Rates of hypertension in the United States have been rising over the past twenty years. Unfortunately, African Americans are at higher risk for early-onset hypertension, placing African American young adults at increased health risk. Healthy eating and physical activity behaviors have been associated with increased blood pressure control and could serve as areas for intervention for the prevention of early-onset hypertension in young adults. Parents have been shown to influence the development of their children’s health risk behaviors, thus providing a possible point of entry for these interventions. The purpose of this study was to investigate the eating and exercise behaviors of mothers in relation to the eating and exercise behaviors, gender, and hypertension risk category of their African American young adult children (n=56 dyads, youth ages 17-20y). Mother and child took part separately in in-depth semi-structured interviews designed to elicit information about eating and physical activity behaviors. In addition, data was collected through descriptive questionnaire, diet history questionnaire (DHQ), and measures of height, weight, and blood pressure. Maternal eating behaviors were categorized into themes, and mothers were coded for each theme (1: reported behavior, 0: did not report behavior). Maternal and child DHQ output was assessed and scores were assigned to reflect adherence to the Dietary Approaches to Stop Hypertension (DASH) diet. Reported physical activity behaviors of mothers and children were assessed and categorized into themes. Physical activity scores were assigned based on participation in
purposeful exercise. Results showed that mothers of high-risk children were more likely to report consuming sweetened beverages (p=0.0030). Mothers of low-risk males were the least likely to report skipping meals, eating fast food, drinking sweetened beverages, and eating out more than once weekly (p=0.042, 0.013, 0.0021, 0.0017, and 0.056, respectively). Mothers of males were more likely to report walking for exercise (p=0.0204), while mothers of high-risk females were more likely to report being unable to exercise due to chronic medical conditions (p=0.015). Eight maternal eating behaviors were associated with DHQ output. Comparisons of mother and child behaviors showed strong inverse relationships between the number of reported eating behaviors of mothers and the intake of their high-risk or female children. In addition, active mothers of males were more likely to have active sons (p=0.033). These results suggest weak associations between maternal eating behaviors and child intake in this age group. Mothers of males, however, seem to have stronger influence over the physical activity levels of their male young adult children. Further research is necessary in order to better understand these relationships for the creation of effective interventions to prevent early-onset hypertension in African American young adults.
THE RELATIONSHIP BETWEEN MOTHERS’ LIFESTYLES AND THE LIFESTYLES AND GENDER-HYPERTENSION RISK CATEGORIES OF THEIR AFRICAN AMERICAN YOUNG ADULT CHILDREN

by

Tiffany Brooke Morton

A Thesis Submitted to
The Faculty of The Graduate School at
The University of North Carolina at Greensboro
In Partial Fulfillment
Of the Requirements for the Degree
Master of Science

Greensboro
2010

Approved by

Committee Chair
APPROVAL PAGE

This thesis has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair
Margaret R. Savoca

Committee Members
Martha L. Taylor
Tracy R. Nichols

Date of Acceptance by Committee

Date of Final Oral Examination
ACKNOWLEDGMENTS

I would like to acknowledge my mentor, Dr. Margaret Savoca, for her guidance throughout this research. I would also like to thank my committee members, Dr. Martha Taylor and Dr. Tracy Nichols for advising me throughout the research and writing process. In addition, I would like to express my appreciation for funding provided by the National Heart Lung and Blood Institute (R21-HL077502) which made the collection of this dataset possible. Finally, I would like express my gratitude to those who chose to participate in this study, without whom this investigation would not have been possible.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
</tr>
</tbody>
</table>

## CHAPTER

### I. INTRODUCTION

1

### II. REVIEW OF THE LITERATURE

4

- Hypertension
  - Clinical and Financial Consequences
  - Risk Factors
  - Prevalence
  - Prevalence in African American Youth
  - Gender Differences in African American Youth
  - Lifestyle Changes That Lower Blood Pressure
  - Intergenerational Transmission of Health Risk Behaviors
  - Maternal Influence and Child Eating Behaviors
  - Maternal Influence and Child Physical Activity
  - Maternal Influence and Child Obesity
  - Maternal Influence and Other Child Health Risk Behaviors
  - Conclusion

19

### III. METHODS

21

- Participants
- Data Collection
- Measures
  - Identification of Eating and Exercise Behaviors
  - DASH Diet Indices
  - Dyad Concordance
- Statistical Analysis

27

### IV. RESULTS

28

- Participants
  - Aim 1: Maternal Behaviors by Young Adult Risk and Gender
  - Eating
  - Exercise
  - Aim 2: Maternal Eating Behaviors by DASH Indices

34
Aim 3: Dyad Comparisons ................................................................. 38

V. CONCLUSIONS .............................................................................. 42

Discussion.......................................................................................... 42
  Aim 1: Maternal Behaviors by Young Adult Risk and Gender .................. 42
  Aim 2: Maternal Eating Behaviors by DASH Indices ...................... 44
  Aim 3: Dyad Comparisons ............................................................ 46
  Conclusions ................................................................................... 47

VI. EPILOGUE ...................................................................................... 50

REFERENCES ..................................................................................... 52

APPENDIX A. YOUNG ADULT CONSENT DOCUMENT ............................ 59

APPENDIX B. PARENTAL CONSENT DOCUMENT .................................... 64

APPENDIX C. CHILDREN’S ASSENT ................................................... 69

APPENDIX D. MOTHER INTERVIEW .................................................... 72

APPENDIX E. CHILD INTERVIEW ........................................................ 79

APPENDIX F. NATIONAL INSTITUTES OF HEALTH DIET HISTORY
  QUESTIONNAIRE ............................................................................. 86

APPENDIX G. MOTHER DESCRIPTIVE QUESTIONNAIRE ..................... 122

APPENDIX H. YOUNG ADULT DESCRIPTIVE QUESTIONNAIRE ............ 123
LIST OF TABLES

Table 1. Point assignment criteria for calculation of DASH score based on the research of Mellen et al. ................................................................. 24

Table 2. Point assignment criteria for calculation of DASH score based on the research of Folsom et al. ................................................................. 26

Table 3. Descriptive characteristics of maternal participants............................ 29

Table 4. Descriptive characteristics of young adult participants.......................... 29

Table 5. Examples of comments for maternal eating behavior categories................. 31

Table 6. Maternal eating behaviors stratified by child risk-gender category .......... 32

Table 7. Examples of behaviors for maternal exercise categories........................ 33

Table 8. Maternal exercise behaviors stratified by child risk-gender category.......... 34

Table 9. Associations between maternal DASH scores and reported eating behaviors ........................................................................................................ 35

Table 10. Intake levels assessed for associations with reported eating behaviors ............................................................................................................ 36

Table 11. Directional relationships between maternal eating behaviors and nutrient or food intakes and associated p values ........................................ 37

Table 12. Child DASH indices and mother eating behavior sum by child risk and gender category ........................................................................... 39

Table 13. Qualifying young adult physical activity behaviors for exercise categories .................................................................................................... 40
CHAPTER I
INTRODUCTION

Rates of hypertension (HTN) in the United States have been increasing over the past two decades and reached 32% for adults over 20 years of age between 2003 and 2006 (1). African American adults in this age range experience even higher rates of HTN (females: 43.5%, males: 40.6%) compared to whites (females: 28.6%, males: 27.6%) (1). Unfortunately, HTN also affects African Americans at younger ages, with African American youth having a higher relative risk of pre-HTN and HTN (1.81 and 1.33, respectively) compared to white youth (2). In addition, African American youth experience higher measures of systolic blood pressure (SBP) as early as 14 years of age in males and 9 years of age in females (3). As African American youth move into adulthood, they experience disproportionate rates of heart failure that have been associated with high measures of diastolic blood pressure (DBP) (4). These findings suggest that African American youth are at an increased risk for early-onset HTN as well as life-threatening co-morbidities associated with uncontrolled high blood pressure (HBP).

Although several risk factors for HTN are non-modifiable (such as older age, male gender, and African American race), health behaviors play a strong role in controlling blood pressure (BP) and preventing the onset of HTN. Modifiable risk factors for HTN include but are not limited to physical inactivity, obesity, excessive sodium
consumption, low potassium intake, cigarette smoking, high blood cholesterol levels, and high caffeine intake (5, 6). Ultimately, risk factors related to exercise and eating habits are modifiable, and may serve as potential areas for the focus of efforts for the prevention of early-onset HTN. Unfortunately, little research has focused on the health risk behaviors of African American young adults as they enter adulthood.

The theory of intergenerational transmission of health risk behaviors postulates that parents communicate attitudes about health behaviors and model health-related behaviors, resulting in the transmission of health-promoting or health-risk behaviors to their children. Multiple studies have shown that mothers, in particular, influence the health behaviors of their children, including exercise, eating, and smoking habits (7-16). Mothers, therefore, may serve as a point of entry for influencing the health risk behaviors of African American young adults. Learning about the relationships between the exercise, eating, and smoking behaviors of mothers and their adolescent children may provide insight into the formation of health behaviors of these young adults. Ultimately, information regarding the influence of maternal health behaviors on their adolescent child’s health behaviors could contribute to the development of tailored interventions for high-risk African American youth.

This study, therefore, aimed to investigate the relationship between the health behaviors of mothers and their African American young adult children with respect to their gender and HTN risk category. The specific aims of this project were:
1. To determine associations between mothers’ self reported behaviors related to diet and physical activity and the gender and HTN risk category of their African American young adult children.

2. To assess associations between maternal self-reported eating behaviors and DASH diet indices and select nutrient intakes.

3. To compare eating and physical activity behaviors of mothers to the dietary intake and physical activity of their African American young adult children and consider differences across adolescent gender and/or HTN risk category.
CHAPTER II
REVIEW OF THE LITERATURE

This study centers on the relationship between health behaviors of mothers and their African American children with respect to their child’s gender and HTN risk category. It is pertinent, therefore, to provide background regarding the etiology and pathophysiology of HTN. As this research is based on the theory of intergenerational transmission of health behaviors, this review of literature will also focus on current research regarding the relationships between maternal lifestyles and child health behaviors.

Hypertension

Blood pressure by definition is the force exerted on the walls of the arteries as the heart contracts (SBP) and relaxes (DBP). Normal BP is a classification defined as consistent BP measurements less than 120/80 mmHg. When an individual’s systolic or diastolic BP falls within the ranges 120-139mmHg or 80-89mmHg, respectively, an individual is classified as pre-hypertensive. Stage I HTN is diagnosed by SBP measures of 140-159mmHg and/or DBP measures of 90-99mmHg, while Stage II HTN is diagnosed as a SBP over 160mmHg and/or DBP over 100mmHg.

Clinical and Financial Consequences If uncontrolled, HTN can lead to increased risk of death due to increased risk of heart failure, myocardial infarction,
angina, atrial fibrillation, left ventricular hypertrophy, aneurysm, stroke, cerebral hemorrhage, hypertensive encephalopathy, pre-eclampsia/eclampsia, kidney failure, decreased blood flow, and gangrene of the lower extremities (5). Hypertensive patients who smoke, are obese, or have diabetes mellitus, hypercholesterolemia, or atherosclerosis are even more likely to develop cardiovascular problems (5). Unfortunately, rates of this condition have been rising recently in the United States, with nearly 32% of adults over 20 years of age experiencing HTN between 2003 and 2006. In 2005, nearly 25,000 people in the United States died as a result of complications resulting from uncontrolled HBP (1). In addition, in 2006 HTN was the primary diagnosis for 35.7 million primary-care office visits and 3.9 million visits to hospital outpatient departments (1). As such, HTN poses a significant burden on the healthcare system. Financial consequences of HTN are apparent as well, as Balu showed that the approximate annual cost of HTN in the United States is $55 billion dollars, representing a substantial economic burden on the health care system (17).

**Risk Factors** One’s individual risk for HTN is influenced by both non-modifiable and modifiable risk factors (5). Non-modifiable risk factors include older age, male gender, and African American race. Modifiable risk factors for HTN include physical inactivity, obesity, excessive alcohol consumption, excessive sodium consumption, low dietary potassium, stress, cigarette smoking, increased blood cholesterol, type 2 diabetes, and excess caffeine intake (5, 6). Modifiable risk factors can by definition be either altered or avoided in an effort to prevent the onset of HTN. As
many of these modifiable risk factors are behaviors, they have the potential to serve as points of investigation for the development on interventions in this field.

