal negative emotional states such as depression. Little attention has been paid to African American women's experiences with sedentary relapse. For example, weight management programs that are designed to treat Caucasian populations do not necessarily work for other ethnic groups (Cotton & Ekeroth, 1996). Cotton and Ekeroth (1996) also reported that the African American women in their study were more satisfied than Caucasian women with modest weight losses that left them lighter but still overweight. The education of African American women about sedentary relapse has assumed a status of prime importance. To gain a greater understanding of the importance of exercise, African

American women need a sense of empowerment and reinforcement about the importance of exercise. Exercise adherence is a lifelong process, requiring constant awareness of environmental experiences that may interfere with the process. Consequently, African American women's experiences with sedentary relapse emerges as an area in need of additional investigation.

Purpose of the Study

The purpose of this study was to determine the lapses, habits and attitudes of African American women who previously exercised regularly, but are now sedentary. More specifically, using a qualitative approach involving semi-structured interviews, an attempt was made to explore the following factors as they related to the experience of African American women's sedentary relapse: a) barriers; b) adherence; c) type of physical activities; d) location of activities; e) motivational factors; and f) how past activity might influence future participation in an exercise program.

Definition of Terms

For the purposes of research, the following definitions were accepted and utilized:

Adherence - The ability to maintain a regular exercise regimen, which includes: three exercise/physical activity days per week, 20

minutes per session, and at least six months of continuous participation in exercise/physical activities (Farquhar et al., 1990; Dishman, 1994).

Aerobic Exercise - A method of exercising that conditions the cardiovascular system by using movements that create an increased demand for oxygen over an extended period of time.

African American – A black racial group of African descent (Merriam-Webster, 1988).

Ethnic – "Of or relating to large groups of people classed according to common racial, national, tribal, religious, linguistic, and cultural origin or background" (Merriam-Webster, 1988, p. 427).

Exercise - "A subset of physical activity which is planned, structured, repetitive, and has a primary objective of improving or maintaining physical fitness" (Caspersen, Powell, & Christenson, 1985, p. 7).

Exercise Habits - The acquired mode of exercise behavior patterns that have become nearly or completely involuntary (i.e., stages of exercise behavior change, adherence, type of physical activities regularly performed, location of physical activities, perceived barriers to exercise, and exercise self-efficacy).

Lapse – Expected slips or mistakes that are usually discrete events and are a normal part of the behavior-change process.

Physical Activity - "Any bodily movement produced by skeletal

muscles that results in energy expenditure" (Caspersen et al., 1985, p.10).

Race – "A division of humankind possessing traits that are transmissible by descent and sufficient to characterize it as a distinct human type" (Merriam-Webster, 1988, p. 969).

Regular Exercise - Exercising at least three times per week for at least 20 minutes without stopping (i.e., exercise that is hard enough to cause a large increase in heart rate or breathing) (Dishman, 1994).

Relapse –The act or an instance of backsliding, worsening or subsiding; to slip or fall back into a former worse state.

Sedentary Relapse - Previously exercising continuously for three to six months, then stopping for at least three months (Dishman, 1994).

Self-Efficacy - "The conviction that one can successfully execute a behavior required to produce an outcome" (Bandura, 1977, p. 11). For the purposes of this study, exercise self-efficacy was defined as the belief that an individual can perform a specified exercise/physical activity in a specific situation with confidence and competence (Roberts, 1992).

Self-Esteem - Self-acceptance, self-respect, and feelings of self-worth. A respect for and favorable impression of oneself.

Worksite Facility - A place offered by an employer located at or near the place of employment where employees can take part in a fitness program.

Assumptions of the Study

This investigation was based on the following assumptions:

1. The interview method is the best way to examine the relapse experiences of the participants.

2. The women selected for this study were able to articulate their relapse experiences.

3. The women were truthful about the information they provided about themselves.

4. External factors at the time of the interview (e.g., stress, motivation, emotion) may have influenced the women's responses.

Scope of the Study

This investigation focused on African American women's sedentary relapse experiences. Women selected for this study represented a convenience sample and may not have accurately reflected the larger population of African American women. Qualitative studies, by their nature, apply to one particular experience with a person (or persons), that may hinder the generalizability of the results to other populations

and other women's experiences. The women in this study were selected from one geographical area in the southeastern United States.

Significance of the Study

The study of African American women's sedentary relapse experiences is meaningful. Exercise researchers have the responsibility to explore the sedentary relapse experiences of African American women because of the dearth of information currently available. Therefore, the intent of this study was to report the experiences of previously-active African American women who have relapsed into a sedentary lifestyle. The results of this study should provide needed insights into the sedentary relapse experiences of African American women. In addition, this research should provide information on what African American women need to know and experience to prepare them for exercise adherence.

The outcome of this research could help improve African American women's participation in an exercise program by increasing their knowledge about the effects of relapsing into a sedentary lifestyle by individuals who had previously participated in a formal or informal exercise program. Improved knowledge about the experiences of currently-sedentary, previously-active African American women may improve the attitudes of women who do not exercise on a regular basis

and decrease the negative attitudes they may have toward exercising on a regular basis.

CHAPTER 2

REVIEW OF LITERATURE

Introduction

The exercise habits of women have been examined in a variety of ways, from the world class competitive athlete to the weekend athlete. Research journals, trade magazines and popular best sellers include discussions of women's exercise habits. However, there is little research on African American women's exercise habits. Analagous research, historical, sociocultural, exercise relapse prevention, adherence to exercise, barriers to exercise, stress, self-esteem, social support, self-efficacy, motivation, overweight and aging and exercise provide insight about this particular group of women. Each of these topics is examined in this chapter.

Historical Perspective on Women and Exercise

In the past, research on exercise was focused primarily on Caucasian men. At the turn of the 19th century women were expected to stay at home; few had access to educational opportunities (Clements, 1990). In response to growing concerns about the poor physical condition of American women during the 19th century, health reformers advocated the increase of physical vigor and health through exercise. As more women joined the work force and attended colleges, employers and administrators began to provide

more physical activities for them (Guttman, 1988).

Eventually, researchers began to include women in their studies on exercise and today, many exercise studies include women. However, it is imperative that researchers realize that women's experiences in exercise should not be generalized from research on one group of women (i.e., Caucasians). Many researchers include in their sample women from only one racial/ethnic group, but generalize their findings to all women (Yancey & Walden, 1994). According to Corbett and Johnson (1993), the only universal exercise experiences found among women of color were those that resulted from shared racial discrimination. It is important to consider social inequalities that may exist for women of color because of differences of race and class. At present, we lack an understanding of how women of color have defined and expressed their exercise behavior (Yancey & Walden, 1994). These women need to be asked critical questions about the diversity and complexity of their exercise behavior and how these differences may be related to race/ethnicity. Moreover, in cultural groups, the exercise experience will vary according to factors such as the type of exercise, body composition, presence of role models, and physical capabilities (Corbett & Johnson, 1993).

Attitude, Sociocultural Influences and Exercise

Studies of health practices should include consideration of factors stemming from social and cultural forces which play a role in determining exercise habits. For example, a woman's attitude about exercise is formed within her cultural environment and is the result of sociocultural experiences (Yancey & Walden, 1994). Different cultures have different degrees of influence on what are considered valued behaviors.

Findings from a study by Greenspan (1983) indicated how socially constructed differences toward appearance contributed toward "thinness" standards for women. Greenspan remarked, "a woman in contemporary patriarchal society is fundamentally identified with her body" (p. 164). This unrealistic standard of beauty has been further distorted by the mass media. Many believe that the emphasis placed on thinner body shapes as the ideal, caused some women to develop eating disorders in an effort to become or remain thin (Pike & Walsh, 1996). According to Wilfley and Rodin (1995), women may develop a poor self-image because they can never attain what is portrayed as the ideal body image. Yancey (1992) found that many women subject themselves to more weight "cycling" than men because of social pressures to achieve thinness. This process of weight gain and loss induces weight gain over time.

Women of color, like many women in American society, are affected by the mass media's portrayal of what is beautiful. Women of color also are

continuously exposed to a White standard of beauty. However, in a study conducted by Rucker and Cash (1992) which examined body image differences between African American and Caucasian women, African American women had more positive attitudes toward their bodies than did Caucasian women. Also, the African American women's distortion of their body size was not as great as that of the Caucasian women; that is, the African American women's perceptions of their bodies were more similar to their actual body sizes. The researchers suggested that in spite of a mass media definition of White standards of beauty as the norm, many African American women identified with a different standard. Rucker and Cash (1992) contended that African American women may detach themselves from the media portrayals, thus, enabling the development of more realistic attitudes.

The Melpomene Institute (1990) in Minnesota has compiled research on women's physical activity and health. In the Melpomene Institute's recent book, The Bodywise Woman, sociocultural influences were shown to have significant effects on body image. Clearly, societal pressure for a body shape that is not attainable by most women can have a negative effect on self-esteem as well as physical health. There is some evidence that this is especially true for younger women. In a study of osteoporosis among women, the Melpomene Institute (1990) researchers reported that older women were more positive about their bodies than were younger women. It

was conjectured that the difference was due to the fact that older women perceived fewer societal pressures associated with their bodies.

Larger women may be even more subject to societal pressure. In their 1990 conference on body image, health, and fitness, the Melpomene Institute stated that many larger women reported prejudice in exercise settings. The one experience shared by all of the larger women was social disapproval based on their body size. According to Rucker and Cash (1992), the key to successful promotion of exercise and health benefits among diverse groups of women is to include women of all body shapes. They suggested that the message conveyed should be that a woman does not have to conform to an ever-changing ideal body image portrayed by the media and fashion industry to be considered beautiful.

Exercise Relapse Prevention

Marlatt and Gordon (1985) developed a relapse prevention model for improving exercise adherence. Initially, their model was developed to aid in the treatment of addictive behaviors such as alcoholism and smoking. This cognitive-behavioral model was designed to help people who are trying to change addictive behaviors anticipate and cope with relapse. Their approach concentrated on helping the individual acquire strategies that are designed to reduce the risk of an initial relapse and prevent lapses that might lead to a total relapse.

In reference to health behaviors, a lapse has been defined as a single event that may or may not lead to relapse (Willis & Campbell, 1992). It is a slip that may be the first sign of "backsliding" (Brownell, 1991). Examples would be eating a "forbidden" food, exceeding a calorie level, or smoking one cigarette (Brownell, 1991). A relapse is regarded as the failure to abstain from an undesirable habitual behavior (Snyder, 1989). Relapse occurs when lapses string together and a person returns to the former habitual state (Brownell, 1991). A woman's perceived loss of control determined whether a lapse becomes a relapse (Brownell, Marlatt, Lichenstein & Wilson, 1986). The emphasis on relapse is considered an integral part of the learning needed for successful habit change. In exercise relapse prevention this is an important strategy that needs to be addressed. The curve for exercise dropouts has been shown to have the same negative acceleration characteristics as those associated with tobacco, drug, and alcohol relapses (Prochaska, DiClemente & Norcross, 1992).

Belisle, Roskies, and Levesque (1987) conducted a study based on the relapse prevention model. They wanted to determine whether individuals exposed to the relapse prevention training model would show better adherence than individuals who received only the regular 10-week exercise program. They looked at adherence during the program and for the critical three month period following termination.

Belisle et al. concluded that instead of searching for a single, perfect

treatment, it may be more profitable to use a variety of low-cost interventions evaluating each in terms of its cost-benefit ratio. This study showed that one simple, easily applicable intervention can not only be cost-effective, but, when combined with other factors such as social support and group cohesiveness can enhance adherence. Baum, Clark, and Sandler (1991) have also found that relapse training resulted in significantly greater weight maintenance than treatment without such training.

Adherence to Exercise

Adherence has been defined in several ways. Corbin (1991) defined adherence as continuing to exercise for a lifetime. Dishman (1991, 1994) has suggested that adherence usually refers to the level of participation achieved in a behavioral regimen after the individual has decided to undertake it. Willis and Campbell (1992) have claimed that adherence is commonly used to imply "sticking to" or faithfully agreeing to a standard of behavior in order to meet a goal.

Although the terms *adherence* and *compliance* have been used interchangeably in the scientific literature, there are differences in their meaning (Willis & Campbell, 1992). Some researchers have suggested that adherence should be the term used when referencing long-term health behavior, while compliance should be used when referencing short-term health behaviors (Dishman, 1988, 1994; Oldridge, 1988). Others have

suggested that the term compliance be used to describe studies of clinical groups who are prescribed exercise, and adherence be used to describe studies of healthy groups who voluntarily participate in exercise (Oldridge, 1988).

Early research on adherence was mostly atheoretical and descriptive in nature (Dishman, 1994). Recent research has focused on theoretical models in an effort to gain greater awareness of adherence predictions (Dishman, 1994; Roberts, 1992). The use of a theoretical model allows the researcher to examine the stages a person passes through from initial entry into an exercise program to the maintenance stages. For example, Dishman (1988, 1994) has emphasized the importance of the stages of exercise adoption. He indicated that being able to categorize people into stages of exercise adoption and then following these people over time promotes a greater understanding of physical participation.

Exercise Classes

Dishman (1994) has concluded that exercise classes should be structured to meet the demands of the participants. Classes should not be too strenuous nor too easy for the participants. If they are too strenuous, participants at a lower fitness level may become discouraged and drop out. Conversely, if the exercise classes are too easy, some participants at higher fitness levels may become bored and dropout. If the rate of progression of

classes is too slow (e.g., to avoid injuries to less fit participants), those who are more fit may not adhere to the program. According to Dishman (1994), this was one of the reasons for non-compliance among many of the apparently fit participants in the Canadian Fitness Survey (1983). In fact, the participants who were considered non-compliers and dropouts were those who were the fittest. According to Dishman (1994), businesses that provide fitness centers should be aware that employees will be attracted to a program that matches their level of ability. Therefore, he suggested that fitness centers should offer a variety of classes for members of various fitness levels in order to increase adherence.

Adherence Factors

Wilson, Wagner and Dwyer (1991) studied problems associated with participant exercise adherence. These investigators suggested that identifying individuals with lower perceptions of motivation, and providing these individuals with support and encouragement might improve adherence. In their study, four factors were identified that may be used to help predict which participants are likely to adhere to an exercise program. The first factor was the individual's perceived motivation prior to beginning the exercise. The second factor was the participant's knowledge of types of exercises; thus it appears that education should be an important part of the program. The third factor was the individual's perception of having an

adequate amount of time to exercise. The exercise program should therefore be time efficient. The fourth factor dealt with participant's concerns about body weight; those who believed they had more of a need to lose weight were less likely to adhere. It was suggested that additional programs for overweight individuals may be needed. Wilson et al. (1991) concluded that a primary benefit of predicting adherence to exercise programs is to develop and market programs for individuals who are at risk of dropping out or of participating at such low frequencies that the benefits of exercise are not achieved.