**Prevalence** As mentioned previously, rates of HTN in adults have increased to 32% in the United States (1). According to data collected from the National Health and Nutrition Examination Survey (1988-2006), HTN rates differ according to race, sex, age, and socioeconomic status (SES). Overall, 30.3% of females and 31.8% of males aged 20 years or older experienced HTN between 2003 and 2006 (1). Rates of HTN were much higher in African Americans (42.2% in females, 44.1% in males) than in whites (28.3% in females, 31.2% in males), exemplifying the increased risk of HTN in the African American population. Prevalence of HTN decreases with increasing socio-economic status, with those at 200% of the poverty line or higher experiencing lower rates of HTN (31.1%) compared to those below 200% of the poverty line (1). Increasing age is also associated with increasing prevalence of HTN, with those persons 75 years or older experiencing the highest prevalence of HTN (65.0% in males and 80.2% in females). Overall, risk of HTN has increased over the last 20 years in the United States, with age-adjusted prevalence at 25.5% in the years 1988-1994, and 31.3% in 2003-2006 (1).

**Prevalence in African American Youth** In addition to a higher prevalence of HTN, African Americans also see an earlier onset of HTN and higher measures of BP in youth (2, 3, 18, 19). Unfortunately, control rates among African Americans are also lower compared to control rates among whites (20). The combination of early onset and poor control of hypertension in African Americans can lead to increased risk of complications and death at earlier ages. Increased rates may be due in part to genetics,
higher rates of obesity, or additional correlates such as physical activity and diet. Although some studies have found no association between race and increased risk of HTN in children, most studies have found additional correlates to HTN prevalence in African American children including gender, SES, and BMI (2, 3, 19, 21, 22).

McNeice et al., for example, investigated a sample of 6790 school age (11-17y) children in the Houston, TX area (51% male, 28% African American) for the prevalence of HTN (2). After three screenings, 81.1% of participants were classified as normotensive, with 15.7% pre-hypertensive and 3.2% hypertensive. Results confirmed a significant increase in the prevalence of both pre-HTN and HTN with increasing BMI (p<0.001). Males and African Americans were more likely to have pre-HTN and HTN compared to females and whites, respectively. This study highlights the increased risk of HTN for African American, male, and overweight youth.

Dekkers et al. also found differences in BP with respect to ethnicity in participants ages 4.9-27.5y (n=745) (3). Participants with a family history of cardiovascular disease were assessed for blood pressure and anthropometric measures annually over ten years. Results showed that African American participants had higher measures of SBP and DSP than white participants from youth (males: 14y, females: 9y) onward. Associations between ethnicity and SBP remained significant even after controlling for growth, adiposity, and SES. Dekkers’ findings also confirmed an increase in BP with increasing BMI.

Ultimately, current research shows higher rates of HBP, pre-HTN, and HTN in African American youth when compared to white youth. Higher measures of BP have
also been directly associated with weight or weight status. Unfortunately, research has not focused on determining associations between measures of BP or HTN risk and health risk behaviors of African American youth such as eating and exercise habits. If these health risk behaviors are related to measures of BP or HTN risk, they may serve as points for intervention for the prevention of the early-onset of HTN.

**Gender Differences In African American Youth** As mentioned previously, African American youth are at increased risk of higher measures of BP and higher rates of HBP, pre-HTN, and HTN when compared to white youth. Within African American youth, gender differences exist both with regard to measures of BP and HTN risk factors such as eating and exercise behaviors.

Hediger et al. found differences in measures of BP by gender within an African American youth sample population. In a three-year longitudinal investigation of urban African American youth (ages 12-17), Hediger aimed to compile resting blood pressure and heart rate distributions for African American adolescents. Resting blood pressure and heart rate were measured annually in 1408 adolescents (all African American, males n=737). Researchers found significantly higher measures of SBP in African American boys as compared to African American girls (p<0.001) after 15 years of age (19).

Hediger also confirmed a significant, positive correlation between weight and SBP, with a stronger correlation in boys (age 12-16: p<0.01, age 17y: p<0.05). These data confirm an increased resting BP within African American adolescent populations, even in normal weight individuals.
African American youth have also been shown to exhibit lower levels of fitness when compared to white youth (23). Shaibi et al. investigated aerobic fitness levels among 73 youth of varying ethnicity ages 7-14 years. VO\textsubscript{2peak} was measured for each participant via treadmill test to exhaustion with open circuit spirometry. Results showed that Caucasian youth had significantly higher measures of VO\textsubscript{2peak} compared to African American and Latino youth. In addition, African American youth exhibited lower VO\textsubscript{2peak} scores relative to fat free mass compared to white youth. Overall, these findings suggest that African American youth may have poorer fitness levels when compared to white youth. Decreased levels of physical fitness, which may imply lower physical activity levels, put African American youth at risk for HBP and other morbidities associated with poor exercise habits.

Several studies have elucidated differences in physical activity levels based on gender, especially in youth (24, 25). Kurc et al. investigated the effects of social support on sports involvement and physical activity in 25,416 youth between grades 9 and 12(24). Participants completed surveys estimating minutes of vigorous and moderate physical activity completed in the last week. A comparison by gender revealed that males were more likely to participate in intramural, varsity, or community sports teams and were less likely to take part in sedentary behaviors (such as watching television or playing video games) when compared to females (p<0.0001).

While these results do not take race or ethnicity into account, several additional studies have found similar statistics in samples of African American youth only. Whitt-Glover et al. investigated disparities in PA behaviors based on accelerometer data from
the National Health and Nutrition Examination Survey for 2,531 participants ages 6-19y (25). Anthropometric data were also assessed including weight and height, as well as demographic data such as gender and ethnicity. Whitt-Glover found that African American females in particular had significantly more hours of sedentary activities (5.88h) compared to Caucasian females (5.61h). Clear differences in achievement of the moderate-intensity physical activity recommendations existed between African American males and females across all age groups, with males being more likely to meet recommendations.

Wang et al. found similar results in comparing obesity-related risk factors among low SES, urban African American students (26). Participants (n=498, males n=218) provided data from demographic surveys, physical examination, and the Youth and Adolescent Questionnaire Food Frequency Questionnaire (FFQ). Results showed clear differences in obesity risk factors in relation to gender. Males, for example, were less likely to be overweight and were more likely to have exercised for at least twenty minutes in the last week (p=0.064).

With regard to eating behaviors, males were significantly less likely to choose unfamiliar fruits compared to females (p=0.016). Females, on the other hand, were more likely to report eating under stress (p=0.052). Overall, both males and females exhibited poor dietary behaviors.

These studies suggest that gender differences exist with regard to eating and exercise behaviors in African American youth. These differences call for tailored
interventions to meet gender-specific needs and therefore further investigation into the gender-based differences in eating and exercise behaviors are necessary.

*Lifestyle Changes That Lower Blood Pressure* Lifestyle changes such as weight loss, reduced fat, alcohol, and sodium intake, increased potassium intake and physical activity, smoking cessation, and stress management are often suggested to aid in BP management (27-36).

Several investigations have shown significant relationships between exercise and weight loss and decreases in BP (32-36). Several longitudinal studies have shown an inverse relationship between fitness level and measures of BP in predominantly white samples (32, 34-36). Bond et al. recently confirmed these associations in African American males with a family history of HTN (33). Georgiades et al. conducted a study to assess the effects of exercise and weight loss on cardiovascular responses in hypertensive, overweight participants (34). Results showed that subjects participating in aerobic exercise alone or in combination with a behavioral weight loss program had lower SBP and DBP compared to controls. These results express the importance of both exercise and weight loss as part of a plan to lower BP in hypertensive, overweight patients.

With respect to diet, the Dietary Approaches to Stop Hypertension (DASH) diet, developed by Sacks et al., has been documented as being successful in significantly lowering measures of BP when compared to the typical American diet (37-40). The DASH diet is high in fruits and vegetables, whole grains, low-fat dairy, and fiber, and low in saturated fat and cholesterol (41). The BP lowering effects of this diet have been
confirmed in African Americans, including low-income groups (29, 42, 43). In addition, several studies have shown stronger BP-lowering effects of the DASH diet in African Americans compared to other groups (44, 45). The DASH diet has also been suggested for African American youth to prevent the early onset of HTN (46).

Several studies have investigated adherence to the DASH diet in relation to incidence of disease (28, 31, 47, 48). These investigations have utilized novel approaches to determining concordance between subject diets and the DASH diet. Most commonly, diet is assessed by FFQ (in one assessment, multiple-pass 24-hour recall is utilized for data collection), and questionnaire responses are compared to target intake levels. While Mellen et al. utilized nine nutrient targets (saturated fat, total fat, protein, cholesterol, fiber, magnesium, calcium, potassium, and sodium) for the basis of creating a DASH score, the more common approach involves the assessment of daily food intake such as servings of fruits, vegetables, whole grains, meat, nuts, seeds, and legumes, sweets or added sugars, dairy, and alcohol (31, 47, 48). In each investigation, subjects are assigned a score based on their intake that describes how closely their intake resembles the DASH diet targets. Assessment techniques such as these serve as useful tools for investigating the healthfulness of diets based on DASH standards. Interestingly, no qualitative approaches to assessing diet adherence have been investigated.

Multiple lifestyle changes have also been studied for their role in decreasing measures of BP. Appel et al. conducted a clinical trial to determine the effects of simultaneous implementation of lifestyle changes (weight loss, sodium intake reduction, increased physical activity, and limited alcohol intake) to lower BP (27). Results showed
significant reductions in SBP for participants who took part in a behavioral intervention (3.7mmHg) and those who received the intervention and followed the DASH diet (4.3mmHg) versus advice-only controls (p<0.001). These findings further support the influence of multiple health behavior changes on decreasing BP in hypertensive patients.

**Intergenerational Transmission of Health Risk Behaviors**

The theory of intergenerational transmission of health risk behaviors postulates that parents model health behaviors and convey attitudes about health and health behaviors to their children. Subsequently, parents transmit either health promoting or health risk behaviors to their children, and therefore maintain a strong influence over their future health.

Wickrama et al. proposed a theoretical model for the transmission of health risk behaviors from parents to adolescent that proposed that adolescents’ health-risk lifestyles are directly influenced by their parents’ health risk lifestyles, ultimately influencing the development of adolescent health-risk behaviors(49). In addition, Wickrama proposed that aspects of parents’ health behaviors directly affect the health behaviors of their adolescent children. It was hypothesized that adolescents would begin to adopt not only specific modeled behaviors, but a general health risk lifestyle (for example, risky or healthy). Adolescents (n=330, grade 7 upon first assessment) and their parents were assessed over five years via self-reports of eating, exercise, smoking, drinking, and sleeping habits. Results showed that parental health risk behaviors related to eating, exercise, smoking, and drinking were significantly correlated with corresponding behaviors in adolescents (p<0.05).
Several studies have investigated parental influence over these health risk behaviors individually (7, 8, 12, 13, 15, 16, 49-60). Mothers, specifically, have been found to have a strong influence over the health risk behaviors of their children with regard to eating and exercising habits, obesity, and other health risk behaviors such as smoking and alcohol use.

**Maternal Influence and Child Eating Behaviors** Neumark-Sztainer et al. investigated adolescents to determine influences over their food choices (15). Results showed that parents’ eating and cooking behaviors, foods purchased by parents, eating and food rules enforced by parents, parental concerns over their child’s diet, family meal patterns, and the culture and religion of the family were all influences over adolescent food choices. These findings highlight the multiple roles that parents play in the formulation of eating behaviors in their children.

Baker et al. also investigated the intergenerational transmission of eating attitudes and behaviors through assessments of college-age men and women (n=91) and their parents (14). Young adults’ attitudes and behaviors were strongly correlated with their perception of their parents’ attitudes, and not self-reports by parents. Interestingly, the single exception to this observation was related to self-reported criticism of daughters’ eating and/or appearance by mothers which was directly associated with higher frequency of weight loss behavior in daughters. This finding highlights the strength of maternal influence and how this influence differs depending on the gender of their child.

Ultimately, research suggests that parents, and more specifically mothers, may serve as an opportunity for intervention in order to alter adolescent eating behaviors and
therefore alter their HTN risk. These studies, however, were conducted in predominantly white samples. Unfortunately, few studies have focused on the relationship between the eating habits of mothers and their African American children (60). Wang et al. conducted one such study by investigating 121 mother-child dyads from a low-income inner-city community (60). Adolescent African American children and their mothers were assessed for dietary intake (via FFQ) and anthropometric measures. Results showed weak associations between the diets of mothers and their adolescent children. Interestingly, adolescents with mothers who were current smokers had stronger associations with maternal poor eating habits. These findings suggest a minimal influence of maternal eating habits over the eating habits of African American adolescents. This study, however, is weakened by the use of FFQ as the sole method of collecting dietary data as this sample was from a group that often suffers from low literacy levels. This may have confounded results and could have been avoided by collecting additional dietary data via interview. Interestingly, research investigating maternal influence over child eating behaviors has largely relied on data collection via questionnaire and has yet to be investigated qualitatively via interview. A semi-structured interview could be utilized to assess maternal and child eating behaviors, and may allow subjects to freely share their views of and attitudes toward their dietary habits, including what they consider negative behaviors. The assessment of relationships between self-reported negative health behaviors of mother and child is a novel approach to investigating maternal influence that has yet to be utilized. Overall, recent studies suggest that a relationship does exist between maternal lifestyle and child eating
behavior. Additional research is required to determine if these findings hold true in African American populations.