Determinants of Physical Activity

An assessment of the determinants of habitual exercise needs to be considered in order to understand their possible relationship to physical activity. Two determinants identified by Dishman (1988, 1994) were: 1) knowledge about health and exercise; and 2) access to facilities. The determinants of habitual exercise impact the types of intervention strategies that may be needed for each individual. According to Dishman (1988, 1994), knowledge of the exercise and health patterns of women are of great importance for the achievement of optimal health benefits and in the development of intervention strategies necessary to help women initiate and maintain an exercise routine.

Barriers to Exercise

Research has shown that many women who are not involved in regular exercise during their early years do not exercise regularly in adulthood. Unfortunately, the likelihood of initiating exercise in adulthood is quite low (Dishman, 1994). Barriers reported by women included lack of energy, low motivation or need, and health reasons (Verhoef & Love, 1992); lack of time (Dishman, 1994); lack of accessible exercise facilities and social support (Verhoef & Love, 1992); and the cost (Nelson, 1991).

In her study on stress and weight control behavior of African American women, Walcott-McQuigg (1995) found that African American women were less likely to exercise when exercise activities conflicted with their family responsibilities. Verhoef and Love (1992) also reported that parenthood is one of the most significant barriers to exercise for women; specifically, parental duties affect the amount of time they are able to spend in exercising.

Stress

Stress is a physiological response and adaption of the body to any kind of imbalance resulting from demands, problems, challenges or changes. Exercise is considered eustress or positive stress and has been found to be both mentally and physically stimulating. Lazarus (1991)

hypothesized that stress is the interaction of person and environment. This view of stress is based on an individual's subjective appraisal that environmental circumstances and demands are too much to handle. Thomas (1995) concurred that stress is a perceptual construct rather than an external event or accumulation of events. However she further stated that an event appraisal that is threatening to one person, might be considered challenging by another.

In her study on stress and weight control, Walcott-McQuigg (1995) found that African American women reported the following as life stressors: 1) the difficulty of being an African American woman in society; 2) safety issues; and 3) lack of career options. Additionally, these women indicated that there were few positive media images and a general lack of attention to issues that are specific to African American women.

Another area of stress that Walcott-McQuigg reported in her study was occupational stress. For example, on the job politics such as favoritism and being passed over for promotions were listed as stressors. Additional stressors included not getting the appropriate respect for their authority from Whites, and being the only African American in the department or in management. Previous research by Outlaw (1993) revealed that a continued bombardment of stress may change an African American woman's appraisal ability to the point that she may view each

event as being harmful or threatening instead of something challenging that she can manage.

Mui (1992) posulated that African American females experience more caregiver strain than White females. In addition, Walcott-McQuigg (1995) found that the African American women in her study had a professional and personal commitment to their work and to the African American community. The findings in the Walcott-McQuigg study showed that stressful events associated with the activities in which the women were involved were responsible for more than 50% of the stressful eating events the women encountered.

Self-Esteem

Warren (1997) suggested that there was a relationship between an African American woman's self-esteem and her ability to cope with stressful life events. She contended that African American women with high self-esteem had a greater ability to cope with stress.

The definition of self-esteem has been widely accepted as an internal image of oneself that is influenced by the perception of others (Rosenberg, 1965; Beeber,1996). Characteristics of individuals with high self-esteem include willingness to take risks, liking themselves, satisfaction with life, self-respect and self-acceptance. In their study of racial identity and self-esteem, Speight, Vera, and Derrickson (1996)

reported that African American women with high self-esteem have a self-attitude of respect, appreciation and merits, a sense of being worthy and an ability to accurately measure weaknesses and strengths. On the other hand, Ra Imani (1996) contended that African American women with low self-esteem viewed themselves as deficient and inadequate. Other characteristics of African American women with low self-esteem include depression, a high negative affective state, increased anxiety and having more somatic complaints (Wade, 1996).

Previously, Rosenberg (1981) examined the relationship between racial or ethnic status and self-esteem. The findings indicated that African American women do not universally have low self-esteem. In an earlier study on African American women, Rosenberg (1979) contended that when socioeconomic factors were controlled, self-esteem levels were reported in the moderate to high range.

Social Support

The way social support is defined in the exercise literature varies. Although many researchers agree about the attributes of social support, specific conceptual and operational definitions vary widely. For example, social support has been defined as information that reassures a person that they are loved and valued. Other theorists define social support more broadly, to include direct services, guidance and access to new

information. Originally, Walker, MacBride and Vachon (1977) defined the social support network as "a set of personal contacts through which the individual maintains her social identity and receives emotional support, material aid and services, information and new social contacts" (p.35). Since that time, there seems to be a consensus among researchers about what types of assistance constitute support. These forms of assistance fall in three major categories: 1) psychological support-knowing one is valued, cared for, and a part of a community; 2) instrumental support-the provision of goods and services; and 3) informational support-all forms of advice and knowledge that may be offered.

Keller, Oveland and Hudson (1997) expressed concern that there has been a failure to distinguish between the support itself and the social environment (i.e., social network) that provides support. They observed that researchers have used social network characteristics (e.g., number of friends, membership in organizations) as a measure of social support. Along the same lines, Walcott-McQuigg, Sullivan, Dan and Logan (1995) pointed out that network characteristics are not always related to well-being in the same way as support itself. Harris (1995) also expressed the need to distinguish the structure of the social network (size, density, etc.) from the functions of the social network (psychological, instrumental, informational). Supportive behaviors are considered the specific efforts that are made to help another person.

These behaviors include: 1) emotional; 2) feedback; 3) advice/guidance; 4) practical; 5) financial/material; and 6) social (Vaux, 1988).

There is agreement among researchers that social support has beneficial effects (Bolla, DeJoseph, Norbeck & Smith, 1996). Furthermore, there seems to be agreement that the support network is that group of individuals to whom a person routinely turns for assistance in helping to manage problems or to achieve goals. On the other hand, there seems to be less agreement about how social support influences psychological adjustment.

Social Support and Exercise Adherence

Social support, that is, the exerciser's social network of support, including family, friends, co-workers, and other participants in the exercise program, has been found to be related to exercise adherence (Willis & Campbell, 1992). Therefore, the American College of Sports Medicine (ACSM) (1991) suggested that assistance from members of an exerciser's social network should be elicited at the beginning of an exercise program.

Moreover, Sallis, Hovell, and Hofstetter (1992) found that the adoption of exercise by women could be predicted by level of education, self-efficacy, and friend and family support. In their study on the interaction between weight-loss treatment (alone versus with spousal support), Wing, Marcus, Epstein, and Jawad (1991) showed that spousal support had a

significant positive influence on exercise adherence. The results of the latter study indicated that women adhered to the exercise program more consistently when they attended the sessions with their spouses.

Research has demonstrated that social support from friends can also have a positive effect on exercise adherence (Dishman, 1994). In a study of the role peers play in encouraging exercise adherence, Rich and King (1986) found that peer support reduced the dropout rate among exercise participants. Developing relationships among members of an exercise group encourages exercise adherence (Willis & Campbell, 1992). As members befriend each other, there is a tendency to establish friendly rivalries that encourage members to reach exercise goals through good-natured competition (Willis & Campbell, 1992). In addition, the ACSM (1991) recommended that exercise leaders encourage the formation of pairs of buddies who contact one another on days between sessions. Greater attendance has been attributed to the buddy system, which is attributed to the reluctance of members to let others down through poor attendance or lack of effort (Willis & Campbell, 1992).

According to Roberts (1992), social support is not a one-dimensional construct. Therefore, he recommends that exercise professionals develop a means for increasing all forms of social support. Due to the growing recognition of the positive benefits of social support in enhancing the likelihood of exercise behavior, many programs are

beginning to include family, friends, buddies, and other members of the exercise group in conjunction with leadership support (Dishman, 1988).

Overweight Women and Social Support

Allison, Kanders, Osage, Faith, Heymsfield, Heber, Foreyt, Elashoff & Blackburn (1995) questioned whether overweight African American women wanted the support of community groups. Their findings on weight related attitudes of obese African American women showed that family and friends were more important sources of social support than were the exercise group and therapist. As a result of their findings, Allison et al. reported that professionals should be aware of the types of support their obese African American women patients prefer.

In addition, Allison et al. (1995) suggested that if African American women wanted the support of community groups, then support in that setting should be increased. On the other hand, if African American women felt less comfortable with community groups and preferred the support of family and friends, then professionals should refrain from using community groups as a source of support (Allison et al., 1995).

Consistent with the findings from Allison et al.'s (1995) study, Thomas (1995) stated, "Connectedness to others is a central element in women's health and well-being throughout the life span" (p. 291). There is also evidence that social support has positive effects beyond

exercise. Beeber (1996) reported that social support had a positive effect on emotional and mental health and may act as a buffer for the negative effects of stress. In a related study by Hauenstein (1996) women with high levels of social support were less likely to develop depressive symptoms than women with little support.

However, not all women may benefit from social support in the same way. Reifman, Biernat & Lang (1991) in a study of married professional women found no stress-buffering effects of social support. In another study, Shumaker and Hill (1991) reported that women with high levels of support had higher mortality rates. In response to these findings, Thomas (1995) suggested that the cost for others in the social network may out weigh the benefits of social support, particularly if the women are shouldering increased amounts of stress (e.g. son's divorce, grandson's illness, friend in jail).

Self-Efficacy

Bandura (1977) defined self-efficacy expectations as beliefs about one's own ability to successfully perform a given behavior. Efficacy expectations are thought to help determine whether behavior will be initiated, how much effort will be expended, and how long it will be maintained when a person is faced with obstacles or aversive experiences. In Bandura's (1986) view, personal efficacy is neither

passive nor characteristic, but a dynamic aspect of the self-system that interacts in a complex manner with the environment and other motivational and self-regulatory mechanisms (i.e., outcome expectations) and with personal capabilities and performance accomplishments.

In addition, Bandura's (1977) concept of perceived self-efficacy is based on judgments of how well one expects to cope with upcoming situations. According to Bandura (1982), perceptions of self-efficacy affect how much effort people will expend and how long they will continue to persist in the face of obstacles and aversive experiences. Self-efficacy judgments also affect cognitive and affective reactions to stress. If individuals have low estimations of their self-efficacy, they tend to give up easily when faced with stress. Individuals with low estimations of their self-efficacy make internal attributions for failure and may experience high levels of anxiety and/or depression. In contrast, individuals with high self-efficacy whose beliefs are persistent, experience less anxiety and depression and avoid self-denigrating attributions. Bandura (1977, 1982) listed four sources of self-efficacy beliefs: 1) performance attainments; 2) physiological states; 3) vicarious learning; and 4) verbal persuasion.

Warren (1997) found that African American women who had perceived high support from their family, friends, and partners had higher self-efficacy for coping with stressful situations. Higher self-

efficacy also predicted better adjustment on psychological measures. The findings by Warren (1997) are that relationships with others can affect perceived self-efficacy, consistent with the predictions of Bandura's theory.

Self-Efficacy and Exercise Behavior

Although many variables associated with exercise behavior have been studied, Dishman (1994) reported that high self-efficacy has received the most support as a determinant of exercise habits. Dzewaltowski, Noble, and Shaw (1990) found in their study of exercise that self-efficacy was the most powerful determinant of perceptions of one's ability to exercise in specific situations. Moreover, a study by Stanley and Maddux (1986) revealed that the intention to exercise was influenced by perceived ability to undertake the exercise and expected outcomes of the exercise. In a later study, McAuley and Jacobson (1991) also found self-efficacy to be a significant predictor of exercise levels in an 8-week fitness program.

These studies validate Bandura's (1986, 1989) findings that the level and strength of self-efficacy can be used to predict behavioral change and that self-efficacy beliefs impart causal attributions. According to Bandura (1982, 1986) the higher the perceived self-efficacy, the more likely it is that individuals will persist in their efforts until they succeed. In fact, one's self-efficacy beliefs can account for most of the outcomes people expect.

Bandura (1982) reported that when measuring self-efficacy and performance, a microanalytic methodology should be employed. The microanalytic approach involves a self-efficacy scale that represents multiple tasks performed in the particular domain being studied. Assessment of self-efficacy through task-specific measures has been shown to be more predictive of behavior than generalized measures (Bandura, 1986). More specifically, Bandura (1986) has suggested that when measuring self-efficacy, generative capabilities should be explored with respect to a task, instead of the singular act that constitutes the task. In support of Bandura's self-efficacy assessment, Roberts (1992) stated:

> If one is interested in assessing participant's self-efficacy with respect to exercise frequency, it is necessary to determine their confidence in being able to exercise at the prescribed regimen in the face of potential barriers or obstacles to attendance. Such obstacles might include schedule conflicts, lack of apparent progress, and perceived lack of attention or support from the exercise leader. (p. 110)

Roberts (1992) also emphasized the impact of the participant's self efficacy on exercise. He noted that although Bandura's (1986) measurement approach is a more accurate method of assessing self-efficacy, it is important to remember that self-efficacy, like exercise, is a process that is continually adjusted as a function of behavioral, cognitive, and environmental information.

Wellness Motivation

Historical Perspective

Initially, motivation was identified as instincts or drives. Instincts are important for survival because they enable individuals to act in certain ways without being taught to do so (Hall, 1961). Freud was the first psychologist to do extensive studies on the motivational properties of instincts such as sex and hunger. Freud's theories had an important influence on some contemporary theories of motivation. Conceptually, instincts lead to drives – if you are hungry you have the desire or need to find food and eat. The concept of motivation as drive reduction was first theorized by Hull (1943), who stated that behavior is initiated by drives and oriented toward seeking things that reduce drives.

Early research on motivation demonstrated that learning occurred when food and water were given to hungry or thirsty animals. In these experiments, the primary drives of the animals made them seek satisfaction with behavior that was considered as drive-reducing in nature. These earlier experiments were focused on primary drives such as hunger and thirst, and therefore could not describe more complex conditions of human behaviors.

Later researchers were not satisfied with these simplistic explanations of motivation based on drives or instincts. As a result, the term "basic needs" began to be used to explain human behavior. The term basic needs

included innate and acquired needs. Murray (1938) developed a list of needs that he believed represented all human motivational patterns. He assumed that all behavior is motivated, making the claim that an individual does something because there is a need to do it. Murray's list of needs included the need: 1) to be aggressive; 2) to play; 3) to be accepted; 4) to be recognized; 5) to achieve; and 6) to defend oneself. These needs are obviously more complex than the need for food and water.

Maslow (1954) later developed another list of needs that is still widely used today. His hierarchical list of six categories included: 1) physiological; 2) safety; 3) belongingness or love; 4) esteem; 5) self-actualization; and 6) aesthetic. Maslow differentiated his motivational hierarchies into two categories: deficiency motivation and growth motivation. According to Maslow, individuals trying to satisfy basic needs such as hunger and thirst have a deficiency motivation. In contrast, individuals whose basic needs are satisfied, and seek to satisfy the needs at the level of self-actualization have growth motivation. Maslow's theory of motivation put emphasis on personal growth and development. In addition, his theory reveals a strong human need for positive social and self-evaluation.