**Maternal Influence and Child Physical Activity** Physical inactivity is related to both risk of obesity and HTN risk. Several investigations have found that parents maintain influence over their child’s physical activity level (11, 12, 25, 50, 56, 58, 59, 61). Trost et al., for example, investigated the determinants of physical activity levels in African American middle school youth by comparing active and low-active participants (n=110) (12). Perceived physical activity levels of parents and access to sporting equipment at home were both variables related to physical activity. Clear differences between boys and girls were evident, as boys were more likely to participate in moderate to vigorous physical activity. These active boys were also more likely to perceive their mothers as physically active. Mother’s physical activity was not, however, influential in active girls. This study expresses the important influence that mothers have over their adolescent child’s health behaviors.

Sallis et al. also found that familial influence significantly affected child physical activity levels in his investigation of children and adolescents (grades 4-12, n=1504) (11). Family support predicted physical activity across all age groups, while parental physical activity predicted physical activity in grades 4-6 (p<0.01). Parental payment of fees also predicted physical activity in grades 7-12 (p<0.01).

Overall, studies suggest that mothers play a significant role in the development of their children’s exercising habits. Specifically, maternal physical activity and support of child’s physical activity seem to be associated with higher levels of child physical
activity. Strong differences between sexes are also apparent, suggesting the need for tailored interventions to increase levels of physical activity in youth and adolescents.

**Maternal Influence and Child Obesity** Overweight and obesity have been implicated as correlates of HBP and HTN. Several investigators have studied the associations between the home environment and parent’s eating behaviors and the development of childhood obesity (2, 19, 22, 62). Johannsen et al. investigated the influence of parental eating habits on the eating habits and weight status of their children. Results showed a significant positive relationship between maternal BMI and child weight. Strauss et al. also found a strong relationship between maternal weight and child weight status (16). Results showed that children (age 0-8, normal BMI at baseline) of obese mothers were 3.62 times more likely to be obese compared to children of normal weight mothers. African American children or children of single moms, moms who did not finish high school, non-working parents, or non-professional parents were also more likely to develop obesity. These results again suggest a strong maternal influence over the development of childhood obesity as mothers who create a home environment supportive of low activity levels and overeating put their children at risk for developing obesity.

Brownell et al. also assessed the strength of maternal influence, but through interventions with youth by evaluating the effects of a program centered on behavior modification, social support, nutrition, and exercise on weight and BP over a 16-month period (54). Groups in which mother and child took part separately in the program were most successful, losing 8.4kg compared to groups in which only the child participated.
(3.3kg) and in which mother and child participated together (5.3kg). One year later, this group was still the most successful with 7.7kg weight loss compared to approximately 3kg for the other two groups. These results elucidate the importance of maternal involvement, but may suggest limiting this involvement in adolescent interventions.

Current research suggests that maternal weight status has a strong influence over the weight status of children. The risk of obesity related to maternal obesity increases for children who are African American or from low-income or single-parent families. These findings suggest a need for interventions to prevent the development of obesity in low-income, African American populations, which could subsequently lower risk of HTN.

**Maternal Influence and Other Child Health Risk Behaviors** Research suggests that parents also have influence over other child health risk behaviors such as tobacco and alcohol use (9, 10, 51). Beal et al. investigated the influence of parents and peers over health risk behaviors in adolescents, and found that parental influences were solely associated with alcohol use (51). Other researchers have found relationships between smoking and substance use and parental factors in older adolescents (9, 10). Distefan et al. found that parental smoking and parental disapproval of alcohol and cigarette use were inversely associated with health risk behaviors (10). Unfortunately, these studies were conducted in samples that consisted largely of white participants. Further research is warranted in order to determine parental influences over African American adolescent health behaviors.

These studies elucidate the power of maternal influence in the transmission of health beliefs and behaviors. In addition, gender differences are made apparent,
revealing variations in the influence of the mother-child relationship based on sex. Additional research is necessary in order to further investigate the role that mothers play in the formation of their child’s health risk behaviors and how these health lifestyles are related to their African American child’s HTN risk category with respect to gender.

**Conclusion**

Current research suggests that parents exercise influence over their adolescent child’s health behaviors, and that health risk behaviors such as poor dietary habits, inactivity, and smoking are related to increased risk of HTN. The implications of parental influence on the risk of chronic disease in African American adolescents have not been investigated. In addition, research efforts have not focused on the investigation of African American adolescents with varying risks for hypertension (63). A qualitative approach, therefore, is the most appropriate method of investigation within this group (63). Qualitative investigations provide an opportunity for rich data collection that may not be possible through alternate quantitative methods with limited cultural suitability or unconfirmed effectiveness within the group of interest (64). Ultimately, qualitative methods such as interviews provide insight not only into the practices of subjects, but their views of and attitudes towards concepts of interest such as health behaviors.

The increased risk of HBP and early-onset HTN in African American adolescents, therefore, calls for a qualitative investigation into maternal influences that may be associated with HTN risk. The roles that mothers play in the development of their adolescent’s health-risk behaviors and subsequent HTN risk is of particular interest. Information regarding these influences and relationships can help to inform the formation
of tailored interventions to reduce HTN risk in adolescents and young adults through behavior modification.
CHAPTER III
METHODS

Participants

Mothers in this investigation were parents of African American young adults who were previously participants in studies investigating the characterization of hemodynamic response to stress (65-67). At the time of initial assessment, participants (n=419) were 14-17 years of age. The dataset available from this study included measures of BP, weight, height, and change in sodium excretion in response to a video stressor for young adult participants (63).

Children were selected for the current investigation based on HTN risk (high or low), ethnicity (African American), and age (17-20 years). Participants qualified as at high risk for early-onset HTN if they met two of three criteria, including a SBP within the top quartile of African American subjects, a gender-specific BMI-for-age > 85th percentile, and/or a change in sodium excretion from baseline to stress ≤ 0. Alternately, subjects with measures of SBP within the lowest half of all African American subjects, a gender specific BMI-for-age > 15th percentile, and a change in sodium excretion from baseline to stress > 0 were classified as low risk. Of the 130 participants who met these criteria, 56 were contacted and eligible. Consent was obtained from participants 18 years and older, and parental consent and child assent were obtained for participants under the age of 18 (Appendices A, B, C).
Data Collection

Four methods of data collection were utilized: a semi-structured interview (Appendices D, E), the National Institutes of Health National Cancer Institute Diet History Questionnaire (DHQ, Appendix F), a descriptive questionnaire (Appendices G, H), and measures of height, weight, and BP. Young adults and their mothers took part separately in in-depth, semi-structured interviews (45-75min) designed in part to collect information concerning lifestyle behaviors related to eating and exercise. Participants were asked to describe when and where their meals took place and what they typically consumed. In addition, participants were asked specific questions regarding vegetable intake (Do you make an effort to include vegetables in your meals? How often do you consume vegetables?) and cooking practices (How many evening meals are prepared at home?). Participants were also asked to describe their level of physical activity during the day, their exercise practices, and exercise history. Interviews were conducted privately by either the Principal Investigator or a Research Assistant.

The DHQ, a 124-item FFQ, is a dietary assessment tool that assesses frequency, portion size, and supplement use. This assessment tool, which requires approximately one hour to complete, utilizes food lists and nutrient databases from the Continuing Survey of Food Intakes by Individuals. DHQ output provides information regarding estimated daily macro- and micronutrient intakes, food group intakes in servings, and added sugar intake in teaspoons.

The descriptive questionnaire was created by the Principal Investigator and Research Assistant and collected the following data: family history of disease and causes
of death, household size, household income, parent education levels, and child high school GPA.

Height and weight were assessed via a digital eye-level scale with a height rod. BP was assessed as the average of three readings using a mercury manometer. Both procedures were performed according to standard protocols (66, 68).

Measures

Identification of Eating and Exercise Behaviors Interviews were audio-taped and transcribed verbatim by medical transcriptions and research assistants. A code book was created based on interview questions and typical participant responses. Interview transcripts were coded using Atlas.ti.5.1.12 qualitative software based on this reference. Text lines coded for eating and physical activity were extracted and summarized for each participant. Behavior summaries were assessed for common themes in eating and exercise behaviors. Participant summaries were reviewed and all participant behaviors were categorized according to these themes. Participants were coded a 1 for a particular theme if their described behaviors were consistent with that theme. Participants were coded a 0 if they described an alternative behavior or did not mention behaviors related to a particular theme in their interview.

DASH Diet Indices DASH scores were assigned to each dyad member to describe diet quality in relation to DASH diet guidance based on three published reports (28, 31, 48).

First, a DASH score was created based on the work of Mellen et al. (28). DHQ responses were assessed for daily percent kcal from total fat, saturated fat, and protein, as
well as daily consumption (per 1000kcal) of cholesterol (mg), fiber (g), magnesium (mg), calcium (mg), sodium (mg), and potassium (mg). Intake levels for these key DASH nutrients were compared to previously determined DASH diet and control diet targets (41). For each nutrient, participants were assigned 1 point if the DASH target was met, 0.5 points if intake was between DASH targets and standard American diet controls, and 0.0 points if intake fell at or below target intakes for the standard American diet (Table 1). Resulting scores can range from 0 (completely non-compliant with the DASH diet) to 9 (completely compliant with the DASH diet).

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>1 Point</th>
<th>0.5 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fat</td>
<td>≤27% total kcal</td>
<td>27.1-32% total kcal</td>
</tr>
<tr>
<td>Saturated Fat</td>
<td>≤6% total kcal</td>
<td>6.1-11% total kcal</td>
</tr>
<tr>
<td>Protein</td>
<td>≥18% total kcal</td>
<td>16.5-17.9% total kcal</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>≤71.4mg/1000kcal</td>
<td>71.5-107.1mg/1000kcal</td>
</tr>
<tr>
<td>Fiber</td>
<td>≥14.8g/1000kcal</td>
<td>9.5-14.7g/1000kcal</td>
</tr>
<tr>
<td>Magnesium</td>
<td>≥238mg/1000kcal</td>
<td>158-237.9mg/1000kcal</td>
</tr>
<tr>
<td>Calcium</td>
<td>≥590mg/1000kcal</td>
<td>402-589.9mg/1000kcal</td>
</tr>
<tr>
<td>Sodium</td>
<td>≤1143mg/1000kcal</td>
<td>1143.1-1286mg/1000kcal</td>
</tr>
<tr>
<td>Potassium</td>
<td>≥2238mg/1000kcal</td>
<td>1534-2237.9mg/1000kcal</td>
</tr>
</tbody>
</table>
Alternately, DASH diet adherence was also assessed based on daily food group intake for each participant, as exhibited by Fung et al. (31). Daily servings of fruits (including juices), vegetables (excluding potatoes and legumes), nuts and legumes, whole grains, dairy, sodium, red or processed meats, and sweetened beverages were assessed. As DHQ output reports added sugar in teaspoons rather than servings, this value was divided by 10 teaspoons per serving in order to estimate the average number of regular sodas consumed. For each food group or nutrient, participants were categorized into quintiles and assigned a score (1-5) based on their quintile. For intake of fruits, vegetables, nuts and legumes, whole grains, and dairy, the number of assigned points were equal to the assigned quintile (one point for quintile one, five points for quintile five). For sodium, red or processed meats, and sweetened beverages, scoring was reversed (five points for quintile one, one point for quintile five), as lower intakes of these foods and nutrients are typically assumed to be associated with improved quality of diet. Resulting scores potentially range from 7 to 35, with 35 points being assigned to the most compliant of the participants.

A third approach to assessment of DASH diet adherence, documented by Folsom et al., also utilized an assessment of food group intake. Participant intake was assessed for total grain, whole grain, vegetable, fruit, dairy, meat (including poultry and fish), added sugar, and nut, seed and legume intakes (servings per day). In addition, DHQ responses were assessed for percent total kcal from fat and saturated fat as well as sodium intake. Points were assigned for each food group or nutrient based on intake (Table 2).
Table 2. Point assignment criteria for calculation of DASH score based on the research of Folsom et al.

<table>
<thead>
<tr>
<th>Food Group of Nutrient</th>
<th>Guidelines For 1 Point</th>
<th>Guidelines For 0.5 Points</th>
<th>Guidelines For 0 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total grains</td>
<td>≥7 servings per day</td>
<td>5-6 servings per day</td>
<td>&lt;5 servings per day</td>
</tr>
<tr>
<td>Whole grains</td>
<td>≥2 servings per day</td>
<td>1 servings per day</td>
<td>&lt;1 servings per day</td>
</tr>
<tr>
<td>Vegetables</td>
<td>≥4 servings per day</td>
<td>2-3 servings per day</td>
<td>&lt;2 servings per day</td>
</tr>
<tr>
<td>Fruits</td>
<td>≥4 servings per day</td>
<td>2-3 servings per day</td>
<td>&lt;2 servings per day</td>
</tr>
<tr>
<td>Dairy foods</td>
<td>≥2 servings per day</td>
<td>1 servings per day</td>
<td>&lt;1 servings per day</td>
</tr>
<tr>
<td>Meats, poultry, and fish</td>
<td>≤2 servings per day</td>
<td>3 servings per day</td>
<td>≥4 servings per day</td>
</tr>
<tr>
<td>Nuts, seeds, and legumes</td>
<td>≥4 servings per day</td>
<td>2-3 servings per day</td>
<td>&lt;2 servings per day</td>
</tr>
<tr>
<td>Sweets</td>
<td>≤5 servings per week</td>
<td>6-7 servings per week</td>
<td>≥ 8 servings per week</td>
</tr>
<tr>
<td>Sodium</td>
<td>≥1500 mg per day</td>
<td>1501-2400 mg per day</td>
<td>≥2401 mg per day</td>
</tr>
<tr>
<td>% kcal from fat</td>
<td>≤30%</td>
<td>31-32%</td>
<td>≥33%</td>
</tr>
<tr>
<td>% kcal from saturated fat</td>
<td>≤10%</td>
<td>11-12%</td>
<td>≥13%</td>
</tr>
</tbody>
</table>

Dyad Concordance  In order to compare the eating and exercise behaviors of mothers and young adults, additional variables were created to represent dietary intake and physical activity behaviors. Previously mentioned maternal eating behaviors statistically related to nutrient or food group intakes used to quantify the DASH indices were used as a basis for comparison of maternal and young adult DASH indices scores.
These behaviors were summed to create a total eating behavior score for mothers. Maternal behavior scores were compared to young adult scores on three DASH indices as previously described based on gender and risk group.

Young adults physical activity behaviors were categorized using the same method described for the mothers: behaviors were categorized according to themes and children were coded (1 or 0) for each theme. The physical activity behaviors of mothers and young adults were divided into three categories: 3 – most active (more than one form of purposeful exercise reported), 2 – moderately active (one form of purposeful exercise reported), and 1 – least active (no purposeful exercise reported). Exercise categories of mother and child were compared based on young adult gender and hypertension risk.

Statistical Analysis

Logistic regression analysis was utilized to assess the main effects of gender, risk, and their interaction with the mothers’ eating and physical activity behaviors (Aim 1). Relationships between mother’s eating behaviors and DASH indices were assessed using analysis of variance (Aim 2). Relationships between maternal eating behaviors and young adults DASH indices were assessed using analysis of variance, while maternal and young adult physical activity behaviors were assessed using logistic regression (Aim 3). Small sample size prevented adjusting for covariates. All statistical analyses were carried out using JMP 7.0 and differences were considered statistically significant at p<0.05.
CHAPTER IV

RESULTS

Participants

There were no differences in maternal age, systolic blood pressure, or diastolic blood pressure based on child risk and gender category (Table 3). Mothers of high risk children were more likely to have higher measures of BMI and were more likely to be diagnosed with HTN when compared to mothers of low risk children (p=0.0004 and p=0.024, respectively). Mothers of females were least likely to have a college degree or more (p=0.017), make at least $50,000 per year (p=0.02), or be married (p=0.015).

Across gender and risk groups, young adults did not differ significantly in age. High risk young adults, as expected, experienced higher measures of SBP (118.9mmHg versus 108.2mmHg, p=0.0002), DBP (73.3mmHg versus 67.4mmHg, p=0.0024), and BMI (33.2kg/m² versus 21.9kg/m², p<0.0001) when compared to low risk young adults (Table 4).

Aim 1: Maternal Behaviors by Young Adult Risk and Gender

**Eating** As mentioned previously, common themes in maternal eating behaviors arose. These eating behaviors included: skips meals, skips more than one meal daily, eats fast food, drinks sweetened beverages, reports low vegetable intake, eats out more than once per week, fries foods at home, eats high-calorie, low nutrient-dense foods (snack foods) between meals, eats sweet snack foods between meals (sweet snacks), and
Table 3. Descriptive characteristics of maternal participants.

<table>
<thead>
<tr>
<th></th>
<th>Mothers of Males</th>
<th>Mothers of Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk (n=15)</td>
<td>Low Risk (n=13)</td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>45.05 ± 5.32</td>
<td>45.64 ± 5.31</td>
</tr>
<tr>
<td>BMI (mean ± SD)</td>
<td>37.03 ± 6.95</td>
<td>31.14 ± 5.37</td>
</tr>
<tr>
<td>Systolic Blood Pressure (mm Hg, mean ± SD)</td>
<td>133.27 ± 14.45</td>
<td>133.64 ± 15.80</td>
</tr>
<tr>
<td>Diastolic Blood Pressure (mm Hg, mean ± SD)</td>
<td>80.49 ± 8.00</td>
<td>81.21 ± 9.85</td>
</tr>
<tr>
<td>Diagnosed as Hypertensive</td>
<td>53%</td>
<td>45%</td>
</tr>
<tr>
<td>Education (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>0</td>
<td>8.33</td>
</tr>
<tr>
<td>High school degree</td>
<td>20</td>
<td>16.67</td>
</tr>
<tr>
<td>Some college</td>
<td>46.67</td>
<td>41.67</td>
</tr>
<tr>
<td>College degree or more</td>
<td>33.34</td>
<td>33.33</td>
</tr>
<tr>
<td>Income (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$30,000</td>
<td>53.33</td>
<td>25</td>
</tr>
<tr>
<td>$30,000 - &lt;$50,000</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>≥$50,000</td>
<td>46.67</td>
<td>50</td>
</tr>
<tr>
<td>Married (%)</td>
<td>60</td>
<td>84.62</td>
</tr>
</tbody>
</table>

Table 4. Descriptive characteristics of young adult participants.

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk (n=15)</td>
<td>Low Risk (n=13)</td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>17.3 ± 4.9</td>
<td>18.4 ± 1.3</td>
</tr>
<tr>
<td>BMI (mean ± SD)</td>
<td>31.9 ± 5.4</td>
<td>22.3 ± 2.8</td>
</tr>
<tr>
<td>Systolic Blood Pressure (mm Hg, mean ± SD)</td>
<td>120.7 ± 12.4</td>
<td>108.4 ± 7.9</td>
</tr>
<tr>
<td>Diastolic Blood Pressure (mm Hg, mean ± SD)</td>
<td>74.7 ± 6.9</td>
<td>67.8 ± 6.3</td>
</tr>
</tbody>
</table>

29
eats salty snack foods between meals (salty snacks). Table 5 provides examples of participant comments for each eating behavior category.

There was no difference in mothers’ eating behaviors based on the gender of their child. There was, however, an effect of child risk category on sweetened beverage consumption as mothers of high risk children were more likely to consume these drinks (p=0.0030).

There were statistically significant interactions for risk and gender for several eating behaviors including: skips meals, eats fast food, drinks sweetened beverages, eats out more than once weekly, and low vegetable intake (Table 6). Mothers of low risk males were the least likely to take part in these behaviors (skips meals: p=0.042, eats fast food: p=0.013, drinks sweetened beverages: p=0.0021, eats out >1 weekly: p=0.0017, low vegetable intake: p=0.056). Alternately, mothers of high risk males were the most likely to skip meals, consume fast food, drink sweetened beverages, and eat out more than once per week.
Table 5. Examples of comments for maternal eating behavior categories.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Qualifications or Common Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skips meals</td>
<td>Skips one of three main meals</td>
</tr>
<tr>
<td>Skips &gt;1 meal</td>
<td>Skips at least two meals of three main meals</td>
</tr>
<tr>
<td>Eats fast food</td>
<td>Eats food from a fast food establishment at or between meals</td>
</tr>
<tr>
<td>Drinks sweetened beverages</td>
<td>Drinks sweet tea, regular soda, sports beverages (e.g. Gatorade or Powerade), or fruit drinks (e.g. Kool-Aid or Hawaiian Punch)</td>
</tr>
<tr>
<td>Low vegetable intake</td>
<td>Doesn’t make an effort to include vegetables in meals, doesn’t like vegetables, or eats vegetables less than five times weekly</td>
</tr>
<tr>
<td>Eats out &gt;1 time weekly</td>
<td>Eats more than one evening meal (e.g. dinner) out each week</td>
</tr>
<tr>
<td>Fries foods at home</td>
<td>Deep fries foods at home</td>
</tr>
<tr>
<td>Eats snack foods</td>
<td>The following low-nutrient dense, high calorie foods were consumed by mothers and categorized as low nutrient-dense foods: Ice cream, cake, vanilla wafers, candy, cookies, candy bars, honey buns, snack cakes, muffins, pecan twirls, moon pies, doughnuts, sweets, chips, fried bologna sandwiches, pork rinds, packs of crackers, and fast food.</td>
</tr>
<tr>
<td>Eats sweet snack foods</td>
<td>The following low-nutrient dense, high calorie foods were consumed by mothers and categorized as sweet snack foods: ice cream, cake, vanilla wafers, candy, cookies, candy bars, honey buns, snack cakes, muffins, pecan twirls, moon pies, doughnuts, and sweets.</td>
</tr>
<tr>
<td>Eats salty snack foods</td>
<td>The following low-nutrient dense, high calorie foods were consumed by mothers and categorized as salty snack foods: chips, fried bologna sandwiches, pork rinds, packs of crackers, and fast food.</td>
</tr>
</tbody>
</table>
Table 6. Maternal eating behaviors stratified by child risk-gender category.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Males</th>
<th></th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk (n=15)</td>
<td>Low Risk (n=13)</td>
<td>High Risk (n=14)</td>
</tr>
<tr>
<td>Skips meals</td>
<td>13 (86.7%)</td>
<td>5 (38.5%)</td>
<td>6 (50.0%)</td>
</tr>
<tr>
<td>Skips &gt;1 meal</td>
<td>5 (33.3%)</td>
<td>1 (7.7%)</td>
<td>5 (41.7%)</td>
</tr>
<tr>
<td>Eats fast food</td>
<td>10 (66.7%)</td>
<td>2 (15.4%)</td>
<td>4 (33.3%)</td>
</tr>
<tr>
<td>Drinks sweetened beverages</td>
<td>11 (73.3%)</td>
<td>1 (7.7%)</td>
<td>7 (58.3%)</td>
</tr>
<tr>
<td>Eats out &gt;1 time weekly</td>
<td>13 (86.7%)</td>
<td>3 (23.1%)</td>
<td>8 (66.7%)</td>
</tr>
<tr>
<td>Low vegetable intake</td>
<td>4 (26.7%)</td>
<td>0 (0.0%)</td>
<td>4 (33.3%)</td>
</tr>
<tr>
<td>Fries foods at home</td>
<td>7 (46.7%)</td>
<td>2 (15.4%)</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>Eats snack foods</td>
<td>7 (46.7%)</td>
<td>5 (38.5%)</td>
<td>7 (58.3%)</td>
</tr>
<tr>
<td>Eats sweet snack foods</td>
<td>3 (20.0%)</td>
<td>4 (30.7%)</td>
<td>7 (58.3%)</td>
</tr>
<tr>
<td>Eats salty snack foods</td>
<td>6 (40.0%)</td>
<td>4 (30.8%)</td>
<td>2 (16.7%)</td>
</tr>
</tbody>
</table>

**Exercise** Common exercise behaviors included: walks for exercise, active at work, taking part in strenuous daily activities, strength training, or cardiovascular training, never exercises, or formerly exercised. Table 7 provides examples of activities that fit into each exercise category.
Table 7. Examples of behaviors for maternal exercise categories.