Recent research on motivation has focused on the arousal, direction, persistence, and vigor of goal-directed behavior (Franken, 1988). This newer trend has had an impact on how motivation has been defined. For instance, Russell (1971) defined motivation as having three qualities:

1) presumed internal force; 2) action-energizing; and 3) guided direction of that action. Bandura (1991) defined motivation as a multidimensional phenomenon that is indexed in terms of the determinants and intervening mechanisms that govern the selection, action and sustained direction of behavior.

The most recent theory about motivation is motivation systems theory (Ford, 1992). Ford described motivation as the organized patterning of three psychological functions that direct, energize, and regulate goal-directed activity: 1) personal goals; 2) emotional arousal processes; and 3) personal agency beliefs (Ford, 1992). In addition, motivational systems theory emphasizes three aspects in human motivation: 1) the selective direction of behavior patterns; 2) the selective energizing of behavior patterns; and 3) the selective regulation of behavior patterns. This theory stressed the fact that an individual acts as a unit. It is also concerned with how an individual fits with the environment. For instance, Ford (1992) stated that to function effectively, individuals must be motivated to conduct the activity until the goal is achieved, have necessary skills to produce the desired outcomes, be physically healthy so the operation can be carried out, and have a supportive environment which facilitates achieving the goal. In this view, true motivation and lasting change have to be developed or happen internally. An individual's internal resources are presumed to include

thoughts that reflect past and present life experiences and past, present and future needs, wants and goals (Helmstetter, 1986).

Cognitive Evaluation Theory

Intrinsic and Extrinsic Motivation

Exercise psychologists are concerned with the individual's initial reasons for engaging in exercise and for persisting in the activity. Understanding motives for participating in and quitting exercise is the first step in implementing strategies for improving retention rates. The basis behind Deci's (1975) cognitive evaluation theory approach to motivation, which has been used in sport and physical activity settings, involves making choices about goal-directed behavior. This theory stressed two primary drives (or innate needs) that provide the individual with the energy for goal-directed behavior. A person who experiences success tends to attribute it to high ability. In this case, the activity is enjoyable and fun, leading to continued participation. A person who participates in activity for its enjoyment without an external reward is said to be intrinsically (internally) motivated. Intrinsic motivation is highly desirable in the exercise setting because it forms the individual's motives for participating in exercise. On the other hand, extrinsic motivation is the desire to perform an activity due to the anticipation of some external reward such as money or a trophy. Research has shown

that intrinsically motivated behaviors are more persistent, more enjoyable, and enhance the individual's self-image as compared to extrinsically motivated actions.

In her study on wellness, Fleury (1996) examined the cultural relevance of the wellness motivation framework in health behaviors change of 14 African Americans, 10 of whom were women. In her study the process of empowering potential consisted of three stages: 1) appraising readiness; 2) changing; and 3) integrating change. There were two categories that provided a cultural context for the process: health value orientation and network affiliation.

The results of Fleury's (1996) study revealed that determinants of motivation in health behavior change for African American women were embedded in a cultural context that included the family, community and religious affiliation. In addition, Fleury indicated that the women were more likely to rely on their supportive networks and informal healthcare systems when illness occurred than on the medical community. Fleury suggested that an awareness of cultural and health values is essential to understanding the pre and post decisional processes that help guide individual health behaviors. Hayashi (1996) stated that cultural differences are often stereotypically and mistakenly associated with an individual's racial or ethnic group. Hayashi found that differences among individuals from alternative ethnic groups (other than mainstream society) are

sometimes attributed to their race instead of to variations in socialization experiences, attitudes, and beliefs (i.e., culture).

Benefits of Regular Exercise and Disease Prevention

Regular exercise has been found to be related to reduction in cardiovascular disease risk factors such as diabetes, hypertension, and osteoporosis (Anderson, Janes, Ziemer, & Phillips, 1997). Moreover, participation in regular physical activity has been shown to reduce blood pressure and increase HDL-cholesterol (Yancey & Walden, 1994).

Claims that exercise can beneficially affect postmenopausal women are promising because these women are at greater risk for developing heart disease (Greendale, Bodin-Dunn, Ingles, Haile & Barrett-Connor, 1996). In a study of the effects of 24 weeks of walking, Duncan, Gordon, and Scott (1991) found that exercise reduced the incidence of coronary heart disease among women with low physical-activity levels. In another study, Vena, Graham, Zielezny, Brasure, and Swanson (1987) concluded that women who were in the most physically active occupations had a reduced risk of death from colon cancer. Concern about the results of the Vena et al. Study have been expressed however, because the researchers did not control for smoking (Dishman, 1994).

Exercise Intervention in Depressive Disorders

Many researchers have noted a negative relationship between exercise and lower levels of depression (Dishman, 1988, 1994). A present concern of some researchers, however, is the causal versus associational nature of the influence of exercise on depression. Dishman (1988, 1994) cited the lack of clarity of results in cross-sectional population studies that report only a correlation between exercise and mental health. Researchers have suggested that more longitudinal studies are needed to determine the effects of exercise intervention on depression. Dishman (1988, 1994) reported that the National Institute of Mental Health (NIMH) concluded that the relationship between exercise and depression was associational rather than causal. These studies have confirmed the association between exercise and lowered depression that have been found by other researchers.

Hauenstein (1996) found that most of the research on depression has been on middle class Caucasian women or lower socioeconomic African American women and not middle class African American women. There are some researchers who have reported that depression may occur as a result of the lack of an individual's social support network system (Yancey & Walden, 1994). For example, Yancey (1992) reported

that African American women named their friends as the best source in helping them deal with their depression. It therefore follows that African American women with few social contacts may be more susceptible to depression.

McGrath, Keita, Strickland and Russo (1992) indicated that it was not clear whether low self-esteem is a causal factor or a symptom of depression. However, Beeber (1996) found that depression in African American women often occurred in conjunction with low self-esteem. In her study entitled, Depression, Stressful Life Events, Social Support, and Self-Esteem in Middle Class African American Women, Warren (1997) reported that there has not been consistent research examining variables which may be associated with depression in African American women. However, she did list three variables from the literature that represent likely candidates: stressful life events, lack of social support, and low self-esteem.

The findings from Warren's study revealed a positive relationship between depression and stressful life events and a negative relationship between depression and social support. However, self-esteem was not found to have a significant relationship to depression, as predicted in Beeber's (1987) model.

Reed, McLeod, Randall and Walker (1996) reported that African American women were affected by stressors associated with their

environment. Warren (1997) also reported that depression may occur as a result of the way African American women cope with their environment and social stressors. African Americans often live in higher stress environments (i.e., more crowding, higher crime rate, and lower incomes) than do Caucasians (Hauenstein,1996).

Nutrition and Exercise Behavior

It is well known that exercise expends energy; however, to achieve optimal health benefits from exercise, a person's diet should be carefully regulated as well. Pike and Walsh (1996) reported that self-efficacy factors were significantly associated with diet and exercise behaviors. According to Grilo, Brownell, and Stunkard (1993), nutrition is just one of the components that should be part of women's overall program for a lifestyle change. They also stressed the importance of understanding the difference between quick-weight loss diets that are usually temporary and eating habits that are essential for permanent weight control.

Weight can be controlled by changing exercise and eating habits so that a caloric deficit occurs. A study by Blair (1991) suggested that regular exercise should be part of any weight maintenance program. Additional research by Grilo, Brownell, and Stunkard (1993) has shown that women who lose weight by dieting without exercise tend to gain the weight back within a year. In contrast, there is strong evidence indicating that women

who have lost weight and incorporated a regular exercise program into their lifestyles are more likely to establish long-term maintenance of weight loss (Blair, 1991).

Obesity

Kuczmarski, Flegal, Campbell & Johnson (1994) found that the majority of research studies have shown weight differentials between African American women and females in other racial groups. However, according to Kuczmarski et al., few studies have investigated the reasons for these differentials. African American women were less likely than White women to exercise and diet in order to lose weight (Serdula, Collins, Williamson, Anda, Pamuk & Byers,1993).

Serdula et al. (1993) found that fewer African American women than White women perceive themselves as being overweight. The reason for this according to Allan (1993) is that African American women do not believe that a woman needs to be thin to be considered attractive. Walcott-McQuigg (1995) believe that these differences about diet and exercise in African American women may be due to certain cultural and lifestyle factors.

Research has shown a significant relationship between positive health practices, higher socioeconomic status and improvements in health. However, in their study on African American women's health

practices, Slater, Lorimor & Larson (1985) revealed that African American women in higher socioeconomic groups had similar weight gain patterns as those in lower socioeconomic groups.

In their study entitled Weight-Related Attitudes and Beliefs of Obese African American Women, Allison, Kanders, Osage, Faith, Heymsfield, Heber, Foreyt, Elashof, & Blackburn (1995) reported that obesity is a serious health problem among African American women. In the Second National Health and Nutrition Examination Survey (NHANES-II) it was reported that 33.5% of African American women between ages 25 and 34 years, 40.8% between 35 and 44 years and 61.2% between ages 45 and 54 years were "severely overweight" (National Center for Health Statistics, 1987).

Obesity and Exercise

An obese person (20% or more over ideal weight) has an excess accumulation of body fat that increases disease risks (ACSM, 1991). Despite the known health-related benefits attributable to regular exercise, research suggested that exercise adherence is poor among obese persons (Dishman, 1994). Research seems to support the proposition that the incidence of obesity increases with age, especially among women (Nelson, 1996). In a previous study, Van Itallie (1985) reported an even more staggering statistic: obesity is as high as 60% among African-American women aged 45 to 75

years.

Generally speaking, obese women are likely to lead sedentary lifestyles (Dishman, 1994). A study by Willis and Campbell (1992) determined the differences in activity levels between obese women and non-obese women. The results indicated that obese women in general are less active than women of normal weight. A growing body of research supports the premise that obese women exercise far less than women of normal weight (Willis & Campbell, 1992).

One of the problems associated with exercise and weight maintenance was evidenced in Kayman, Bruvold, and Stern's (1990) study. The results of their study showed that 90% of formerly obese women who had lost weight and kept it off (maintainers) exercised more per week (minimum of three times a week for more than 30 minutes), compared with 34% of obese women who had lost and regained weight (regainers). Nelson (1996) found that the combination of exercise plus diet led to greater weight loss than dieting alone.

After studying lifestyles (the way of life of an individual, group or culture) among exercisers, Dubbert (1992) made some specific recommendations. He suggested that less intense or moderate activities may promote better initiation and maintenance to an exercise program than intense activities. Similarly, Sallis, Priski, Grossman, Patterson, & Nader (1988) found that the dropout rate for participants in moderate activities

was 25%-35%, which is nearly half of the 50% dropout rate reported for participants in vigorous activities. These findings indicate that less intense or moderate activity should be recommended for obese women. Exercise that employs moderate activity has been shown to be more readily maintained over the life span when compared to more vigorous activities, which tend to decrease with age (Dubbert, 1992).

A present concern of some researchers is that programmed exercise has been associated with soreness and fatigue as well as the need to set aside blocks of time to travel to a facility to participate (Willis & Campbell, 1992). Recent data indicated that lifestyle programs should be employed for obese women in order to maximize the possibility of weight management program successes. Lifestyle programs are flexible and easier to work into a woman's everyday routine, thus presenting fewer barriers for the participants (Evans & Nies, 1997). This trend toward lifestyle programs is expected to continue. It has been determined that for long-term success in a weight loss program, exercise must be a permanent part of a woman's lifestyle (Allison et al., 1995).

Modeling and Adherence

Modeling can provide motivation in the initial and maintenance stages of exercise participation. Modeling is a form of vicarious learning that has an important influence on self-efficacy (Bandura, 1986). Vicarious

experience involves observing another person perform successfully (Bandura, 1986). A woman's own expectations will be increased when she observes someone similar to herself successfully making a transition from one physical activity to another (e.g., from walking to jogging) (Bandura, 1986).

Additionally, Dishman (1994) has stated that exercise leaders with similar cultural and demographic characteristics as women participating in an exercise program are more likely to encourage women of minority groups to adhere to an exercise program. Willis and Campbell (1992) also suggested that a model who is similar to the observer in gender, age, and race may enhance the chances of increasing adherence. Finally, characteristics such as socioeconomic status and self-esteem of the model are factors that may influence exercise adherence (Willis & Campbell, 1992).

Exercise Leadership

Due to the fact that few American women exercise at an appropriate intensity level, several studies document the role effective leadership plays in exercise adherence. In a study of exercise adherence, Gillett (1988) tested the hypothesis that there is a mutual interaction between specific leadership techniques and adherence. Results of this study supported the hypothesis that adherence is enhanced by leadership techniques and characteristics,

which include answering specific questions about exercise, individual feedback, flexible goal-setting, praise, and concern for participant safety.

Dishman (1988, 1994) stated that the role of the exercise leader is to educate the participant regarding why and how to exercise. In fact, Dishman (1988, 1994) contended that participation in an exercise program depends largely on the leadership as well as on the type of program. Therefore, he recommended the inclusion of parallel classes that offer different types of exercise leadership in order to promote adherence. Additional support for the importance of exercise leadership comes from Willis and Campbell (1992), who noted that the exercise leader can have a positive effect on the behavior of the client. However, Willis and Campbell reported that it is difficult to define effective leadership precisely because the variables such as uniqueness of the group and traits of the leader and group members are constantly changing.

In relation to exercise leadership, Dishman (1994) suggested that one way to attract minority group members to exercise is to employ exercise leaders who are culturally and demographically similar to the particular minority group participating in exercise. The successful use of culturally similar exercise leaders with an exercise group was demonstrated in the Zuni Indian Diabetes Project (Heath, Leonard, Wilson, Kendrick & Powell, 1987). This project was a community-wide exercise promotion program aimed at controlling non-insulin-dependent diabetes among Native

Americans. It was noted that exercise adherence increased among the Zuni Indians in the project when Zuni Indians were given active leadership roles in the program.

Chapter Summary

One of the primary benefits of predicting adherence to exercise programs is to develop and market programs for individuals who are at risk of dropping out or participating at such low frequencies that they do not receive the benefits of exercise (Evans & Nies, 1997). Accordingly, Dishman (1994) suggested that researchers need to identify potential dropouts, that is, those who are at risk for dropping out at the beginning of an exercise program. Dishman also suggests that after the potential dropouts have been identified, exercise programs should be structured so that the program leader can initiate behavior modification that may contribute to the participant's adherence.

Taken together, the findings of the studies cited in this review provide a consistent message: in order to have an exercise program that enhances the likelihood of participant adherence, characteristics associated with adherence (e.g., exercise habits) must be identified. According to Dishman (1994), knowledge of individual's stages of exercise initiation, life stages, and transitions (e.g., transition from school to the work force, parenthood, retirement and other situations) can aid efforts to tailor interventions to

various segments of the population. Unfortunately, the knowledge base related to such life stages and transitions remains meager.

The studies mentioned in this chapter have had a great impact in elucidating the areas of weight maintenance, exercise habits, and exercise adherence. Over the years, there has been a transition from studies of the exercise habits of Caucasian men to those that include Caucasian women. Despite this transition, there are few studies of the exercise habits of women from diverse racial/ethnic groups (Yancey & Walden, 1994). The present investigation was intended to address this need.

CHAPTER 3

METHODOLOGY

Introduction

The purpose of this study was to determine the lapses, habits and attitudes of African American women who previously exercised regularly, but are now sedentary. More specifically, using a qualitative approach involving semi-structured interviews, an attempt was made to explore the following factors as they related to the experience of African American women's sedentary relapse: a) barriers; b) adherence; c) type of physical activities; d) location of activities; e) motivational factors of why a person participates in an exercise program; and f) how past activity influences future participation in an exercise program.

For the purposes of this study, I used Dishman's (1994) definition of sedentary relapse that is defined as exercising continuously for three to six months, then stopping for at least three months. My intent in this study was to explore the incidents of sedentary relapse in the participants' lives. Guba and Lincoln (1994) stated:

> Human behavior, unlike that of physical objects, cannot be understood without reference to the meanings and purposes attached by human actors to their activities. (p. 106)

Therefore, I chose a qualitative method of interviewing for this study. This type of method encouraged participants' personal reflections and stories in response to open-ended questions. I was linked to the

participants through interaction that helped create the findings, with a final consensus of themes taken from the whole of the experience.

My purpose was not to control and predict but, in the nature of constructivism, to understand and reconstruct. The type of semi-structured interview used in this study provided an atmosphere in which the examination of the participants' perceptions could flourish in a forum of acceptance of their human experience. As such, this "dialogic" process allowed me to build rapport and trust with the participants.

Rationale

The proposed method for this research was the semi-structured interview. Categorized as qualitative research, interviews can be distinguished from other research inquiries by their philosophy and method. Interviewing is a data collection technique that is used by qualitative researchers to ascertain the participant's perspective on a specific phenomenon (Marshall & Rossman, 1989). It has been described as an interaction or a friendly conversation involving the interviewer and the interviewee with the main purpose of seeking valid and reliable information (Marshall & Rossman, 1989; Spradley, 1979). Interviewing leads the researcher toward understanding in considerable detail, how people think and how they arrive at the perspectives they hold (Polkinghorne, 1989).

In this study, I used semi-structured interviews to find out information about the participants' self-perceptions regarding past and present feelings related to their sedentary relapse experiences. I used semi-structured interviews to seek explicit information that might provide comparable data across participants (Bogdan & Biklen, 1992). I decided to use interviewing because it involved asking questions that differ from those posed in survey questionnaires in three ways: 1) interviews are usually less structured; 2) specific questions are generally open-ended and void of response options; and 3) there is no intent of converting responses for later statistical analysis. Instead, the uncoded responses are considered to be the data.

The use of a semi-structured interview allowed each participant to determine what she thought was important to tell about her experience. This approach, used in conjunction with my probes to assist in clarity and understanding, resulted in both a deep and broad examination of the issues as well as variation between and among participants.

Peer Debriefing

I have held professional positions in my discipline for 10 years at various colleges, universities, healthclubs, and wellness centers. These positions have taken me on a path of viewing health and wellness as important aspects of one's life. This belief influenced my selection of and

approach to the topic of this dissertation. I realized that it would not be easy to keep my own projected personal experiences and beliefs from surfacing while listening to others describe their own experiences. Therefore, two qualitative researchers provided evaluation of the data from different frames of reference and helped me identify my personal biases in the interviews and in the development of themes.

A bracketing interview in which I was interviewed by another researcher concerning my own experience of the topic was conducted before I began to collect data. This interview challenged my biases by another researcher who played the role of the "devil's advocate."

Bias Statement

The bracketing interview revealed my own biases regarding the issue of sedentary relapse. Regular exercise has been a part of my daily routine all of my life. I grew up listening to my mother speak about the importance of eating a well-balanced meal and watching her exercise daily. My mother often told me about how I should take care of my body and my mind. In the bracketing interview, I discovered that I had a preconceived notion that other women knew that they should be taking care of themselves and that they should be exercising daily. My reasoning was based upon what I had been taught by my mother over the years. I thought that anyone would like to exercise on a regular basis

once they found out how enjoyable it could be if done consistently. I also discovered that my biases were based on a belief that most women would exercise regularly and enjoy doing so if they could work it into their daily schedules.

As a result of the findings in the bracketing interview, I was determined to let the participants describe their own accounts of sedentary relapse with regard to their choices, options and alternatives. After reading the bracketing interview results, I realized that the participants may feel differently than I do about exercising regularly or exercising at all. Consequently, I encouraged the participants to detail their own experiences regarding issues of sedentary relapse.

The bracketing interview made me keenly aware of preconceived notions that I had about sedentary relapse and exercise in general based on my own experiences. I used this knowledge of my preconceptions to refrain from jumping to conclusions if a participant described an experience or expressed a belief that differed from my own.

The bracketing interview allowed me to name my prejudices against individuals who do not exercise regularly, rather than claim objectivity or impartiality. It helped me become more aware of my personal biases and become more sensitive to positions different from my

own. The bracketing interview allowed me to bracket my assumptions by being interviewed on the very experience that I was investigating. Since exercise has always been a vital part of my life and I too am an African American woman, after the bracketing interview I was more careful when asking questions and when probing in order to avoid influencing the interpretation of the data.

Participants

The quality of the data in this study was directly related to the participants' ability to provide a narrative of their sedentary relapse experiences and my ability to elicit descriptions of their experiences. Participants in this study were 10 African American women ages 35-54 living in the Southeastern United States. This age group was selected because of the relatively small amount of research on this population and because African American women in this age group are at risk for coronary heart disease and other illnesses associated with a sedentary lifestyle (Dishman, 1994).

Recruitment of Participants

The women in this study were recruited through suggestions from friends and colleagues. I telephoned each prospective participant and those who expressed interest in the study were asked to participate. I

informed all individuals that there would be no monetary compensation for participating in the study and that their anonymity was guaranteed. I also informed the participants that they could withdraw from the study at any time. Once an individual agreed to participate, I gave her an Introduction Letter (Appendix A) that briefly explained the nature of the study and the projected time needed to complete the interview. Once I received confirmation of her willingness to participate, I made arrangements to schedule a convenient time, date and place to conduct the interview. I personally conducted all interviews.

Interviews

Interview Process

Without exception, all participants stated that they thought sedentary relapse was an interesting topic and they enjoyed reflecting on their experiences. Interviews were conducted in locations and at times mutually agreed upon by myself and the participants. The only requirements were that the place be private, with few distractions, to allow the interview to continue without interruptions. Since the site of the interview was determined by the participants, it was assumed that the places chosen were comfortable for them. All interviews were conducted at the participants' workplaces and lasted between 30 and 45 minutes.

All participants knew the topic of the interview ahead of time. They did not know exactly what questions I was going to ask during the interview. Prior to each interview, I discussed the project and the informed consent process with each participant. I also reminded participants that all interviews would be audiotaped and that they would have the opportunity to reconsider their commitment to participate. The women in this study were not identified by their real names. Instead, each individual was asked to choose a pseudonym by which she would like to be known. A pseudonym was chosen to protect the participant's confidentiality. After I described the purposes of the interview and the study participants chose their pseudonyms and signed the consent form (Appendix B), I began the interview.

Interview Guide

I constructed an Interview Guide (Appendix C) to assist me in keeping track of the topic. The Interview Guide was judged by a researcher who teaches qualitative research classes and has published numerous qualitative studies. This researcher was familiar with the literature in the area being studied. Her assessment of the Interview Guide was based on her knowledge in the area of sedentary relapse. This knowledge guided her expertise in determining whether or not the questions being asked of the participants would allow me to build a

conversational style while maintaining focus on the subject matter being studied.

The interviews focused on three primary areas: exercise during youth, barriers to exercise and recent exercise experience(s). The findings were centered upon the participants' perceptions of each of these pivotal areas. Three questions served as the preliminary guide to each interview. The following questions guided the overall research:

1. Tell me about your participation in exercise/physical activities during your youth.

2. Tell me about your participation in exercise/physical activities during your adult years.

3. Tell me about your current exercise, even if it is not regular.

The data for the study were gathered during July and August, 1998. I asked all participants the same questions in order to find commonalties and to identify unique differences. To learn about the participants' daily lives, I asked questions to probe for information regarding family matters, marital status, children and outside activities. I explored each participant's experience in order to obtain clarification and an understanding of what she was saying. For instance, at various times during the interview, I stated my understanding of what the participant said in order to obtain any necessary clarifications.

Data Collection

I used tape recordings and non-verbal cues to gather data. The purposes of these techniques were to enhance the collection and interpretation of the data. I used a small micro-cassette tape recorder to tape interviews with the participants. Each recording was transcribed by a paid transcriber who signed a statement of confidentiality (Appendix D). Afterward, I reviewed the transcripts for the final analysis.

I used non-verbal communication techniques to obtain information through nonlinguistic signs. These signs included body movements, pausing, voice quality and volume. Notes reflecting the participants' body language and mannerisms were added to the transcripts when deemed relevant. Tapes were kept under lock and key. After each interview was transcribed, tapes were erased for the purposes of confidentiality.

Data Analysis

In analyzing the data, I became familiar with the data in all the interviews in many ways: 1) during the interviews; 2) while listening to the tapes; 3) while reading the transcribed interviews; 4) while working with my colleagues; and 5) when reading over and checking for themes.

Personal experience is how we define and justify ourselves and our actions. It was important that this work reflect the experiences of the women in this study. Each participant was given a transcribed copy of

her interview and the right to amend any information that was inaccurate, a misrepresentation of her experience, or even if accurate, any information that she may not have wanted to be included in the portrayal of her experience. The participants were asked to contact me to correct any misconceptions on my part that may have occurred during the interview. I did not receive any suggested changes from the participants.

Transcripts were read and re-read in order to identify themes. After reading over each interview several times for familiarization, I conducted a line-by-line analysis of the interview transcripts, coded and then categorized them by the general topic and the participant's response. Afterward, categories were refined and some overlaps were collapsed into integrated categories. My continual reading and coding of data led to theme locations. I analyzed each transcript first by topic, divided the responses into broad themes, followed by categories, and then into smaller subtopics (which could then be followed and fitted back into the larger categories and themes). This inductive approach offered emergent themes and relationships that could be located and eventually continually separated or matched with each other. After the categories were ultimately defined and sorted, I examined the data for relationship patterns and results.

Summary

This investigation examined the sedentary relapse experiences of African American women in order to develop an understanding of why some women are able to overcome these experiences while other women are not (Dishman, 1994). I emphasized an approach that investigated the meanings that these women constructed around events in their daily lives and the influences that have helped to create this meaning. More specifically, I examined the phenomenon of sedentary relapse experiences and the type of influences that contributed to the participants' beliefs and how the relationships and interactions of peers, family, and culture mediated these beliefs.

CHAPTER 4

RESULTS

Introduction

The purpose of this study was to determine the lapses, habits and attitudes of African American women who previously exercised regularly, but are now sedentary. More specifically, using a qualitative approach involving semi-structured interviews, an attempt was made to explore the following factors as they related to the experience of African American women's sedentary relapse: a) barriers; b) adherence; c) type of physical activities; d) location of activities; e) motivational factors of why a person participates in an exercise program; and f) how past activity influences future participation in an exercise program. All participants in this study had at one time exercised regularly for at least three to six months and then stopped for at least three months (sedentary relapse).

This chapter is divided into three different segments. First, a description of some of the general features of the interviews is given, including some of the participants' reflections about the general nature of sedentary relapse and its importance in their lives. Second, a description of each participant is presented. Third, each of the major themes emerging from the analysis of the interviews is presented together with numerous examples from the interviews. These examples were chosen to illustrate how each theme was supported by comments obtained in the interviews and how the interrelationships among themes revealed a

general understanding of the experience of sedentary relapse.

General Description of the Interviews

The 10 women who volunteered their time and energy to this project demonstrated a high degree of curiosity and interest in the subject of sedentary relapse. They described a total of 125 different experiences, with each participant describing either three or four experiences of sedentary relapse. Together they described similar experiences with a considerable degree of detail and often with much passion.

Participants were asked to think of specific situations or times when experiences of sedentary relapse occurred. All participants knew ahead of time what the interview would be about and all had reflected on the subject beforehand. Therefore, all participants had fairly clear views about what sedentary relapse meant to them; some mentioned they had thought about the subject a great deal even before they were asked to be a part of the study. Some participants came to their own conclusions about the general nature of the experience of sedentary relapse as it had been revealed in their own lives.

When participants described their personal "perceptions" of sedentary relapse, they were describing a personal stance toward the topic that was part of the experience of each participant. They described

sedentary relapse as a defining force in their lives; for these women, the experience of sedentary relapse seemed important to the way they viewed themselves.

The participants made it clear to me that the topic of sedentary relapse was an important aspect of their everyday experience and one that held special meaning for them in their personal lives. This was shown in their perceptions of sedentary relapse, and in their statements about the effects of sedentary living on ways they viewed themselves,

The Participants

The women in this study told me about their exercise experiences during their youth and as adults. There were obvious differences in their exercise habits during both periods in their lives. The following is a summary of each participant in chronological order of their ages.

Anjoinette

"Anjoinette" is the youngest of the participants at 35 years of age. She is the third of seven children in a family of three girls and four boys. She was raised in the rural south. Her mother was a cleaning lady and homemaker. Her father worked at an automobile factory. Anjoinette stated that when she was a young girl she was very active. She recalled, "We used to play ball games." Anjoinette spoke of her two favorite sports

when she was a young girl. She asserted, " I used to go outside and play basketball and softball and run up and down the street where I lived."

Anjoinette is separated from her husband and living with her parents. She graduated from technical school and is currently a Cosmetologist. As a youngster, Anjoinette played a lot of ball sports, but as she got older, she stated that she preferred to "walk" for exercise.

Jessie

"Jessie" is a 36 year old clerical worker. She is the fourth of six children: three boys and three girls. Her mother was a homemaker and her father was a factory worker. She did not graduate from college, but does have some technical college background. Jessie is currently divorced and living with her two small children without a partner. When Jessie was a young girl growing up in the rural south she "jumped rope" and played "kickball." She also enjoyed participating in ball games such as "softball" and "basketball."

During the time that Jessie was a young girl, there were not very many choices of programs on television. Jessie stated, "We did not have all the modern conveniences of technology like today." She said that she was always doing something active and did not watch very much television as a child because, "You only had three (channel) choices."