<table>
<thead>
<tr>
<th>Exercise Behavior Category</th>
<th>Qualifying Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walks for exercise</td>
<td>Walking 30 minutes at lunch, walking 3-4 times each week, walking the track, talking 30 minutes 5 times each week, walking 30 minutes daily, walking 2 miles twice a week, walking 35 minutes, walking, walking one hour daily, walking 45-50 minutes 3-4 times each week, or walking during the summer</td>
</tr>
<tr>
<td>Active at work</td>
<td>Walks at work, active at work, takes the stairs, stands at work, on feet at work</td>
</tr>
<tr>
<td>Strenuous daily activities</td>
<td>Yard work, housework, playing with grandchild, niece, or other children, laundry, active during the day, cleans, shopping, fishing, participating in praise team, or moving around a lot</td>
</tr>
<tr>
<td>Strength training</td>
<td>Abs, sit ups, using an in-home machine, leg exercises, push-ups, stretching, or resistance training</td>
</tr>
<tr>
<td>Cardio</td>
<td>Exercise tape, treadmill, gym, jogging, jazzercise, biking, basketball, dancing, or cardio</td>
</tr>
<tr>
<td>Doesn’t exercise</td>
<td>Does not currently exercise</td>
</tr>
<tr>
<td>Formerly Exercised</td>
<td>Previously took part in an exercise program, but does not currently exercise</td>
</tr>
<tr>
<td>Unable to exercise</td>
<td>Unable to exercise due to chronic medical issues</td>
</tr>
</tbody>
</table>

Mothers’ exercise behaviors did not differ between risk groups, but when behaviors were compared based on child gender, mothers of males were more likely to walk for exercise (46.4% compared to 18.9%, p=0.0204). Mothers of females were more likely to report being former exercisers (53.6% versus 21.4%, p=0.0119).

There was a statistically significant interaction for risk and gender for inability to exercise (Table 8). Mothers of high risk females were the most likely to report being unable to exercise, while none of the mothers of low risk males reported being unable to exercise (p=0.0153).
Ultimately, several eating behaviors were common among all mothers. Reports of these eating behaviors differed by child risk category and well as by risk:gender category, but not by gender alone. Similarly, several physical activity behaviors were common among these mothers. These behaviors differed by child gender and risk:gender group, but not risk category alone.

**Table 8. Maternal exercise behaviors stratified by child risk:gender category.**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Males</th>
<th>Females</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk (n=15)</td>
<td>Low Risk (n=13)</td>
<td>High Risk (n=14)</td>
</tr>
<tr>
<td>Walks For Exercise</td>
<td>5 (33.3%)</td>
<td>8 (61.5%)</td>
<td>3 (25.0%)</td>
</tr>
<tr>
<td>Active at Work</td>
<td>7 (46.7%)</td>
<td>6 (46.2%)</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>Strenuous Daily Activities</td>
<td>4 (26.7%)</td>
<td>8 (61.5%)</td>
<td>4 (33.3%)</td>
</tr>
<tr>
<td>Strength Training</td>
<td>3 (20.0%)</td>
<td>1 (7.69%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Cardio</td>
<td>5 (33.3%)</td>
<td>3 (23.1%)</td>
<td>1 (8.3%)</td>
</tr>
<tr>
<td>Never Exercises</td>
<td>6 (40.0%)</td>
<td>5 (38.5%)</td>
<td>8 (66.7%)</td>
</tr>
<tr>
<td>Formerly Exercised</td>
<td>4 (26.7%)</td>
<td>2 (15.4%)</td>
<td>5 (41.7%)</td>
</tr>
<tr>
<td>Cannot Exercise</td>
<td>2 (13.3%)</td>
<td>3 (23.1%)</td>
<td>5 (41.7%)</td>
</tr>
</tbody>
</table>

**Aim 2: Maternal Eating Behaviors by DASH Indices**

Validity of maternal eating behaviors was assessed by comparison with DASH nutrient indices as reported by Melen, Folsom, and Fung (28, 31, 48). Three maternal eating behaviors were associated with Folsom, Fung, and/or Mellen DASH scores: skips meals, eats out more than once weekly, and fries foods at home (Table 9). Mothers who skipped meals tended to have lower Folsom and Fung DASH indices compared to mothers who did not report skipping meals (p=0.0009 and p=0.0035, respectively).
Eating out more than once per week was associated with lower scores for all three indices (Mellen p=0.0030, Folsom p=0.0199, and Fung p=0.0050). Mothers who reported frying foods at home on average had lower Fung scores compared to mothers who did not report this behavior (p=0.0237).

Table 9. Associations between maternal DASH scores and reported eating behaviors.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>DASH Index</th>
<th>Reporting Behavior</th>
<th>Not Reporting Behavior</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skips meals</td>
<td>Mellen</td>
<td>1.5 ± 0.2</td>
<td>1.8 ± 0.3</td>
<td>0.3527</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>4.7 ± 1.2</td>
<td>6.0 ± 1.6</td>
<td>0.0009</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.0 ± 3.2</td>
<td>22.7 ± 3.4</td>
<td>0.0035</td>
</tr>
<tr>
<td>Skips &gt;1 meal</td>
<td>Mellen</td>
<td>1.7 ± 0.3</td>
<td>1.6 ± 0.2</td>
<td>0.8114</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>4.9 ± 0.4</td>
<td>5.4 ± 0.2</td>
<td>0.2889</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.4 ± 0.9</td>
<td>21.3 ± 0.5</td>
<td>0.3868</td>
</tr>
<tr>
<td>Eats fast food</td>
<td>Mellen</td>
<td>1.4 ± 0.2</td>
<td>1.8 ± 0.2</td>
<td>0.3915</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>5.2 ± 0.3</td>
<td>5.3 ± 0.3</td>
<td>0.7651</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>21.1 ± 0.7</td>
<td>21.1 ± 0.7</td>
<td>0.9808</td>
</tr>
<tr>
<td>Drinks sweetened beverages</td>
<td>Mellen</td>
<td>1.3 ± 0.3</td>
<td>1.8 ± 0.2</td>
<td>0.1810</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>5.3 ± 0.3</td>
<td>5.3 ± 0.3</td>
<td>0.8875</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.8 ± 0.7</td>
<td>21.4 ± 0.6</td>
<td>0.5323</td>
</tr>
<tr>
<td>Low vegetable intake</td>
<td>Mellen</td>
<td>1.1 ± 0.4</td>
<td>1.8 ± 0.2</td>
<td>0.1378</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>5.0 ± 0.4</td>
<td>5.3 ± 0.2</td>
<td>0.4763</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.3 ± 1.0</td>
<td>21.3 ± 0.5</td>
<td>0.4073</td>
</tr>
<tr>
<td>Eats out &gt;1 time weekly</td>
<td>Mellen</td>
<td>1.2 ± 1.1</td>
<td>2.4 ± 1.6</td>
<td>0.0030</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>4.9 ± 1.2</td>
<td>5.9 ± 1.8</td>
<td>0.0199</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.2 ± 3.5</td>
<td>22.9 ± 2.9</td>
<td>0.0050</td>
</tr>
<tr>
<td>Fries foods at home</td>
<td>Mellen</td>
<td>1.5 ± 0.3</td>
<td>1.7 ± 0.2</td>
<td>0.6730</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>4.9 ± 0.3</td>
<td>5.4 ± 0.2</td>
<td>0.2198</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>19.5 ± 2.9</td>
<td>21.8 ± 3.6</td>
<td>0.0237</td>
</tr>
<tr>
<td>Eats snack foods</td>
<td>Mellen</td>
<td>1.4 ± 0.3</td>
<td>1.8 ± 0.2</td>
<td>0.2442</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>5.0 ± 0.3</td>
<td>5.5 ± 0.3</td>
<td>0.1574</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.6 ± 0.7</td>
<td>21.5 ± 0.6</td>
<td>0.3515</td>
</tr>
<tr>
<td>Eats sweet snack foods</td>
<td>Mellen</td>
<td>1.5 ± 0.2</td>
<td>1.7 ± 0.2</td>
<td>0.6475</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>5.2 ± 0.3</td>
<td>5.3 ± 0.2</td>
<td>0.7783</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.8 ± 0.8</td>
<td>21.2 ± 0.6</td>
<td>0.7089</td>
</tr>
<tr>
<td>Eats salty snack foods</td>
<td>Mellen</td>
<td>1.6 ± 0.3</td>
<td>1.6 ± 0.2</td>
<td>0.9140</td>
</tr>
<tr>
<td></td>
<td>Folsom</td>
<td>4.9 ± 0.4</td>
<td>5.4 ± 0.2</td>
<td>0.2330</td>
</tr>
<tr>
<td></td>
<td>Fung</td>
<td>20.1 ± 0.8</td>
<td>21.5 ± 0.6</td>
<td>0.1759</td>
</tr>
</tbody>
</table>
In addition to examining the relationship between each eating behavior and DASH index, eating behaviors were examined relative to DASH-related nutrient and food group intakes (Table 10). Eight behaviors were significantly related to one or more of these nutrients or food groups (Table 11). Two behaviors (skips more than one meal and eats salty snack foods between meals) were not associated with DASH-related intakes. Behaviors related to intake include skips meals, eats fast food, drinks sweetened beverages, low vegetable intake, eats out more than once weekly, fries foods at home, eats snack foods, and eats sweet snack foods.

Table 10. Intake levels assessed for associations with reported eating behaviors.

<table>
<thead>
<tr>
<th>Nutrient Intakes</th>
<th>Intake Levels Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>kcal/1000kcal</td>
<td>g Fiber/1000kcal</td>
</tr>
<tr>
<td>% Protein/1000kcal</td>
<td>mg Calcium/1000kcal</td>
</tr>
<tr>
<td>% Fat/1000kcal</td>
<td>mg Magnesium/1000kcal</td>
</tr>
<tr>
<td>% Saturated fat/1000kcal</td>
<td>mg Sodium/1000kcal</td>
</tr>
<tr>
<td>mg Cholesterol/1000kcal</td>
<td>mg Potassium/1000kcal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Food Group Intakes</th>
<th>Intake Levels Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of grain servings</td>
<td>Dairy servings</td>
</tr>
<tr>
<td>Whole grain servings</td>
<td>Total meat servings</td>
</tr>
<tr>
<td>Vegetable servings</td>
<td>Nut/seed/legume servings</td>
</tr>
<tr>
<td>Fruit servings</td>
<td>Added Sugars</td>
</tr>
</tbody>
</table>

The sum of the number of reported eating behaviors related to intake was determined for each mother. Total number of eating behaviors was significantly related to all three DASH indices (Mellen: \( p=0.0141 \), Folsom: \( p=0.0163 \), Fung: \( p=0.0059 \)) such that mothers who reported more eating behaviors were more likely to have lower
Table 11. Directional relationships between maternal eating behaviors and nutrient or food intakes and associated p values. * Trending association

<table>
<thead>
<tr>
<th></th>
<th>Skips meals</th>
<th>Eats fast food</th>
<th>Drinks sweetened beverages</th>
<th>Low vegetable intake</th>
<th>Eats out &gt; 1 time weekly</th>
<th>Fries foods at home</th>
<th>Eats snack foods</th>
<th>Eats sweet snack foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy</td>
<td>0.0208</td>
<td>0.4598</td>
<td>0.0307</td>
<td>0.7359</td>
<td>0.8253</td>
<td>0.8742</td>
<td>0.3984</td>
<td>0.0198</td>
</tr>
<tr>
<td>% kcal from Protein</td>
<td>0.7589</td>
<td>0.0262</td>
<td>0.0112</td>
<td>0.4731</td>
<td>0.3420</td>
<td>0.1417</td>
<td>0.2926</td>
<td>0.6473</td>
</tr>
<tr>
<td>Fiber</td>
<td>0.0492</td>
<td>0.0658</td>
<td>0.0365</td>
<td>0.5570</td>
<td>0.0065</td>
<td>0.2691</td>
<td>0.0578</td>
<td>0.3525</td>
</tr>
<tr>
<td>Calcium</td>
<td>0.6956</td>
<td>0.1631</td>
<td>0.0452</td>
<td>0.0286</td>
<td>0.0258</td>
<td>0.0164</td>
<td>0.2161</td>
<td>0.2362</td>
</tr>
<tr>
<td>Magnesium</td>
<td>0.2765</td>
<td>0.0898</td>
<td>0.0326</td>
<td>0.0455</td>
<td>0.0074</td>
<td>0.0538</td>
<td>0.3279</td>
<td>0.1999</td>
</tr>
<tr>
<td>Potassium</td>
<td>0.6224</td>
<td>0.0223</td>
<td>0.1726</td>
<td>0.0184</td>
<td>0.0074</td>
<td>0.1015</td>
<td>0.0573</td>
<td>0.0279</td>
</tr>
<tr>
<td>Grains Servings</td>
<td>0.0167</td>
<td>0.1877</td>
<td>0.0684</td>
<td>0.6643</td>
<td>0.7858</td>
<td>0.7951</td>
<td>0.7709</td>
<td>0.1021</td>
</tr>
<tr>
<td>Whole Grains Servings</td>
<td>0.0107</td>
<td>0.4810</td>
<td>0.7383</td>
<td>0.6686</td>
<td>0.2259</td>
<td>0.2751</td>
<td>0.9072</td>
<td>0.5071</td>
</tr>
<tr>
<td>Vegetable Servings</td>
<td>0.0319</td>
<td>0.2841</td>
<td>0.4228</td>
<td>0.4840</td>
<td>0.2479</td>
<td>0.5761</td>
<td>0.9114</td>
<td>0.0549</td>
</tr>
<tr>
<td>Total Meat</td>
<td>0.1980</td>
<td>0.5816</td>
<td>0.1862</td>
<td>0.5862</td>
<td>0.5523</td>
<td>0.6828</td>
<td>0.5089</td>
<td>0.0119</td>
</tr>
<tr>
<td>Nuts, Seeds, and Legumes</td>
<td>0.0007</td>
<td>0.5240</td>
<td>0.7654</td>
<td>0.6645</td>
<td>0.0223</td>
<td>0.0300</td>
<td>0.7367</td>
<td>0.5927</td>
</tr>
<tr>
<td>Sweets Servings</td>
<td>0.0300</td>
<td>0.0200</td>
<td>0.0917</td>
<td>0.1825</td>
<td>0.4182</td>
<td>0.4709</td>
<td>0.4211</td>
<td>0.0565</td>
</tr>
</tbody>
</table>
DASH indices and therefore less adherence to the DASH diet. No interactions were found regarding young adult gender or risk group.