As an adult, Jessie contends that her current exercise of choice is

"walking." She said she does not do much walking, but when she does walk it is "around my neighborhood" or "during my lunch break."

L.T.

The participant "L.T." is a 42-year-old divorced clerical worker. She has two grown children who live with her. L. T. is the fifth of six girls born in the rural south. Her mother was a homemaker and her father was a factory worker. L.T. attended college, but did not graduate. As a child, L.T. participated in ball sports such as "basketball" and "softball." She stated that she enjoyed playing softball but did not join a league until her senior year in high school. L.T. admitted that since she had her children, she had not participated in any type of physical activity on a regular basis.

Sarah

"Sarah" grew up in the rural south. She is a 46-year-old married clerical worker and mother of three. Sarah is the youngest of five children, three brothers and one sister. Her mother was a homemaker and her father was a welder. Sarah enjoyed playing softball as a young girl with her three brothers. She stated, "We played softball constantly, all summer long."

As an adult, Sarah admitted that she had not engaged in exercise

much since her children were born, although she stated that whenever she engages in exercise such as "aerobics" she gets a "rush" and " I have all this energy." She contended that she had not exercised regularly in a long time. Sarah stated that she knew exercise was good for her but she tries to "get by" with what she "necessarily has to do." She said that if she has to get out there and "strain" and "kill herself" trying to make herself lose weight, then it is not worth it.

Janna

"Janna" has four older brothers and one younger sister. She grew up in a rural southern town. Her mother was a homemaker and her father was a factory worker. Janna is a Director of Student Affairs at a local college, holds a master's degree and is currently married with two grown children who live with her.

Janna stated that she was a very active child. She participated in basketball as a young girl. Janna played intramural basketball in high school. As an adult, Janna asserts that she realizes the health benefits of exercising regularly, but she does not participate in exercise on a regular basis because of her health. She noted that sarcoidosis affected her in terms of her respiratory system and stated, "I have problems breathing and it diminishes my stamina." Although this may be true, Janna stated, "It is a vicious cycle," because "I can't build it [stamina] up unless I get

into a regular exercise program." She finally said, "I think I'll use any excuse not to exercise." Janna went on to say that she periodically joins an exercise program that would "force" her to work out, because " I won't do it on my own."

Willette

"Willette" is a divorced 49-year-old Academic Advisor at a local college and mother of four. She holds a master's degree and lives alone. Her mother was a homemaker and her father was a factory worker. Willette grew up in a rural southern community. She described her neighbors as "hard working and blue-collar." Willette has three younger brothers and one older sister.

As a child Willette stated that she was very active. She said, "We didn't have computers and things so we weren't sitting at home playing Nintendo." Willette noted that she participated in a variety of sports, particularly ball sports such as, "basketball" and "softball." She did not play on any team sports in school. She just enjoyed playing ball with her friends after school.

As an adult, Willette states that she is aware of the benefits of exercising regularly on one's health, but she has not been able to "fit" a regular amount of exercise into her busy schedule.

Anna

"Anna" is a 50-year-old married clerical worker. She is the mother of five children. All of her children are grown and do not live with her. Anna's mother was a homemaker and her father was a factory worker in the small rural southern town where she grew up. She has five brothers and two sisters. Anna attended college, but did not graduate.

As a child Anna noted that she enjoyed participating in many different types of exercise. She admitted that since she has been an adult, there have been very few times when she has participated in exercise on a regular basis. Anna said, "Occasionally, I'll walk through the malls or something" and "When I exercise, I do feel better." Overall, Anna stated that she knew she needed to exercise, but did not feel too bad about herself as long as she did not "stuff herself."

Helen

"Helen" is a 52-year-old divorced supervisor and mother of three grown children who live with her. Helen graduated from technical school. She has four older brothers, one younger brother and one younger sister. Her mother was a cleaning lady and homemaker and her father was a handyman in the rural southern town where she grew up.

Helen commented that as a child she participated in outdoor activities such as, "softball" and "basketball". She did not play on a

formal team at school. She went on to say that as a child, they did not have any type of formal team sports at her school for boys or girls. All their activities took place after school. As an adult, Helen mentioned that she would sometimes "walk over at the school." This was the only type of exercise that she has participated in as an adult.

Ginger

The participant named "Ginger" has one younger brother, two younger sisters and three older brothers. Her parents were farmers. She is a 52-year-old clerical worker, married and has three children who are grown and do not live with her. Ginger was raised in a rural southern town. When she was a young girl, Ginger participated in activities such as "basketball" and "softball" on a regular basis with her friends after school. As an adult, Ginger acknowledged that exercise is a means of valuable experience in maintaining health, but currently she does not participate on a regular basis. She noted, "I find myself not diligent in doing it." Ginger added, "Knowing that it [exercise] should be done, but not doing it." She did state that she knew that when you walk you should have your heart rate up to a "certain point" for an "extended period of time." While Ginger said that she knew the importance of walking, she admitted that she had only done it a "couple of times." She asserted, "I know I need to but I haven't yet."

Cookie

At age 54, "Cookie" is the oldest of the participants. She is a divorced clerical worker and mother of two grown children who do not live with her. Cookie attended college, but did not graduate. Her mother was a homemaker and her father was a factory worker in the small rural southern town where she grew up. She has four older sisters and two younger brothers.

As a young girl, Cookie stated that there were no formal exercise programs in her school. She mentioned that she was very active as a child in "ball sports" and her father was a "big sports fan." Cookie noted that after she was married she no longer participated in regular exercise. The only type of exercise that she participated in since her marriage was walking. She maintained that whenever she would "think of it, I'll go, you know, walking." Cookie mentioned that whenever she walked it was on the "weekends." She stated, "I go over to the mall and walk." Cookie also noted that she knew exercise was beneficial to her health and that she "felt better" after she exercised. Even though Cookie was aware of the benefits of exercise and "felt better" after she exercised, she still did not participate in exercise on a regular basis.

Presentation of Themes

In this section, I present the participants' descriptions of their experiences of sedentary relapse. Four themes emerged from the data and were identified as: 1) Barriers/Motivators; 2) Self-Image/Current Body Weight; 3) Unrealistic Expectations; and 4) Lifestyle Change.

Theme I: Barriers/Motivators

This theme was the most prominent in each interview. Participants described barriers to exercise, and often perceived themselves as having little power to overcome these barriers. For most participants, concerns related to their sedentary relapse increased as adults. When the participants were asked to tell me about their participation in exercise/physical activities during your adult years, their answers were similar. There were six subthemes that emerged: 1) time; 2) commitments to and responsibilities for family and others; 3) convenience; 4) negative aspects of exercise; 5) personality factors; and 6) social support.

Subtheme I: Not Enough Time

All participants discussed at least one experience of not having enough time in their schedules to exercise. Sarah noted that she did not have enough time, but also admitted that if she was going to get serious

about exercising she would have to block out time to do it.

Sarah said:

> I don't have time to be bothered with that right now. And it's sort of like the same thing as you have to make yourself do it just like you just have to set a time aside to read your Bible. You've got to set aside, I've got this time marked off. I have to do it here. And that's one thing. And the Bible thing is just like the exercise is, oh well, I'll do it later. And later never comes and you don't get it done.

Helen's comments were similar to Sarah's. Helen maintained:

> I just don't have time, because when I'm not here working, I'm at home. Just doesn't leave a whole lot of time.

Similar to Sarah and Helen, Willett stated that she just did not have enough time in her daily routine to exercise. Willett said:

> I don't have any more time to exercise.

Although Willett and Helen were not as specific as Sarah about why they did not have enough time to exercise, Anjoinette went a step further and stated that she did not have much time to exercise after she was married.

Anjoinette explained:

> Not too long after I had gotten married, and you know, I took, I really couldn't find the time. I really had trouble finding the time.

Within this group of participants, many viewed "time" as being something that they did not have enough of during the day. Each participant expressed a desire to have more time to exercise.

Subtheme II: Commitments to and Responsibilities for Family and Others

Related to time concerns were commitments to and responsibilities for family and others in their lives. The participants reported that they were responsible for the welfare of their children and were committed to raising them.

Sarah expressed a desire for a change in her daily routine. She explained:

> I'm busy constantly with the kids. The kids are 17 and 12, so they are into so many things and I'm running left and right with them all the time. I guess we know that exercise is running up and down the stairs at home. And that's it for right now. But getting it, just making myself do it is the thing. And I'll sit and I'll go I've got other things to do. Coming in after work, pick the kids up, go drop one here, drop one there, go back and get the other, try and go home, get dinner cooked. Take care of the usual stuff at home. After work I need to get back home. And up until a few months ago when my daughter started driving her own car, I had to leave here and go straight, especially when you know school is open, and pick her up. She would have an activity at school and she'd be there until almost six o'clock and then I'd have to pick her up on my way home, pick my son up, get him to soccer practice or whatever he's involved in, if he, or else to the tutor in the evening. So, it's kind of something I can't do. Someone told me, well you can do that. I said, no, you can't tell me what I can do with my schedule. I know what my schedule is, and I cannot fit something like that into my schedule. I know what my schedule is, and I cannot fit something like that into my schedule after work, and I don't think I ever will, unless the kids are gone. But by then I'll be ready to retire and move out of here.

Similar to Sarah, Helen expressed the desire that her children were taken care of daily. Helen also added that she had been involved in her busy daily routine since she was married at an early age and that she

had to work. Helen stated:

> I was young and got married at an early age. I had just turned 18 when I got married right out of high school. That's when I gave up exercise. I started having children. After that, in the work force, trying to raise three children. First husband died at age 29, my exercise program went out the window. Work and kids. By the time I'm home, I'm cooking, I'm washing, I'm cleaning, it's time to go to bed. It's time to get up and start all over again. On Sundays, I'm in church on Wednesday nights I'm in church. Okay, I've got seven grandchildren that I deal with, a fourteen-year-old that I've still got at home, so exercise is on the back burner again. Okay, we're dealing with too many other things.

Sarah and Helen expressed the desire that their children were taken care of daily. Ginger, like Helen mentioned how she had ties to work. Ginger maintained:

> I find myself getting home and having other things to do or getting home late and not getting it (exercise) done. I know I need to get into something. And I just don't know what. I haven't found, well I have. I haven't really looked lately because I'm involved with quite a few other things after work, commitments. And until I know that I could commit to something I'm not one to say, hey I'm going to do this, and then I don't do it. I just haven't committed to anything that I want to do yet. I'm involved on some things after work that, you know, I have meetings and I'm involved with the choir, and I find that I can't do anything that means that I have to go somewhere after work, you know, three or four nights in a row. I need something that would fit into the schedule of other commitments that I have.

Similar to Sarah, Helen and Ginger, Willett specifically stated that she had family and work ties that prevented her from exercising. Willett went a step further and stated that she was a housewife and the family moved from place to place. Willett was not only taking care of her children, but she also was taking care of her husband.

Willett noted:

> And then after that, being the housewife, we started moving around different places and I started to work when my youngest child was about three-years-old. And so I didn't really do any formal exercising then, but I thought, I'm a busy person. Like I have too much to do, so exercising took low priority cause remember by that time I'm driving one to kindergarten and one to, well we didn't call it day care, a child care program maybe with a friend. And coming home, and my husband was in graduate school then. And so I felt like I had so much to do that I'm getting my exercise. But I can remember when I was doing so much. My husband's in school and I'm trying to help him out. I've got these two children. I am really busy, and because I'm so busy I'm getting my exercise. I'm driving kids, I'm picking up everybody, you know, it was constant.

Janna, like Sarah, Helen, Ginger and Willett stated that she too had family responsibilities that kept her from participating in exercise. Janna pointed out that she tended to put everyone else's needs in front of her own.

Janna declared:

> I have two kids, a daughter that, as I said, does cheerleading and gymnastics, and a son that does soccer, and a husband that has diabetes, that he walks and exercises on a regular basis. So I see them doing it, and it's one of those things, I think women sort of put themselves on the back burner and we give ourselves sometimes excuses that we really shouldn't, to avoid doing things that we know we need to do to take care of ourselves.

Cookie contended, much like the other women that her family took precedence over exercise. Cookie expressed the desire to exercise, but her responsibilities did not permit her to do so.

Cookie commented:

> I had to, you know, get up earlier in the morning in order to get out and get to work. And then by the time I got home in the evening and picked the kids up and did what I had to do or whatever, then, you know, the time was gone, and it was time to go to bed. So that was when I started slowing down as far as the exercising is concerned.

Even though the participants talked about children having a negative impact on their exercise experiences, they were positive in wanting to start families. Many of the women started their families fairly young and put exercise on the "back burner" because they perceived that their roles as mothers and wives required extended hours and commitment. These women have a "do what it takes" approach toward raising their children and providing a family atmosphere. If that approach meant putting their exercise on hold, they would. They all mentioned how important their children were to them, and also talked enthusiastically about their work.

Subtheme III: Convenience

A major factor mentioned as a barrier to exercise, lack of transportation, at one time had been the impetus for exercise. Both Jessie and Cookie said that when they did not have cars and if they could not get a ride with someone else, they had to walk. Jessie mentioned that after she purchased a car she gained 50 pounds.

Jessie stated:

> And then I got a car. Then it (walking) stopped. And that's when I gained a lot of weight. Probably about 50 pounds over about an eight-year period, cause I got a car.

Cookie similarly declared:

> We walked a lot cause we didn't have a car at that time. So, everywhere we went, if our boyfriends didn't take us, you know, we walked. And it was, we thought it was fun then. Now I'd die.

The participants' statements about lack of transportation are interesting. Jessie and Cookie did not mention the possibility of alternate modes of transportation (i.e., bus, cab). They stated if they did not get a ride with someone else they had to walk everywhere they went prior to purchasing a car. Their responses indicated that the experience of purchasing a car contributed to their lack of exercise because it gave them a choice of whether they wanted to walk or drive to get to their destinations.

Some of the participants stated that they had exercise equipment such as a stationary bicycle and weight machines at home, but this was not enough to motivate them to exercise. This situation affected some participants' perceptions about their exercise success or failure. Janna stated:

> I have a bicycle at home, a stationary, and yet I don't even use that. So I know there are things I need to do, and I haven't forced myself to do it on a regular basis.

Jessie had a similar experience. She explained:

> I tried exercising just on my own around the house. But I'd say it probably didn't last more than two or three weeks. Then there would be a break. I probably stopped for another few months, then start back maybe two or three weeks, and then just stop.

Ginger said that she thought buying weight machines would really motivate her to exercise. Instead, she found that once the weight machines were purchased, she had no desire to use them. Ginger commented:

> I have two weight machines at home that my husband has purchased and I find that I will not do that (exercise) at home. I will not get on a rowing machine. I've had a rowing machine and I've had a bicycle. I don't like that. I don't know if it's that it's in the home setting and I don't look at a home setting as a place for exercising or what. But I find it doesn't work. That doesn't work for me.