Ultimately, reported maternal eating behaviors were significantly associated with DASH adherence indices as well as selected DASH-related nutrient and food group intakes.

**Aim 3: Dyad Comparisons**

Mothers eating behavior scores were compared to the DASH adherence indices for their children. While no statistically significant relationship existed, a trend was demonstrated suggesting that as the number of maternal eating behaviors increased, the DASH adherence indices for their children decreased (Mellen: p=0.1680, Folsom: p=0.1339, Fung: p=0.1235). A significant relationship exists between the eating behaviors of mothers of high risk children and the intake of their children according to the Mellen index (p=0.0235) such that as the Mellen DASH score of a high risk child decreased, his or her mother reported a greater number of poor eating behaviors. This relationship between maternal eating behaviors and Mellen scores was also evident in mothers of female young adults (p=0.0127). No other relationships were evident based on risk and gender group (Table 12).
Table 12. Child DASH indices and mother eating behavior sum by child risk and gender category.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk (n=15)</td>
<td>Low Risk (n=13)</td>
</tr>
<tr>
<td>Mellen Index</td>
<td>1.27 ±</td>
<td>0.85 ±</td>
</tr>
<tr>
<td>(Child, mean ± SD)</td>
<td>1.18</td>
<td>1.19</td>
</tr>
<tr>
<td>Folsom Index</td>
<td>5.67 ±</td>
<td>5.58 ±</td>
</tr>
<tr>
<td>(Child, mean ± SD)</td>
<td>1.28</td>
<td>1.80</td>
</tr>
<tr>
<td>Fung Index</td>
<td>23.40 ±</td>
<td>24.46 ±</td>
</tr>
<tr>
<td>(Child, mean ± SD)</td>
<td>3.81</td>
<td>4.12</td>
</tr>
<tr>
<td>Eating Sum</td>
<td>4.53 ±</td>
<td>1.69 ±</td>
</tr>
<tr>
<td>(Mother, mean ± SD)</td>
<td>1.41</td>
<td>1.49</td>
</tr>
</tbody>
</table>

With respect to physical activity, mothers were categorized into three groups: 3 – most active (more than one form of purposeful exercise reported), 2 – moderately active (one form of purposeful exercise reported), and 1 – least active (no purposeful exercise reported). Purposeful exercise included the following categories: walking for exercise, strength training, cardiovascular training, or active daily activities (Table 7).

Child physical activity was also assessed in order to compare maternal and child exercise behaviors. As described previously, young adult physical activities were identified from interview narratives and divided into categories based on themes (Table 13). Themes that arose included participation in strength training, cardiovascular training, sports teams, strenuous school activities, active jobs, strenuous activities at home, typical school activities, or walking. Many children also reported no participation in exercise. Like their mothers, the children were divided into three categories based on level of physical
activity. For young adults, categories qualifying as purposeful exercise included:
strength training, cardiovascular training, sports teams, or physically exerting activities at
school. Male young adults were more likely to be active when compared to females
(average PA score = 2.78±0.09 versus 2.42±0.09, p=0.010).

Table 13. Qualifying young adult physical activity behaviors for exercise categories.

<table>
<thead>
<tr>
<th>Exercise Behavior Category</th>
<th>Qualifying Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength Training</td>
<td>Abdominal exercises, push-ups, “little exercises,” curl-ups, squats, weights, lifts, pilates, yoga</td>
</tr>
<tr>
<td>Cardiovascular Training</td>
<td>Biking, football, exercise class, running, basketball, Tae-Bo, kickball, gym, trampoline, treadmill, jumping jacks, one hour cardio daily, walking 3-4 miles, dancing, wheeling around</td>
</tr>
<tr>
<td>Sports Teams</td>
<td>Taking part in organized school sports: volleyball, basketball, football, wrestling, track, soccer</td>
</tr>
<tr>
<td>Active School Activities</td>
<td>Taking part in active school activities such as band, physical education class, flag squad, ROTC, weight lifting class</td>
</tr>
<tr>
<td>Active at Work</td>
<td>Walking, standing, lifting, or taking the stairs at work</td>
</tr>
<tr>
<td>Active at Home</td>
<td>Playing with children, cleaning, or caring for disabled mother</td>
</tr>
<tr>
<td>Typical School Activities</td>
<td>Walking to class, taking the stairs, walking around campus</td>
</tr>
<tr>
<td>Walks</td>
<td>Walking to get from one place to another or out of necessity rather than for purposeful exercise: walking down the street, around the mall, to the bus stop, home, to the car, or walking the dog</td>
</tr>
<tr>
<td>Does Not Exercise</td>
<td>Reports no exercise</td>
</tr>
</tbody>
</table>

Maternal physical activity was significantly related to the physical activity of their sons (p=0.0332). Sons reporting low levels of physical activity were more likely to have mothers who also reported low levels of physical activity.
Ultimately, statistically significant relationships between maternal eating behaviors and child intake existed only between mothers of high risk children and mothers of females. Relationships between maternal and child physical activity behaviors were only significant in dyads with sons, with no differences based on risk or risk:gender groups.
CHAPTER V
CONCLUSIONS

Discussion

This study is the first to investigate the relationship between young adult risk for the development of a chronic disease and the eating and exercise behaviors of their mothers. While this analysis cannot denote causality, this work is based on the model of intergenerational transmission of health risk behaviors. Ultimately, these results elucidate the need to consider maternal behaviors when trying to understand the establishment of lifestyle behaviors among children and when developing interventions to promote healthy lifestyles in African American youth.

Aim 1: Maternal Behaviors by Young Adult Risk and Gender Mothers of low risk males stood out as exhibiting the most healthful behaviors among all other risk:gender groups. These mothers were the least likely to report eating behaviors associated with poor DASH diet adherence such as skipping meals, consuming fast foods, drinking sweetened beverages, eating out more than once weekly, and consuming few vegetables. In addition, these mothers were more likely to have higher Folsom and Fung DASH indices, indicating a diet more aligned with DASH directives. These results suggest that mothers with low risk sons may exhibit eating behaviors that influence the behaviors of their sons. Further research is warranted regarding the preventative effects
of positive maternal eating behaviors on the hypertension risk category of African American young adult children.

With regards to physical activity, these results suggest that mothers of daughters are more likely to be former exercisers and not currently exercise. Mothers of high risk daughters, in particular, were more likely to report being unable to exercise. This trend also extended to young adult participants, as daughters were likely to be less active than sons. Previous research efforts have also revealed lower levels of physical activity in female young adults compared to males (12, 24, 26). Having an exercising maternal role model may aid in the development of positive physical activity behaviors in young adult daughters, and could provide an area for intervention for the reduced risk of hypertension in these young adult females. While a statistically significant relationship between maternal and young adult physical activity level did not exist across all groups, potential still remains for investigation into the relationships between maternal physical activity and the exercise habits of their children. Ultimately, these results suggest the need for and potential benefit of interventions to provide positive role models for young adults, especially females with physically challenged mothers, in an effort to increase the physical activity levels of these young adults.

Previous research has shown that increased physical activity levels can lead to decreased weight and BMI (20, 27, 29, 69). In addition, physical activity has been shown to have a significant influence on blood pressure control (20, 69). As maternal exercise and eating behaviors were related to gender and hypertension risk categories of young
adults, these behaviors may provide a platform for intervention to not only improve the risk status of African American young adults, but their mothers as well.

**Aim 2: Maternal Eating Behaviors by DASH Indices** Comparison of food frequency measures and eating behaviors demonstrated the link between nutrient intake and eating behaviors. Several maternal eating behaviors were statistically associated with DHQ outcomes, supporting the validity of reports of these behaviors as indicators of dietary quality. Mothers’ total eating behaviors were associated with all three DASH indices, indicating that the combined effects of meal patterns and food choices are related to overall adherence to DASH guidance.

Over-reporting of perceived positive eating behaviors is a common phenomenon, especially in females or overweight individuals, and even in adolescents (70, 71). Because socially acceptable responses can lead to a poor understanding of an individual’s intake, an alternate approach may be to focus on self-reported negative eating behaviors as areas for intervention. Working with individuals on their admitted poor eating behaviors could allow for the formulation of small, achievable, and tailored goals (such as limiting how often foods are fried at home or how often fast food is eaten) to alter behavior and therefore intake. The findings here suggest that most negative eating behaviors reported by mothers were associated with DASH-related intakes. Reports of negative eating behaviors, therefore, may provide a rapid assessment of dietary quality, and may provide starting points for intervention efforts. Additional research with a larger group is necessary in order to determine if these associations remain statistically significant.
This was an exploratory investigation composed largely of open-ended questions regarding general intake and meal patterns. As mentioned previously, behaviors such as vegetable consumption and eating out practices were questioned directly, while other behaviors such as consumption of sweetened beverages, fast food intake, and frying foods at home were not directly addressed, but rather were brought up by the participants as they described their typical intake. While this may result in under-reporting of some behaviors that participants neglected to mention, the purpose of the open-ended questioning was to allow participants to talk about food in their own language. Without direct questioning of most behaviors, responses may have been less shaped by desire for social acceptability, resulting in the collection of more reliable information regarding eating behaviors, as many reported behaviors were shared based on unsolicited free will of the participants.

While negative behaviors may be under-reported, these results suggest that those negative behaviors that are, in fact, reported are significantly related to the intake of mothers and their African American young adults, and may represent only a small portion of the negative dietary behaviors of the individual.

The DASH indices used in this investigation were chosen to provide a broad picture of the intake of the participants. The indices selected vary in how participant intake is rated. Both the Mellen and Folsom indices compare an individual’s intake to predetermined standards, while the Fung index ranks individuals based on intake. Although both the Mellen and Folsom indices compare intakes to standard goals, the scores differ from one another in the sources of DASH standards used, resulting in
different cut-off levels for point assignment. The indices also vary in which intake values are assessed. Although the Mellen index focuses on assessing nutrient intake, the Folsom and Fung indices also include components assessing DASH-related food group intakes. Each index, therefore, describes the sample population differently. Mellen scores across all participants in this study were low, while Fung scores allowed participants to be ranked, resulting in a wider distribution of scores. As mentioned previously, when maternal eating behaviors were compared to DASH indices, a low Fung score was associated with reports of three different eating behaviors, while the Mellen score was only statistically related to one behavior. These findings may suggest that the utilization of a DASH index that describes adherence to strict standards may not be appropriate when assessing this population. Alternately, ranking individuals within this population may be a more appropriate approach to assessing DASH adherence and describing the intake of individuals.

**Aim 3: Dyad Comparisons** Few relationships between mother and child with respect to eating and exercise behaviors were found. With regards to eating behaviors, only a weak relationship existed between the eating behaviors of mothers and the DASH indices of their children. This relationship is significant, however, in dyads with high risk young adults or female young adults. Overall, this data may indicate that by early adulthood there is a weaker link between mother and child diet and that the effects of maternal diet are more pronounced during childhood.

The strongest relationship was regarding physical activity in that inactive sons were more likely to have mothers who were also inactive. These results are similar to the
findings of Trost et al., who found that perceived maternal physical activity level correlated directly with the activity levels of their male, but not female, children (12). While Trost focused on African American youth, the sample population was younger (11.4 ± 0.5 years) than the population in the current study (18.6 ± 1.2 years). These findings support past findings that male and female young adults differ in influence over physical activity and may further describe the relationship between mothers and young adult sons with respect to exercise behaviors.

Efforts to provide interventions to decrease risk of hypertension in African American young adult populations through improved exercise behaviors may find benefit from the inclusion of male participants as well as their mothers. Previous investigations have also found benefit to the inclusion of maternal role models. Brownell et al. found success in the inclusion of mothers in adolescent weight loss interventions (54). Interventions that involved both mother and adolescent (although in separate classes) boasted significantly more weight loss compared to other groups (adolescent alone or mother and adolescent in the same class), even at one year follow-up. These results suggest that interventions addressing exercise habits of African American young adult males to reduce hypertension risk could benefit from the inclusion of their mothers.

Conclusions

Overall, this study suggests that maternal eating and exercise behaviors are related to the gender and hypertension risk categories of their African American young adult children. It is clear, however, that separate strategies are needed based on young adult gender and hypertension risk category.
Additional research is necessary in order to determine the nature of relationships between the eating and exercise behaviors of mothers and daughters. The presence of a relationship between maternal eating behaviors and Mellen DASH indices suggests that a link may exist between mother and young adult daughter eating. Further research is needed to determine if this relationship holds up, and to investigate the best way to take advantage of this relationship in the development of interventions to prevent the early onset of HTN.

It is important to note that complex dynamics of gender, income, marital status, and stress influence the lives of these mothers, therefore influencing their eating and physical activity behaviors. It was shown here that the eating behaviors of mothers were associated with the intakes of their daughters. Physical activity behaviors of mothers were not, however, related to the physical activity of their daughters, highlighting clear differences between groups. In addition, mothers of females were more likely to report being former exercisers. These differences may arise from the differences in income level, marital status, and education levels among mothers of daughters and mothers of sons. Mothers of daughters within this sample tended to be less educated, unmarried, and of lower socioeconomic status, putting them at risk for poor nutrition status. In addition, these mothers may be less likely to have time for exercise, influencing their physical activity behaviors. These differences again highlight the need to tailor interventions with young adults according to gender.

Interestingly, the relationship between the eating behaviors of mothers and the intake of their children were strong within dyads containing high risk youth. This
relationship may provide an opportunity to strongly influence the eating behaviors of at-risk young adults through mother-daughter or mother-son interventions.

Limited interactions related to eating behaviors in this study may suggest that young adults are more independent at this age. Investigations of younger age groups are necessary in order to determine if stronger relationships between mother and child health behaviors exist earlier. In addition, research into the ways in which the lifestyles of mothers and daughters overlap compared to mothers and sons is necessary to provide insight into these relationships or lack thereof. Ultimately, investigations such as these would aid in the determination of strategies for intervention with this group.

Interventions to decrease hypertension risk through physical activity in this young adult population may be more beneficial when focusing on mother and son, as relationships between exercise behaviors within these dyads were stronger within this sample. Interventions taking advantage of the relationships between mothers behaviors and the gender and hypertension risk factors of their African American children may prove to be more effective in decreasing hypertension risk in these young adults. Additional research is required in order to investigate these relationships further and determine the most appropriate ages and topics for mother- and child-based interventions.
CHAPTER VI

EPILOGUE

Qualitative research provides an opportunity to learn about others in their own language. Having the opportunity to work on this project and develop my qualitative research skills has been valuable and greatly rewarding. In planning and writing this project, I have learned a great deal about the research process. The skills I have developed are invaluable and will serve me well as I begin my career in dietetics. The planning and implementation of this project have given me insight into the analysis of qualitative data as well as an appreciation for the rich story that qualitative research can provide.

This experience has allowed me to expand my skill set dramatically. I feel confident in my ability to critically assess current literature not only for conclusions and applications of findings, but for strengths and weaknesses in methodology and analysis that could affect these applications. With regards to data analyses, I feel comfortable assessing narratives for common and relevant themes. I have developed the skills necessary to navigate the qualitative analysis program Atlas.ti.5.1.12 as well as the statistical analysis program JMP 7.0. The use of these tools has enabled me to develop analysis skills related to qualitative data analysis and statistics. I have improved dramatically in my ability to perform and interpret statistical analyses while working on
this project. The writing process has also provided me with ample writing experience and has allowed for the expansion and development of my writing skills. Finally, this experience has helped me to improve my skills associated with professionalism and professional communication. I have developed a larger appreciation for the importance of collaboration within the professional community. This experience has taught me to appreciate the input and work of others.

I greatly value the opportunity to have worked on this project. I have developed skills that will continue to benefit me professionally. I would like to take this opportunity to again thank my mentor, Dr. Margaret Savoca, for her support and guidance throughout this process. It is because of her experience and willingness to teach that I was able to take advantage of this amazing opportunity for growth. I would also like to thank my committee members, Dr. Martha Taylor and Dr. Tracy Nichols, for their input, guidance, and willingness to devote their time and energy to this project, which has had such a large impact on my education and career.
REFERENCES


APPENDIX A. YOUNG ADULT CONSENT DOCUMENT

YOUNG ADULT CONSENT DOCUMENT

Risk of HTN: Young Adult Lifestyles & Parental Influence

Principal Investigator: Margaret R. Savoca, Ph.D.
Sub-Investigator: Gregory Harshfield, Ph.D.
Frank Treiber, Ph.D.
Corner Evans

INVITATION TO PARTICIPATE:
I have been invited to participate in a research study. This study will look at how young adults and their mothers understand hypertension (high blood pressure) and lifestyle activities, such as eating and exercise. I have been asked to take part in this study because I am African-American between 17-20 years of age, and a past participant in one of Dr. Harshfield’s studies at the Georgia Prevention Institute. I will be one of 60 young adults to participate in this study.

PROCEDURES:
If I participate, I would meet with the researcher, Dr. Savoca. This meeting will last about two hours. Dr. Savoca and the research assistant will measure my blood pressure, weight, and height. Then the researcher will take me into a private room to interview me. She will ask me some questions about my views about high blood pressure and its development. She will also ask me about my current and past activities, such as eating and exercise. The interview will take about one hour. In addition to the interview, there will be a questionnaire session that will last one hour. During this time, a research assistant will ask me questions about my family health history and academic grades and complete a diet history questionnaire. At any time during the interview or the questionnaire session, I can refuse to answer any of the questions. Dr. Savoca or the research assistant will skip that question and move to the next topic or question. Similar information will be obtained from my mother. However, none of the information that I provide will be shared with my mother and my mother’s information will not be shared with me.

Our interviews with the researcher will be recorded on audio cassette tapes that only Dr. Savoca and the research assistant (RA) will get to hear. At any point during taping, I can
ask that the taping be stopped. The tape recorder will not be turned back on unless I give permission to do so.

Dr. Savoca and the RA will transcribe (write down) all of the information that they collect on each tape. I will not be identified by name in these transcripts. Dr. Savoca will destroy our cassette tapes as soon as she has finished the transcripts. Other researchers will not listen to the tapes or read the transcripts. The transcripts will only be used to learn about how all the young adults and their parents answered the questions. A general summary of the results for all participants will be prepared. Only this general summary will be provided to other researchers.

Sometimes when people are interviewed for a research project, short summaries of the interviews are used to help people understand the results. If the interviews of my mother and me are summarized, any information that might identify us will be changed. That means names, occupations, or events will be changed so that a reader will not recognize us from what is written.

**COSTS:**
I will be responsible for the costs of transportation to GP! and MCG.

**SUBJECT PAYMENT:**
I will each receive a $50.00 check in the mail after I complete the interview and the background/diet history questionnaires.

**RISKS AND/OR DISCOMFORTS:**
There are no risks or discomforts involved in this study. I do not have to answer any questions that make us feel uncomfortable.

**POSSIBLE BENEFITS:**
I may not personally benefit from this study. My participation in this study may provide important information regarding future prevention and treatment of hypertension in African American teenagers.

**ALTERNATIVE TREATMENTS:**
The only alternative for this study is to not participate.

**COMPENSATION:**
While no harm should be expected from my participation in the study, I understand that the Medical College of Georgia assumes no obligation to pay any money or provide free medical care in case this project results in any harm to me.

**QUESTIONS:**
If I have any questions about the study procedures or about my participation in this study, I may contact Dr. Margaret Savoca at (706) 721-5426. If I have any questions or concerns about the "rights of research subjects", I may contact the Chairman of the Human Assurance Committee, Dr. George S. Schuster at (706) 721-2991.
VOLUNTEER PARTICIPATION:

My participation in this study is voluntary. I may revoke my consent and withdraw from the study now or at any time in the future without penalty or loss of care or other benefits to which I am otherwise entitled. I can do this by telling a member of the study team that I want to stop participating. I understand that my refusal to participate in this study will not prevent me from participating in other studies at this institution.

PRIVACY NOTICE:
The researchers are asking for my written authorization before using my health information or sharing it with others in order to conduct the research described. However, under certain circumstances, the researchers may use and disclose my health information without my written authorization if they obtain approval through a special process to ensure that research without my written authorization poses minimal risk to my privacy. Under no circumstances, however, would the researchers allow others to use my name or identity me publicly.

The researchers may also disclose my health information without my written authorization to people who are planning a future research project, so long as any information identifying me does not leave our facility.

Information about people who have died may be shared with researchers using the information of the deceased person, as long as the researchers agree not to remove from our facility any information that identifies these individuals.

CONFIDENTIALITY:

Only the investigator, members of the research team, authorized officials from state and federal governments and authorized representatives from the Medical College of Georgia or MCG Health Inc. will have access to confidential data which could identify me, unless specifically required to be disclosed by state or federal law. I will not be identified by name in any report or publications resulting from this study.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:

If I sign this document, I give permission to Dr. Savoca, Dr. Treiber and/or Dr. Harshfield at MCG/MCGHI to use or disclose (release) my health information that identifies me for the research study described above. The researchers may use and share my protected health information only to conduct the research and must remove from my protected health information any disclosure that could be used to identify my child or me.

The protected health information that the investigator(s) may use or disclose (release) for this research includes:

- From the interviews, information about my views of hypertension, its causes, and treatment.
- My blood pressure, weight, and height.
- The following background information:
  - Family history: My recollection of the history of hypertension (high blood pressure), diabetes, and heart disease of my parents and my grandparents. If any
of these family members are deceased, it will include our memory of the cause of death and the age of death.

Academic Performance: The overall average grades during my most recent academic experiences.

Diet History Questionnaire: A history of the foods that I have most often eaten over the past year.

The health information listed above may be used by and/or disclosed to the study’s research assistant.

MCG/MCGHII is required by law to protect my health information. By signing this document, I authorize MCG/MCGHII to use and/or disclose my health information for this research. Those people who receive my health information may not be required by Federal privacy law (such as the Privacy Rule) to protect it and may share the information with others without my permission, if permitted by laws governing them.

If all information that does or can identify me is removed from my health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.

MCG/MCGHII may not refuse to treat me whether or not I sign this Authorization.

I may change my mind and revoke (take back) this Authorization at any time. Even if I revoke this Authorization, Dr. Savoca may still use or disclose health information they already have obtained about me as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, I must write to:

MCG/MCGHII, Dr. Margaret Savoca, 1120 15th Street, HS-1640, Augusta, GA 30912

This Authorization does not have an expiration date.

I have read this form that serves as an informed consent document and an authorization and have been given the opportunity to ask questions. If I have questions later, I can contact Dr. Savoca at (706) 721-5426. I will be given a signed copy of this document for my records. I authorize the use of my identifiable information as described in this document.

The risks and benefits to me if I participate in this study have been explained. I am encouraged to and will have the chance to ask questions and these questions will be answered. I voluntarily agree to participate and to authorize the use of my protected health information in this study.

_____________________________
Subject’s Name

_____________________________
Subject’s Signature

_____________________________
Date

Version Date: 4/1/04, 5/2/04

Subject’s Initials

HAC FILE # 04-04 375

HAS APPROVED INFORMED CONSENT DOCUMENTS
APPROVAL FROM

SUBJECTS AFTER THIS DATE

H THIS DOCUMENT IS NO LONGER VALID TO ENROLL

62
Witness’ Name (print)

Signature of Witness to the informed consent process and to the signature of the subject and/or subject’s parent and/or legal guardian

Date

INVESTIGATOR’S STATEMENT:
I acknowledge that I have discussed the above study with this participant and answered all of his/her questions. They have voluntarily agreed to participate. I have documented this action in the subject’s medical record or source document. A copy of this signed document will be placed in the subject’s medical record or source document. A copy of this document will be given to the subject or the subject’s legally authorized representative.

Printed name of investigator obtaining consent

Signature of investigator obtaining consent Date

Version Date: 4/1/04, 5/3/04  HAC FILE # 0Y-04-345
HAC APPROVED INFORMED CONSENT DOCUMENT
APPROVAL FROM 5/1/04 TO 4/1/05
THIS DOCUMENT IS NO LONGER VALID TO EnROLL SUBJECTS AFTER THIS DATE.
APPENDIX B. PARENTAL CONSENT DOCUMENT

PARENTAL CONSENT DOCUMENT

Risk of HTN: Young Adult Lifestyles & Parental Influence

Principal Investigator: Margaret R. Savoca, Ph.D.
Sub-Investigator: Gregory Harshfield, Ph.D.
Frank Treiber, Ph.D.
Conner Evans

INVITATION TO PARTICIPATE:
My child and I have been invited to participate in a research study. This study will look at how young adults and their mothers understand hypertension (high blood pressure) and lifestyle activities, such as eating and exercise. We have been asked to take part in this study because my child is African-American, 17-20 years of age, and a past participant in one of Dr. Harshfield’s studies at the Georgia Prevention Institute. My child will be one of 60 young adults and I will be one of 60 mothers to participate in this study.