Willett mentioned that she had exercise equipment at home, but never started exercising, so she decided to sell it.

Willett stated:

> I have exercise equipment in my garage, which is not doing me any good. But that was when I was highly motivated. Well, since I'm not going to the center, I'll just do it in my home. I'll convert this room or I'll put it in the den and bicycle in front of the TV. Never did get started, so, now I'm having a garage sale to sell my own equipment.

The participants described their experiences at a health club. Sarah stated that she did not agree with paying fees when you are not working out. She also mentioned that the health club was not appealing to her. Ginger stated that she felt obligated to go and exercise if she was

paying for it. The following excerpts describe their experiences.

Ginger commented:

If I pay to go to a class I'm kind of more tied into it.

Sarah talked about how she thought it was a waste of money to pay for the use of a fitness facility when you are not using it. Sarah declared:

> I guess basically I don't want to really put up that kind of money to do what I need to do. I know people from past experience, they'll go all out in paying all this money to go to these gyms and everything to exercise, do it for a couple of months and they go, oh well, I'm too tired. I would like to go to a place where I can go and just pay as I want to go and not have to come up front and say you owe, you pay this much to join and then you have your membership is to go in and use it, I'll give you ten dollars to let me use your equipment and I'll pay you ten dollars when I come back again. So, I guess it's the amount of money to me it's a frivolous cost.

The participants' perceptions about the difficulty of adhering to exercise were linked to their reasons for not joining a health club. The women made it clear that their desire to exercise was always weakened in some way by their perception of money needed to join a healthclub. Their perceptions about joining a healthclub were based on whether or not these healthclubs could satisfy their needs. These participants revealed different needs in terms of exercising at a healthclub. Some needs were related to the content of financial means needed to join a healthclub. In other words, the women mentioned that healthclubs were expensive and they could use the money some other way. Other needs

were associated with the need to pay for a healthclub facility that one is not using. The participants believed that if they paid for but did not use the healthclub, then they were throwing away money.

Subtheme IV: Negative Aspects of Exercise

Some of the participants described negative aspects of exercising such as sweating. For some, the thought of perspiring closed the possibility of exercising. There were descriptions of their colleagues at work exercising on their lunch breaks and returning to work afterward.

Sarah maintained that she had no desire to sweat:

> I'd go through periods of maybe doing a little bit of trying to do a little bit of exercising and walking, but not really sticking with it. I hate to sweat.

Ginger, like Sarah viewed sweating as somehow being a very personal experience, asserting that she is uncomfortable when she sweats. Ginger stated:

> Okay, now this is going to sound really dumb, but it's the actual honest to goodness truth, I hate sweating. I mean, I hate, like the way I feel once it's done. But I hate being sweaty. There are people who walk, they bring their shoes and they go to the facility close by here at work and they walk at lunch time. I can't do that kind of thing because I perspire and I feel very uncomfortable when I'm like that. So, you know, immediately, whatever it is I do, I must take a shower right afterwards and get fresh again. So, that aspect of it [exercise] is uncomfortable for me. That sounds really silly, but it is true.

Anna revealed that she did not like to sweat. She stated that if she perspired she would have to take a shower before putting her regular clothes back on for work. Anna noted:

> I just don't like walking in the afternoon and perspiring, and have to come back and sit down and start working with my clothes on.

Willett also stated that she would need to take a shower before putting her regular clothes back on. Willett said:

> You know, if you were not one to undress or dress in front of people and not wanting to get my hair wet for swimming, not wanting to be able to take a shower and put my clothes back on and go to other, another class and I'm like that sort of now because the idea of putting clothes back on without a shower, I don't think I could do it.

For these participants perspiration is undesirable and linked with a negative aspect of exercise. For them, it is easier to skip the exercise and therefore, not have to worry about taking a shower before going back to work.

The participants discussed other negative experiences, for example, feeling frustrated by the difficulty they had during certain periods of exercise. Sometimes the changes were necessitated by factors beyond the participants' control such as an injury. Sarah, Anna, Cookie and Ginger reported experiences of injuries that occurred while exercising. Sarah was injured three different times in her life when she was exercising. She noted that these injuries had an effect on her

willingness to try exercising again.

Sarah revealed:

> So we took the bikes out to the park. They had a Civil War Memorial Park. One section was very steep and hilly. The other kind of mild. My husband liked the steep part. He took me over there one day and I never got on a bicycle again. I fell off and tore my everything up, arms, and everything. And that was the last time I rode a bicycle. I went back to doing nothing, and I think that was the last time I ever did a lot of exercising.

Sarah went on to talk about another incident that had occurred:

> Then after having the baby I took aerobics classes, but aerobics were not good for me because of my knees, because of my experiences in high school getting whacked in the knee with the hockey stick. It messed something up in my knee so that was not a good experience. My knees would swell and get stiff, you know, really had trouble with it. So I had to stop that for a while. Two or three days later here it comes again. The knees would start, you know, swelling so aerobics were not good for me. I couldn't handle them.

Anna, Cookie and Ginger described having back pain from their experiences with exercise.

Anna explained:

> It was one, I don't know what bone, what, the vertebrae you call this back here. But it knocked it out of whack because the weight, the pounds of the weight were entirely too heavy for me to be lifting at the time. And I became injured and once I got injured and I believe it was like that for a long time, maybe two months or more. I had to go to the doctors and all. So that turned me right off.

Cookie had this to say:

> I was doing real good until October, September of last year, I hurt

> my leg and that took forever to heal. It was my sciatic nerve. What happened was I was having back problems. I went to the emergency room and they gave me crutches and you know, kind of crazy stuff. I was really in pain. But anyway that ruined my exercise program that I had been on.

Ginger stated:

> I probably would still be in that (exercise) program had it not been for the fact that I was experiencing some problems with my back.

Interestingly, the participants also mentioned illnesses that limited their ability to exercise. Willett was ill due to smoking, and Janna has a pre-existing medical condition. Willett talked about how she had to stop exercising due to a recent illness.

Willett noted:

> But I smoked until I became ill very recently, and so I stopped exercising.

Janna stated that her experiences were limited because she could not do anything about her illness. Janna said:

> I have a condition known as sarcoidosis. I don't know if you know anything about it, but it's one of those conditions that is a chronic condition and it affects my respiratory system. So the stamina is not there. I have been on medication since my daughter was two-years-old and she is now thirteen. So that's a long, long time. And within that time period of being identified as sarcoidosis, I have been in health programs at the University of Tennessee Medical Center where they have a cardio-pulmonary workout session. I was there for about a year and a half.

The participants stated that illnesses and injuries were responsible

for them being turned off from exercise. The participants said they were determined to survive their illnesses and injuries. Unfortunately, this survival did not include participating in exercise.

Subtheme V: Personality Factors

Personality factors also contributed to these participants' lack of exercise. Some participants discussed feelings of laziness when it came to exercising. Helen described wishing that she did not have to walk from her car to her house. Helen said:

> Here lately, I've not done anything myself, anything to exercise. No bike riding, no nothing. As a matter of fact, I'm so lazy now, if I could drive my car all the way up into my house, I would to keep from that little walk.

Sarah commented:

> Just exercising in itself, I've just gotten lazy and don't want to do it. You get to a point in your life where you say, you go, what's the use.

Anna also believed that she was not doing enough exercise due to her laziness. Anna stated:

> So now, I exercise a little. I should do more, but I'm lazy.

These participants gradually developed a perspective about laziness. Some participants stated that they wanted to exercise when

they arrived home each day, but were unwilling to go out again. Cookie mentioned that if she was going to exercise a particular day, the decision had to be made before she arrived home.

Cookie stated:

> I go straight home and whenever you go straight home you sometimes you don't want to come back out. And sometimes I make myself come back out, you know, and go walk.

Ginger also indicated that she was not motivated to leave the house to exercise once she arrived home. She stated that if she was going to exercise that she had to go straight from work. Ginger asserted:

> I find that I must go straight from work there. Once I go home, I will not make myself change clothes and go back out and do it. I would always go (exercise) straight from work. I would change clothes and go straight from work to the facility, exercise, and then go home. I found that was successful for me.

Willett noted:

> It's just that I got out of the habit. When I get off from work I want to go home, take my clothes off, read my mail, work my puzzle, see my kids.

Anna added the following:

> To me, after five o'clock I'm ready to go home.

The participants' level of motivation was highly variable. In the past, Ginger was motivated to exercise because of her desire to go after work. Willett, Anna and Cookie were satisfied with only exercising periodically. They did not want to exercise directly after work, nor did

they want to leave the house to exercise once they arrived home for the day.

Subtheme VI: Social Support

A major factor motivating some of the women to participate in exercise was social support. For instance, having an exercise partner was a powerful motivator for the participants to exercise. The following excerpts explain how social support motivated Helen, Janna and Cookie to exercise.

Helen reported:

> I would probably have to be in a program with some other women. You know, I tried that at one time and we decided we'd throw in the kitty and whoever lost the most weight would win the kitty. That was interesting because then you're shooting for something besides just, you know, self-gratification or whatever. The money was enticing because you would figure well, and you'd lose the weight too. Maybe buy yourself an outfit or something. But I didn't win the money. The other lady won the money and she bought everybody lunch.

Janna explained how she stopped exercising when her partner stopped. Janna said:

> In college I did a little tennis with a roommate who was a PE major. So she would get me out in the evenings and on the weekends because she wanted to play and she needed a partner. That was essentially all. So what I didn't do with my roommate, I really wasn't active at all.

Cookie had a similar experience. She stated:

> We did start exercising when I was in college cause I had a cousin that was really into, you know, fitness and everything, so we wanted to look like her, and she was in college. She was older than we were. So she got us on, my sister and I, on an exercise program and we were exercising together. My sister and I kind of worked out together and walked together. We just made a point to do that.

Cookie also mentioned that when she didn't have an exercise partner she no longer participated in exercise. Cookie declared:

> And then we moved out here, and I really got inactive, you know, because I think I didn't have someone to, you know, a partner, exercise partner or anything. I never really got back into, you know, really exercising or anything, and that was back in '86. There was an old lady who worked here and she's retired now. She had to retire for physical reasons. And she's the one who really got me into walking two years ago.

The participants believed that if they had social support from family and friends they would exercise more. This belief gave much meaning to their exercise effort. Another pattern which emerged from this group was that most of the women were aware that they needed to exercise with someone. The pressure from their exercise partner seemed to work toward motivating them to exercise when they were not motivated to exercise on their own.

Theme II: Self-Image/Current Body Weight

The participants discussed the importance of how they felt about themselves. The perception of how others felt or behaved towards them

also was important. The intense power of the emotions expressed in many of the interviews regarding the concern the participants had in the area of body weight indicated that these concerns were a central aspect in their lives.

Anna revealed her complicated feelings about her weight gain and how she thinks it is perceived by others. Anna declared:

> When I was in college and got married and started having children, and then I began that bulge in my stomach and that's when I felt the need to start. But I don't do it with any intensity or I felt a need to do it on a consistent basis because I was never a large person. My bone structure is, I'm small boned.

Cookie's response about her body type was just the opposite of Anna's. Cookie stated that she was always a large woman. She remembered different periods in her life when she was a smaller size. Even though she was smaller, she recalled that she was never (unlike Anna) a small woman. Cookie wanted to make other people realize that although she was not a small woman, it was not because she was not able to lose weight, instead it was because she had always been a large woman. Cookie explained:

> I've always been a big woman and I'm considerably bigger now than I was when I was, when I was in high school or anything. But I've always been big. I've never been little. I guess I was mid-size. I think the biggest I was when I was coming up maybe was 180, which is heavy, but it's a lot lighter than I am now. Let's see, when I got into college I thinned down quite bit. But I think I have gained about, I said at one time, it was ten pounds for every year I've been here. I know it hasn't been ten pounds, but it just feels

like it. Now I think I've gained the whole thing back. But I now I'm trying to you know, work back into, but it takes a heck of a lot to get back into it gain.

Similar to Cookie and Anna, Jessie admitted that she was aware of her weight gain over an eight year period. Jessie stated:

I've gained a lot of weight. Probably about 50 pounds over about an eight year period. I didn't do any exercises and stayed home with the children and watched television. Hardly any exercises at all except for housework.

Willett emphasized that she wanted to look good. She noted:

I was very conscious of wanting to keep my 24-inch waist. Yes, I brag about that. I was so proud of the way I looked having one child, and I thought oh, I still look so good. Cause my wedding dress was a 24-inch waist. I wanted to look good as a mother of two children.

On the other hand, Willett added:

I am very dissatisfied with myself because I've gained weight and I'm no longer wearing the size that I wore all of my life, even through pregnancy. And to show you how desperate I was, I asked my doctor could I have liposuction. I felt that if I could just get the fat off of here then I could get back down and lose the pudge. But my doctor does not believe in it at all, and he figures that you can be more disciplined and control yourself. He said I will absolutely not recommend you because I needed his referral for my insurance purposes, you know. And I said, really, I'm so unhappy with myself, please, if you get me started, let me have liposuction, take all this unnecessary fat out of me, I'll start over and I'll really do real good. He wouldn't do it. I have a girlfriend who is about my age and she just had liposuction and she looks tough, let me tell you. She puts her blouses inside and can wear a belt. I can't do that, see, and I'm really jealous of her, and I told her how good she looks, because I do believe in giving compliments. But she had liposuction. As a matter of fact, she had it twice. Emotionally I don't feel good about me because I never looked like this, you

> know. I'm just sitting here talking with you today, and I'm sure it's 90 degrees outside, I have on a jacket because this is my camouflage so you can't see how round I am.

Willett concluded by stating:

> I'm not in the best of shape, not by a long shot, but sometimes you have to stop and say am I satisfied with where I'm at? I could always lose more weight, which is one of the things I go up and down on, but at the moment I think I'm kind of okay with it. Maybe not with my husband, but my own, with myself for right now, now I don't want to do it. So I'm one of your sedentary people who just likes to get by with all, only on what I necessarily have to do, actually required to do and that's it. I don't want to do any more than that.

Another aspect of their self-image was seeing themselves in comparison to others. Sarah reported visiting a gym and watching health club participants from a distance.

She stated:

> I don't particularly like going to gyms or to any of those centers and places like that. They don't appeal to me because they seem to be a bit, how can I put it? False glamour type places. Of course, you don't want to go in with a body like this, then you see all these firm butts and things walking around. I don't like them.

Many participants talked about how hard it was to lose the weight they had gained. This concern affected their self-esteem. The participants also had problems in adjusting themselves to their weight gains as adults. However, the participants' low self-esteem for the most part had no effect on their motivation to exercise. As a result, these participants still did not initiate any type of exercise.

Subtheme I: Modest Goals

The participants in general perceived themselves as powerless in in their ability to effect significant change. They were happy with even the modest weight loss. The following excerpts illustrate these complex feelings.

Anna mentioned that she knew she was overweight, but she did not think that she had a weight problem. Anna said:

> As soon as I start losing a pound or two, I don't feel that I really have a weight problem, but it would make me feel healthier. Take some of the baggage off the shoulders that you carry day to day.

Cookie, like Anna was aware that she was overweight. She had gained a sense of what she did achieve (weight loss) and what she did not achieve (did not gain all the weight back) in terms of weight gain. Cookie emphasized:

> I think I've gained about ten or more like twenty pounds back. But at least I haven't gained the whole thing back.

Helen's response about her weight gain was similar to Cookie's and Anna's.

Helen added:

> If I exercised or I walked and I lost five pounds or whatever that I wanted to lose, then I was done with it.

These participants' motivation to exercise varied with weight gain and loss. All three participants seemed content with the modest weight losses that they had experienced in the past. Exercise solved an

immediate concern to them that was no longer motivating.

Theme III: Unrealistic Expectations

All participants had previously exercised regularly for at least three to six months, and then stopped for at least three months (sedentary relapse). Currently, all participants were living a sedentary lifestyle. The participants described experiences in which they had been living a sedentary lifestyle for years, but one day decided that they were going to lose the weight they had managed to put on over the years.

The participants described how they were disappointed when they did not see quick results. Jessie talked about how she thought that she could lose all the weight she had put on over the years in one week. When she realized it was not going to happen, she stopped exercising.

Jessie commented:

> I don't know, probably cause I didn't see any results, cause I was exercising to lose weight and plus I didn't change any of my eating habits. I try to diet but, at the same time I was exercising, I was dieting and probably because I didn't see any quick results and just gave up and never did make a routine of it.

Willett stated how she tried to lose all the weight she wanted to lose in one week. She explained:

> I thought I could look good in a week. So I went (to the health club) and I begged, I knew what the equipment was like. I got on this equipment and I'm working at breakneck speed. My pulse started

> racing, my heart started racing and I had to sit down. So the lady (at the health club) came over and said, Hon what's the matter? I said, I'm just sort of out of breath. She said, I think you were going too fast. She said weren't you here yesterday? And she asked me how old I was and I told her and she gasped for breath. She said I didn't realize you were that age. She said come every other day for like fifteen minutes, then work gradually up. Oh no, I said I'm coming every day and she said I really can't let you come everyday cause we're liable for your health. When she instructed me to start coming every other day, it broke my routine. She broke my routine, so I just stopped going altogether.

These participants spoke of learning to make use of the knowledge they had acquired about exercise and weight control (i.e., knowing they needed to change their eating habits). Such insight-oriented experiences gained a particular prominence in those interviews in which the participants emphasized the importance of a personal interest in losing weight quickly. While the participants stated that they knew what to do in order to lose weight, they had unrealistic expectations of losing the weight immediately. As a result of not getting quick results, there were references to "feeling upset," "guilty," or "disappointed" in relation to sedentary relapse.

Theme IV: Lifestyle Change

A gap that hasn't been bridged successfully seemed to exist between the participants' aspiration for healthier lives and their realities of attainment. This was demonstrated by their acknowledgment of the health benefits of exercise contrasted to their current lack of engaging in

exercise on a regular basis. Although they were somewhat motivated by a desire to feel better, these women knew they would have to change their lifestyles. Obtaining a healthier lifestyle was perceived as a way of escaping their unhealthy environment. As a result, the ambitions of these women were consistent with those found in the literature; that is, one that is shared by many women, to feel better and have a healthier lifestyle (Dishman, 1994). Although the participants expressed that they had a desire to live healthier lifestyles, their sedentary lifestyles suggested otherwise.

Subtheme I: Lack of Interest and Motivation

Frustration and anger were common emotions expressed by the participants when discussing their lack of motivation to exercise. Sarah noted how she would rather do other things (not exercise) when she had time:

> Like I said, it's a feeling you have, it's like losing weight and going on a diet. You have to really, you have to want it and say that this is what I am going to do. Nothing's going to get in my way. And if you don't have that attitude, which I don't, it's not going to happen. I sit and watch and look and read and everybody comes up with these brilliant ideas to do this and do that, and I'm like no, that's okay. I don't want to participate.

Cookie recalled how important it was for her to think of exercise as something that she needs to strive to do:

> I just have to, I know that you know what I have to do is get myself

> motivated to get back into that mode and start doing what I need to do to continue to lose. I know I can't lose it fast. I've got to lose it slow. And I've got to get fit.

Willett described what [to her] was a very serious matter. She had a lack of interest in getting motivated to exercise. Although she had thought about it frequently, the reality of not being able to adjust her lifestyle so that she could adhere to exercise left her unable to talk in any depth about it.

Willett declared:

> Maybe I have to laugh at myself to get seriously motivated about myself so I can get back looking the way I want to.

The participants' responses indicate a lack of interest in exercise and a resistance to changing their current lifestyles. Their attitude toward changing their lifestyles varied over time and circumstances. Sarah, Cookie and Willett indicated that currently they did not have any interest in exercising.

Summary

The themes indicate that the participants' experiences were complex. There was an interplay among the themes that wove together to make the overall experience. Many participants perceived themselves as needing to have more control over their lives, and in order to exercise regularly, their ability to effect change. The participants' experiences with sedentary relapse varied in duration. Some experiences were short, as in

"not exercising in three months" or longer, as in " not exercising for at least ten years." Also implied was that some sedentary relapse experiences were to be expected, for example, when an exercise partner did not show up or when there were "too many commitments."

The four themes that emerged from the interview data were not isolated, distinct themes, but were interrelated and connected to each other. The majority of participants' worries involved "what ifs" about their health due to their weight gain. Participants expressed feeling many concerns for their present weight, and also were aware of their frustration and anger regarding their sedentary relapse. The participants were acutely aware that their weight made them more vulnerable to health problems. Despite the participants' knowledge of the health benefits of exercise and their positive exercise experiences, they described themselves as presently unaware of their weight control behaviors on a day to day basis. The participants described being acutely aware of the severity of their sedentary lifestyles on their health. They painfully expressed the reality that they may have health problems if they did not confront their weight problems.

The past and the present were both described in terms of significant events and feelings. Significant events included family, amount of weight gain and perception of self. All participants discussed many emotions surrounding these significant events. The women in this

study were keenly aware of the fact that they had not been active and not worried about their weight. As sedentary adults, many times their feelings were described as "apathetic," "burdened" and "worrisome." They tended to emphasize the present, rather than dwell on the past, and described how their weight had affected their adult lives and relationships. They described relationships with family members as being very important to nurture and maintain, often at the expense of maintaining a program of exercise.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The primary aim of this study was to gain an understanding of African American women's sedentary relapse experiences. More specifically, using a qualitative approach involving semi-structured interviews, an attempt was made to explore the following factors as they related to the experience of African American women's sedentary relapse: a) barriers; b) adherence; c) type of physical activities; d) location of activities; e) motivational factors; and f) how past activity might influence future participation in an exercise program. Sedentary relapse was defined as: previously exercising continuously for three to six months, then stopping for at least three months (Dishman, 1994).

Analysis of interview data produced four themes that described the structure of the participants' experiences. These themes were: 1) Barriers/Motivators; 2) Self-Image/Current Body Weight; 3) Unrealistic Expectations; and 4) Lifestyle Change. This chapter presents a discussion of the results as they relate to other literature on the topic of sedentary relapse. Thematic structure is discussed in relation to the concerns of the participants that were perceived to be tied to their experiences of sedentary relapse.

During the interviews, the discussion moved back and forth among all four themes. Subthemes augmented the four primary themes and illustrated the multifaceted depth of the participants' sedentary relapse experiences. Although each participant's interview provided a unique description of her experience with different themes and subthemes emphasized, the four primary themes were present in all of the interviews.

The perception of how much control the participants perceived they had over who they were varied: some believed that if they had more discipline in accomplishing their goals, that would change them. Others believed that they were who they were and "no amount of discipline can change that." The participants were quick to point out that they were below average in exercise adherence when compared to their peers, but they did not see themselves as particularly different from the rest of the African American population. The perception that they were "like others" was interpreted as a positive aspect for their future success, but also a factor that contributed to their sedentary relapse experiences.

Discussion of Results by Theme

In this study an interview approach was used to gather first-person descriptive data from African American women about their experiences of sedentary relapse. In the following section I address the participants'

experiences through a thematic description of experiences of interpersonal connections.

Barriers/Motivators

Perceived obstacles prevented the participants from engaging in exercise on a regular basis. Lack of time, commitments to and responsibilities for family and others, negative aspects of exercise, personality factors and social support were the most prevalent subthemes that emerged from the primary theme Barriers/Motivators.

Wilson, Wagner and Dwyer (1991) suggested identifying individuals with lower perceptions of motivation, and providing these individuals with support and encouragement. In their study, factors were identified that may be used to help predict which participants were likely to adhere to an exercise program. If not identified, these factors could serve as barriers to exercise. The first factor was the individual's perceived motivation prior to beginning the exercise. Another factor was the individual's perception of having an adequate amount of time to exercise. They suggested that an exercise program should be time efficient.

Time/Commitments to and Responsibilities for Family and Others

The participants described a variety of commitments and responsibilities that prevented them from exercising regularly. These

commitments and responsibilities included family, church, and social organizations. Family obligations were mentioned most frequently. Many of the women have school-age children who demand attention.

Walcott-McQuigg (1995) found that African American women were less likely to exercise when exercise activities conflicted with their family responsibilities. Several of the women were rearing children as single parents. Even the women with grown children were over committed with aging parents or other obligations. Verhoef and Love (1992) reported that parenthood was one of the most significant barriers to exercise for women; specifically, parental duties affected the amount of time they were able to spend in exercising. These findings suggested that the over-committed way of life that has become common in our society contributed to the sedentary relapse experiences of these women.

Negative Aspects of Exercise

The participants appeared to be very much aware of the positive health benefits that can be gained from exercising regularly. However, this awareness seemed to be fostered by previous negative experiences with exercise, such as injuries that were sustained as a direct result of exercise. Some participants experienced injuries such as "back pain" and "knee pain." These injuries presented themselves as large hurdles that the participants could not get over.

The findings in this study were consistent with Stephens and Craig's (1990) study of women's barriers to exercise. In their study, women reported that injury played an important role as a barrier to exercise. Many of the participants in the present study who had been injured during or due to exercise stated that they had not participated in exercise since the injury.

Another negative aspect of exercise was sweating. The discomfort of "sweating" and needing a "shower" were reasons the participants decided not to participate in walking on their lunch hour. They had "no desire to sweat." Society has contributed to the negative image of looking and feeling sweaty, especially among females. Currently, there is a deodorant commercial that is run daily on television that states "sweat stinks." This commercial shows very sweaty people working out at the gym as well as walking in the park. It is unfortunate that the media has portrayed such a negative image about perspiration, a natural bodily function. Popular themes such as these may have contributed to the participants' feelings of not wanting to exercise during their lunch hour unless they were able to shower before returning to work. Many of the participants viewed sweating as too much of an inconvenience. It was clear that the participants' experiences of sweating due to exercise affected their willingness to participate in exercise during their work hours.

Personality Factors/Social Support

The participants indicated that social support was an important aspect of exercise adherence. Social support had both a positive effect and negative effect on some participants' willingness to engage in exercise. Participants experienced social support as positive when they received helpful, constructive feedback from their family and friends, or when family or friends were willing to exercise with them. When their environment was supportive, exercising was easier. A powerful motivator was "having someone to exercise with." For instance, one participant recalled how her "sister would walk with her" as well as "a lady from work." This participant exercised until this social network was unavailable, then she relapsed into a sedentary lifestyle. Negative experiences were reported by some participants when they felt unsupported.

The participants' experiences echo previous studies that have consistently supported the contribution of support group participation to increased adherence to exercise (Dishman, 1994; Reed, McLeod, Randall & Walker, 1996). The present findings are in agreement with those of Bolla, DeJoseph, Norbeck and Smith (1996) which showed that social support has beneficial effects on the behavior of people. Willis and Campbell (1992) found that an exerciser's social support network included family, friends, co-workers, and other participants in an exercise

program. Greater attendance at exercise programs has been attributed to the buddy system, which is attributed to the reluctance of members to let each other down by their poor attendance or lack of effort (Willis & Campbell, 1992).

The importance of social support to exercise adherence also has been recognized by the American College of Sports Medicine (ACSM) (1991). This organization has suggested that assistance from members of an exerciser's social network should be elicited at the beginning of an exercise program.

Family and friends were more important sources of social support for some of the African American women in this study than were other social groups and therapists. This evidence strongly suggests that social support does not necessarily have to come from trained personnel. This is interesting to note because it is in line with other discussions on this subject, particularly as they pertain to a person's mental health. For example, Reed, McLeod, Randall and Walker (1996) found that African American women who had social support from family members had lower levels of depression. Warren (1997) found that relationships with others can affect perceived self-efficacy.

Self-Image/Current Body Weight

To understand the theme of self-image/current body weight, it is necessary to discuss briefly what has been written concerning self-esteem that is tied to a person's self-image. As stated in the review of literature, the definition of self-esteem that is most widely accepted is that of an internal image of oneself that is influenced by the perception of others (Rosenberg, 1965; Beeber,1996). Characteristics of individuals with high self-esteem include willingness to take risks, liking themselves, satisfaction with life, self-respect and self-acceptance. In their study of racial identity and self-esteem, Speight, Vera, and Derrickson (1996) reported that African American women with high self-esteem had a self-attitude of respect, appreciation and merits, a sense of being worthy and an ability to accurately measure weaknesses and strengths. In contrast, African American women with low self-esteem viewed themselves as deficient and inadequate (Ra Imani, 1996).

The findings in this study supported those of the previously-mentioned studies on self-esteem. For example, many of the participants stated that they were aware of their bodies and the way that they looked. One participant shared her experience of previously bragging about her "24-inch waist" and her pride in the way she looked. In contrast, now she is dissatisfied with her appearance. She noted that she had been so desperate to get her 24-inch waist back that she had consulted a

physician about liposuction. This participant stated that her husband was not okay with her weight. She concluded by saying that she realized she needed to lose weight, but currently she was "okay" with the way she looked.

The concept of the role the media plays in persuasion is important to note in terms of one's self-image. The media portrays "skinny" as the preferred way a woman should look. All the participants in the present study were living sedentary lifestyles and were overweight. The women in this study stated that they did not see many images of themselves on television that portray beauty. The participants demonstrated through their own projections of self-esteem that they render the traditional standards of beauty in mainstream society such as, being young, White and thin unattainable.

The general standard of beauty in our society can be thought of as a commercialization process in which beauty becomes a commodity rather than an absolute consideration. Largely an intentional consequence of the media, this commercialized trend has resulted in a situation that distances many women in our society. Unfortunately, for many decades the media has been a regulator of our free market economy in terms of what is considered desirable and it affects many of the public's views about what women should look like. The responses from some of these women suggest that is no longer the case, at least not

for them. While none of the women in this study fit the mode of mainstream society's "standard of beauty" many of them stated that they were "okay" with the way they looked, even though others in their lives may think otherwise.

Unrealistic Expectations

Some of the participants said that sometimes they would exercise and try to lose the weight they had put on over the years. However, their expectation was that this weight gain would be gone in a week. When they did not lose the weight in a week they would stop exercising. One participant stated, "I thought I could look good in a week."

The theme of unrealistic expectations was important because the participants knew that it was not realistic to expect to lose weight they had put on over the years in one week. Yet, even with this knowledge, the participants mentioned that they stopped exercising when they did not lose the weight quickly.

The findings in this study were consistent with Wilson, Wagner, and Dwyer's (1991) study on problems associated with participant exercise adherence. These investigators reported that participants who had more weight to lose were less likely to adhere to an exercise program. The extent of participant involvement in a "quick fix" exercise routine is a telling finding of the controversial and problematic nature of our society's

belief that everything should be done quickly (i.e., fast food restaurants, drive-through windows for food, dry cleaning).

Wilson, Wagner and Dwyer (1991) also suggested that education of the type and amount of exercise should be an important part of the program. Based on the interviews in this study, it appeared that the participants were knowledgeable of what was needed to lose weight. They spoke in terms of knowing the type of exercise and the amount of time that has been suggested by the ACSM (1991), but emphasized a need to want it [weight loss] now instead of doing what they knew they needed to do in order to lose it.

Lifestyle Change

Lack of interest and motivation was the subtheme that emerged from the Lifestyle Change theme. Many of the participants in the present study seemed to want to begin exercising regularly, but had a lack of interest and motivation. They were frustrated because of this, but as one participant put it, "I don't want to participate."

Another participant stated that she knew she needed to change her lifestyle in order to get interested in exercising. She was aware that she should get motivated to exercise, but she was not quite sure how she was going to get motivated. This participant stated, "I have to get myself motivated to get back into that [exercise] mode." The participants stated

that African American women need to be exposed to numerous exercise educational resources. "Decision making," "accountability," and "collaboration" were mentioned by the participants as determinants of the motivation to exercise. The participants' negative experiences with motivation to exercise involved refusing to start an exercise program for themselves because of lack of interest in taking the time out for themselves.

Recently, Evans and Nies (1997) recommended that lifestyle programs should be employed for overweight women in order to maximize the possibility of weight management program successes. They also suggested that lifestyle programs can be flexible and easier to work into a woman's everyday routine, thus, presenting fewer barriers. This trend toward lifestyle programs is expected to continue. It has been determined that for long-term success in a weight loss program, exercise must be a permanent part of a woman's lifestyle (Allison, Kanders, Osage, Faith, Heymsfield, Heber, Foreyt, Elashof, & Blackburn 1995).

Difficulties (i.e., injuries, illnesses) associated with exercise adherence affected the participants' interest in and motivation to exercise. Many of the participants mentioned that they needed to motivate themselves to put more effort into exercising. The participants recognized that there was a positive relationship between the effort they invested in adhering to exercise and the success they would achieve.

Some of the women in this study did not perceive that effort was tied to a lack of success in exercising. Instead, they tended to blame others for their sedentary relapse. For example, they attributed their non-successful exercise adherence to external causes such as having too many "family commitments" and "responsibilities." Other women's motivation was influenced by a general attitude towards life. These women tended to be "easy" on themselves, saying that they did not want to exercise and that they were satisfied with their bodies. The participants' lack of interest in and motivation to exercise varied according to the meaning that they attached to sedentary relapse. This was dependent upon their beliefs of how important exercise was to them in a particular situation.

A clear linkage between exercise adherence to personal goals and the commitment to achieving these goals was the most important factor that motivated these participants to exercise. Those who were clear about their goals and knew the meaning exercise adherence had to the achievement of their goals tended to be more motivated to exercise. On the other hand, those who did not have clearly-defined goals and did not attach great significance to exercising were less motivated to exercise. However, motivation to exercise does not necessarily translate into exercising. It was evident that irrespective of whether they had goals or

not, the women in this study needed to explore reasons why they are currently experiencing sedentary relapse.

The more the participants knew what to expect from their environment, the better they could adjust and persist in pursuing their goals. Preparedness for changes in their lifestyles and realistic expectations for exercise achievements are necessary to get participants interested in exercise and to sustain their motivation to exercise. In addition, the participants' previous ideas about and experiences with exercise affected their exercise participation.

The participants' barriers to exercise, and their motivation toward personal change, showed that homelife (partners), personalities and perceptions of exercise influenced their ideas about exercise. For instance, when the participants were asked about perceived barriers to exercise, their responses varied from "lack of time," "laziness" and "being tired," to "not being motivated." The response, "lack of time" is the number one reason given in the literature for not exercising regularly (Dishman, 1994).

Although participants did not come right out and say that lack of interest was a factor, this implication was evident. The results of this study were consistent with those of Sallis, Hovell and Hofstetter's (1992) research that examined the determinants of exercise in a community sample. They found that the highest non-motivating factor reported by

participants in their study was "lack of interest." As a result, they concluded that many people who do not exercise are simply not interested in doing so.

The participants in the present study found it helpful to learn things they thought would help them achieve their exercise goals. However, they did not express a clear understanding of how they were going to begin engaging in regular exercise. Comments about how exercise had improved their health revealed that these participants were actively striving for an understanding of exercise-related changes in health. Some of the women in this study mentioned that they had noticed a positive change in their health whenever they exercised. For instance, one participant noted that in the past, prior to exercising, she was "tired all the time." However, when she exercised she said, "I felt a rush."

It seemed that the participants' feelings about how their health had taken a positive turn whenever they would began participating in exercise was a catalyst for change. In addition, the participants' comments revealed that they were concerned about their personal health, but this was not enough to get them to exercise regularly.

The participants mentioned that exercise was "fun" when they were younger. In contrast, their responses about exercising as adults was negative overall. Many of the participants stated that their preferred type

of exercise as adults was walking, but it was a "chore." Their comments showed that while they had found a particular type of exercise that they thought was safe (walking), they still did not have the interest or motivation to "stick with it."

Summary

Participants in the current study described factors that led to their sedentary relapse experiences. Four integrated themes, Barriers/Motivators, Self-Image/Current Body Weight, Unrealistic Expectations and Lifestyle Change formed the basic structure of their experiences. Participants reported their experiences in both positive and negative terms. The type of changes that occurred in the participants' lives showed that their habits and attitudes toward exercise were complex and open to many interpretations. According to Dishman (1994), despite the known health-related benefits attributable to regular exercise, the available research suggests that exercise adherence is poor. Research also supports the proposition that the incidence of obesity increases with age, especially among women (Nelson, 1996). This appeared to be the case for the women in the present study.

Conclusions

The participants' comments suggested that experiences of sedentary relapse vary in duration. They may be short such as, "I've never gone more than three months without exercising," or longer, as in the ten years that one participant reported. The participants implied that sedentary relapse experiences were ordinary or "everyday," for example, as part of a daily routine, due to too many "commitments" and "responsibilities." On the other hand, some experiences with sedentary relapse seemed to stem from not having social support such as, "not having an exercise partner" or due to lack of interest.

If additional support is needed, African American women may want to look for support from a significant other, such as a spouse, friend, child or a support group. African American women should look for congruence between their lifestyles, personality and the type of exercise in which they decide to participate. African American women should choose exercise routines that represent their interests. Exercise adherence is a lifetime process that may be made more difficult if a person has little or no interest in the type of exercise they have selected.

Social support from others was helpful to many of the participants. Without social support some women may experience a prolonged state of uncertainty as they work through the process of factors leading to sedentary relapse. Subsequently, resolution of

sedentary relapse may be delayed because effective sedentary relapse strategies are not used. As a result, lack of regular exercise could result in health problems. Health care providers treating sedentary lifestyles should explore African American women's experiences of sedentary relapse. Primary prevention strategies might include teaching women to explore avenues for support and validation when unsure of the right way to begin an exercise program. Promotion of high self-esteem and health might be achieved through recognition of the usefulness of exercise adherence in changing self-behaviors and other's behaviors.

The results of this study have implications for health care providers or anyone who counsels women about health-related matters. Understanding women's sedentary relapse experiences serves as a check for the assessment of important elements in women's lives. Additionally, women may gain an understanding of their own realities of sedentary relapse through reading these findings. These findings should be helpful to health care practitioners who talk with reluctant exercise participants about enrolling in exercise programs.

Recommendations for Researchers

The qualitative research method provides a foundation for an understanding of the human experience. It is suggested that qualitative research methods be used in other studies related to African American

women's sedentary relapse experiences. The following specific recommendations for further research are offered:

1. Women from other race/ethnicities should be included as interview participants in addition to African American women. The inclusion of women from other race/ethnicities would provide additional perceptions of factors leading to sedentary relapse and whether or not there is a cultural link.

2. Women from other regions of the United States should be included as interview participants. This would provide further insight into the generalizability of sedentary relapse experiences of women.

3. The experiences of women of different racial/ethnic groups at different exercise stages should be examined. These stages might include currently exercising, recent sedentary relapse and long-term relapse.

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APPENDICES

APPENDIX A

INTRODUCTION LETTER

Hello,

I am currently a graduate student pursuing a Ph.D. in Sport Psychology at the University of Tennessee, Knoxville. I am doing a research study on the sedentary relapse experiences of African American women. The reason for this study is to gain awareness of how African American women's self-perception and self-efficacy are related to their sedentary relapse experiences.

Research has shown that within the first six months 50% of individuals will drop out of an exercise program. Nearly all the previous research has focused on responses from an overrepresentation of one group of women and an under-representation of other groups. I would like to compare the responses received from African American women.

The responses from African American women are critical in ensuring that results reported in research represent more than one group of female's attitudes toward exercise. This information will be crucial in determining the future direction of research in responding to issues of exercise and female diversity.

If you are an African American woman between the ages of 35-54 and have exercised regularly* in the past for a period of at least 3 months, but are not currently exercising regularly, I would like to request an interview with you regarding your sedentary relapse** experiences. Please complete the rest of this form or if you know someone who would like to be a participant in this study, please pass this information to her.

The interview will last approximately 30-60 minutes. Your responses will be audiotaped and transcribed. An analysis of the interviews will be conducted. You will have access to the results of your interview. Your answers will be strictly confidential.

This is your chance to be completely honest about your feelings toward exercise. If you decide to participate, my email and telephone number are listed at the bottom of this sheet. Thank you for your time and patience.

*Regular Exercise is defined as: Exercising at least three times per week for at least 20 minutes without stopping (i.e., exercise that is hard enough to cause a large increase in heart rate or breathing).

** Sedentary Relapse is defined as: Exercising continuously for three to six months, then stopping for at least three months.

Sincerely,
Serena Reese
Email *********
Phone Number (423) 974-1283

APPENDIX B

INFORMED CONSENT

You are invited to participate in a research project. The purpose of this study is to explore the sedentary relapse experiences of African American women. The interview is part of a research project conducted by Serena Reese to obtain her doctoral degree in Sport Psychology at the University of Tennessee, Knoxville.

You are asked to participate in an audiotaped interview that will last approximately 30-60 minutes in a place of your choice. You will be asked to share your lived experience of sedentary relapse. Subsequent questions will be based on your comments and responses. This interview will be audiotaped so that the principal investigator can use your words to compare with words of other women. These interviews will be transcribed into written form to allow comparative analysis. Your name will not appear on the tape or the transcript. Tapes and transcripts will be kept in a locked file at the University of Tennessee, Cultural Studies Department. You may contact the principal investigator following the interview and during the analysis to clarify the interpretations of your experience. Tapes and transcripts will be destroyed after completion of the study. No incentives are offered to you for your time and effort in participating; however, you may personally benefit by talking about your experience.

The nature and direction of the interview will be determined by you and the investigator and will unfold as the interview progresses. You may have concerns related to the potential sensitivity of disclosure of your personal feelings of sedentary relapse. There also is a possibility of evoking memories of emotional experiences. You are free to choose not to participate in this study or you can withdraw from this study at any time by notifying Serena Reese. Your audiotape and/or transcripts would be destroyed upon your request.

Any and all information you provide will be kept confidential. Neither your name nor any identifying information will be used in any reports although your words may be used to support the interpretation and analysis. At no time will your words be linked or traceable to you.

Your involvement in this study is an important step in understanding the sedentary relapse experiences of African American women. Should you have any questions or concerns in the future, you may contact Serena Reese at (423) 974-3340 or Dr. Craig Wrisberg, Serena's college advisor, at (423) 974-1283. In addition, if you have any questions regarding your rights as a research participant, you may contact the University of Tennessee Office of University Research at (423) 974-3466.

PARTICIPANT'S STATEMENT

This study has been explained to me and I voluntarily consent to serve as a participant in this study. I have had an opportunity to ask questions and understand that I may ask further questions at any time in the future by contacting the principal investigator named above. I can withdraw from the study at any time without penalty. I have received a copy of this consent form. I understand that I may receive a copy of the results of the study.

_____ _____ _____

(Participant's Signature) (Participant's Phone Number) (Date)

Principal Investigator: Serena Reese, University of Tennessee, Cultural Studies Unit
1914 Andy Holt Ave.
Knoxville, Tennessee 37996

APPENDIX C

INTERVIEW GUIDE

1. Tell me about your participation in exercise/physical activities during your youth.

2. Tell me about your participation in exercise/physical activities during your adult years.

3. Tell me about your current exercise, even if it is not regular.

APPENDIX D

TRANSCRIBER'S PLEDGE OF CONFIDENTIALITY

As the transcriber for this research project, I understand that I will be hearing tapes of confidential interviews. The information on these tapes has been shared with the principal investigator (Serena Reese), with the understanding that all material remain strictly confidential. Recognizing this confidential aspect of the interviews, I hereby pledge to keep all of the information on these tapes in the strictest of confidence, sharing it with no one other than Serena Reese or Craig Wrisberg, her doctoral advisor. Any violation of this agreement would constitute a breech of the ethical standards to which I herein pledge myself.

_____ _____

Transcribing Typist Date

_____

Serena Reese
Principal Researcher

VITA

Serena Reese was born in Dayton, Ohio where she attended Jefferson High School. In August of 1985, she graduated from the University of California, Los Angeles (UCLA) with a Bachelor of Arts degree in History. Upon completion of her undergraduate degree, Serena enrolled in the Master's program in Exercise Science at California State University, Long Beach, California. In August, 1996 Serena graduated with a Master of Arts degree in Kinesiology. She then enrolled in the doctoral program in Cultural Studies at the University of Tennessee, Knoxville in 1996. In the Spring, 1999 she received the Doctor of Philosophy degree in Education from the University of Tennessee, Knoxville. Serena is presently working as an Assistant Professor in the Physical Education Department at Spelman College in Atlanta, Georgia.