PROCEDURES:
If we participate in this study then we would meet with the researcher, Dr. Savoca. This meeting will last about two hours. During this time, the researcher will take me into a private room so that she can interview me. She will ask me some questions about my views on high blood pressure and its development. She will also ask me about our current and past activities, such as eating and exercise. The interview will take about one hour. During the interview, my child will remain in another private room so that a research assistant can ask him/her some questions about our family background and medical history. He/she will also fill-out a diet history questionnaire. When the researcher is finished talking with me then Dr. Savoca will interview my child. Dr. Savoca will ask my child the same or similar questions that she asked me. While my child is being interviewed, I will answer some questions about our background/medical history and fill-out a diet history questionnaire. At any time during the interview or the questionnaire session, my child and I can refuse to answer any of the questions. Dr. Savoca or the research assistant will skip that question and move to the next topic or question.

Before the interviews begin, Dr. Savoca and the research assistant will measure my child’s and my blood pressure, weight, and height.

Version Date: 4/1/04, 5/3/04
HAC FILE # 04-04-345
HAC APPROVED INFORMED CONSENT DOCUMENT
APPROVAL FROM 5/1/04 TO 4/30/05
THIS DOCUMENT IS NO LONGER VALID TO ENROLL SUBJECTS AFTER THIS DATE.

Parent/ Guardian’s Initials _______
Our interviews with the researcher will be recorded on audio cassette tapes that only Dr. Savoca and the research assistant will get to hear. At any point during taping, my child or I can ask that taping be stopped. The tape recorder will not be turned back on unless I or my child gives the permission to do so.

Dr. Savoca and the RA will transcribe (write down) all of the information that they collect on each tape. We will not be identified by name in these transcripts. Dr. Savoca will destroy our cassette tapes as soon as she has finished the transcripts. Other researchers will not listen to the tapes or read the transcripts. The transcripts will only be used to learn about how all the children and their parents answered the questions. A general summary of the results for all participants will be prepared. Only this general summary will be provided to other researchers.

Sometimes when people are interviewed for a research project, short summaries of the interviews are used to help people understand the results. If the interviews of my child and me are summarized, any information that might identify us will be changed. That is names, occupations, or events will be changed so that a reader will not recognize us from what is written.

**COSTS:**
I will be responsible for the costs of transportation to GPI and MCG.

**SUBJECT PAYMENT:**
My child and I will each receive a $50.00 check in the mail after we complete the interview and the background/diet history questionnaires.

**RISKS AND/OR DISCOMFORTS:**
There are no risks or discomforts involved in this study. We do not have to answer any questions that make us feel uncomfortable.

**POSSIBLE BENEFITS:**
We may not personally benefit from this study. Our participation in this study may provide important information regarding future prevention and treatment of hypertension in African American teenagers.

**ALTERNATIVE TREATMENTS:**
The only alternative for this study is to not participate.

**COMPENSATION:**
While no harm should be expected from our participation in the study, I understand that the Medical College of Georgia assumes no obligation to pay any money or provide free medical care in case this project results in any harm to my child or my self.

**QUESTIONS:**
If I have any questions about the study procedures or about our participation in this study, I may contact Dr. Margaret Savoca at (706) 721-5426. If I have any questions or...
concerns about the “rights of research subjects”, I may contact the Chairman of the Human Assurance Committee, Dr. George S. Schuster at (706) 721-2991.

**VOLUNTARY PARTICIPATION:**
My participation in this study is voluntary. I may revoke my consent and withdraw us from the study now or at any time in the future without penalty or loss of care or other benefits to which my child is otherwise entitled. I can do this by telling a member of the study team that I want to stop participating. I understand that my refusal to participate in this study will not prevent my participation in other studies at this institution.

**PRIVACY NOTICE:**
The researchers are asking for my written authorization before using my child’s or my health information or sharing it with others in order to conduct the research described. However, under certain circumstances, the researchers may use and disclose my child’s or my health information without my written authorization if they obtain approval through a special process to ensure that research without my written authorization poses minimal risk my child’s or my privacy. Under no circumstances, however, would the researchers allow others to use our names or identity us publicly.

The researchers may also disclose my child’s or my health information without my written authorization to people who are planning a future research project, so long as any information identifying us does not leave our facility.

Information about people who have died may be shared with researchers using the information of the deceased person, as long as the researchers agree not to remove from our facility any information that identifies these individuals.

**CONFIDENTIALITY:**
Only the investigator, members of the research team, authorized officials from state and federal governments and authorized representatives from of the Medical College of Georgia or MCG Health Inc. will have access to confidential data which could identify my child or my self, unless specifically required to be disclosed by state or federal law. We will not be identified by name in any report or publications resulting from this study.

**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:**
If I sign this document, I give permission to Dr. Savoca, Dr. Treiber and/or Dr. Harshfield at MCG/MCGHI to use or disclose (release) our health information that identifies us for the research study described above. The researchers may use and share my child’s and my protected health information only conduct the research and must remove from my child’s and my protected health information any disclosure that could be used to identify my child or me.

The protected health information that the investigator(s) may use or disclose (release) for this research includes:
- From the interviews, information about my child’s or my views of hypertension, its causes, and treatment.
- My child’s and my blood pressure, weight, and height.

Version Date: 4/1/04, 5/3/04
MAC FILE #: 04-9Y-385
MAC APPROVED INFORMED CONSENT DOCUMENT
Parent/Guardian’s Initials
APPROVAL FROM 5/1/00 TO 4/30/05
THIS DOCUMENT IS NO LONGER VALID TO ENROLL SUBJECTS AFTER THIS DATE.
The following background information:

Family history: My child's and my recollection of the history of hypertension (high blood pressure), diabetes, and heart disease of my parents and the parents of my child's father. If any of these family members are deceased, it will include our memory of the cause of death and the age of death.

Socioeconomic Information: I will be asked to provide my age, education level and the age and educational level of my child's father.

Academic Performance: The overall average grades of my child.

Diet History Questionnaire: A history of the foods that we have most often eaten over the past year.

The health information listed above may be used by and/or disclosed to the study's research assistant.

MCG/MCGHI is required by law to protect our health information. By signing this document, I authorize MCG/MCGHI to use and/or disclose our health information for this research. Those people who receive our health information may not be required by Federal privacy law (such as the Privacy Rule) to protect it and may share the information with others without my permission, if permitted by laws governing them.

If all information that does or can identify me or my child is removed from our health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.

MCG/MCGHI may not refuse to treat us whether or not I sign this Authorization.

I may change my mind and revoke (take back) this Authorization at any time. Even if I revoke this Authorization, Dr. Savoca may still use or disclose health information they already have obtained about me and my child as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, I must write to: MCG/MCGHI, Dr. Margaret Savoca, 1120 15th Street, HS-1640, Augusta, GA 30912.

This Authorization does not have an expiration date.

I have read this form that serves as an informed consent document and an authorization and have been given the opportunity to ask questions. If I have questions later, I can contact Dr. Savoca at (706) 721-5426. I will be given a signed copy of this document for my records. I authorize the use of my and my child's identifiable information as described in this document.

The risks and benefits to us if we participate in this study have been explained. I am encouraged to and will have the chance to ask questions and these questions will be answered. I voluntarily agree to participate and to authorize the use of our protected health information in this study.

HAC FILE #: D7-04-5855
Version Date: 4/1/04, 5/3/04
HAC APPROVED INFORMED CONSENT DOCUMENT
APPROVAL FROM 5/1/04 TO 7/31/04
THIS DOCUMENT IS NO LONGER VALID TO ENROLL SUBJECTS AFTER THIS DATE.
Subject's Name (print)

* Parent or Guardian's Name (print)

* Parent or Guardian's Signature
  Date

* The individual above verifies that he/she is the natural parent and/or legal guardian of __________ and as such has the legal authority to consent to the study outlined above.

Witness' Name (print)

Signature of Witness
  Date
  to the informed consent process and to the signature of the subject and/or subject’s parent and/or legal guardian

INVESTIGATOR’S STATEMENT:
I acknowledge that I have discussed the above study with this participant and answered all of his/her questions. They have voluntarily agreed to participate. I have documented this action in the subject’s medical record or source document. A copy of this signed document will be placed in the subject’s medical record or source document. A copy of this document will be given to the subject or the subject’s legally authorized representative.

Printed name of investigator obtaining consent

Signature of investigator obtaining consent
  Date

Version Date: 4/1/04, 5/3/04

HAC FILE #: CV-04-3MS

HAC APPROVED INFORMED CONSENT DOCUMENT
APPROVAL FROM 5/10/04 TO 7/10/05

THIS DOCUMENT IS NO LONGER VALID TO ENROLL SUBJECTS AFTER THIS DATE.
APPENDIX C. CHILDREN'S ASSENT

CHILDREN'S ASSENT

Risk of HTN: Young Adult Lifestyles & Parental Influence

Principal Investigator: Margaret R. Savoca, Ph.D.
Sub-Investigator: Gregory Harshfield, Ph.D.
Frank Treiber, Ph.D.
Conner Evans

INVITATION TO PARTICIPATE:
I have been invited to participate in a research study. This study will look at how young adults and their mothers understand hypertension (high blood pressure) and the way that health-related behaviors (like eating and exercise) can help or hurt them. I have been asked to take part in this study because I am an African-American between the ages of 17 to 20 years old who has participated in one of Dr. Harshfield’s past studies at the Georgia Prevention Institute. I will be one of 60 young adults to participate in this study.

PROCEDURES:
If I participate in this study then my mother and I will meet with the researcher, Dr. Savoca. This meeting will last about two hours. During this time, the researcher will take my mother into a private room so that she can ask her some questions about blood pressure and lifestyle activities, such as eating and exercise. I will stay in another private room so that a research assistant can ask me some questions about our family background and medical history. I will also fill-out a diet history questionnaire. When the researcher is finished talking with my mother then she will interview me. The researcher will ask me some of the same questions she asked my mother and some that might be different. I should try and be as honest as I can when I answer her questions. I do not need to answer any questions that make me feel uncomfortable. If I do not want to answer a question, I will tell Dr. Savoca and she will ask me the next question. Dr. Savoca will not share my answers with my mother at any time. My mother will wait in the other room while I am with the researcher. She will answer the same questions I did about our family background and medical history. She will also fill-out a diet history questionnaire.

Our interviews with the researcher will be recorded on audio cassette tapes that only Dr. Savoca and the research assistant (RA) will get to hear. At any time, I can ask Dr. Savoca...
to turn the taped recorder off. The tape recorder will not be turned back on unless I tell Dr. Savoca to begin taping again.

Dr. Savoca and the RA will transcribe (write down) all of the information that they collect on each tape. My name will not be in these transcripts. Dr. Savoca will destroy our cassette tapes as soon as she has finished the transcripts. No other researchers will listen to the tapes or read the transcripts. The transcripts will only be used to learn about how all the children and their parents answered the questions. One report that describes how the children and their parents answered these questions will be written. Only this report will be read by other researchers.

Sometimes when people are interviewed for a research project, short summaries of their interviews are used to help people understand the results. If my and my mother’s interviews are summarized, any information that could identify us will be changed. That means any names, types of jobs, school activities, or family events will be changed so that someone who reads the summary can not tell who are from what is written.

**SUBJECT PAYMENT:**
I will receive a $50.00 check in the mail after I complete the interview and the diet history questionnaires.

**RISKS AND/OR DISCOMFORTS:**
There are no risks or discomforts involved in this study. I do not have to answer any questions that make me feel uncomfortable.

**POSSIBLE BENEFITS:**
I may not personally benefit from this study. My participation in this study may provide important information regarding future prevention and treatment of hypertension in African American teens.

**ALTERNATIVE TREATMENTS:**
The only alternative for this study is to not participate.

**QUESTIONS:**
If I have any questions about the study procedures or about my participation in this study, I may contact Dr. Savoca at (706) 721-5426. If I have any questions or concerns about the “rights of research subjects”, I may contact the Chairman of the Human Assurance Committee, Dr. George S. Schuster at (706) 721-2991.

**VOLUNTARY PARTICIPATION:**
I do not have to be in this study. I can stop any time I want to. If I do stop or if I do not want to be in the study, it’s okay. No one will be mad at me. I understand that if I decide not to be in this study, I can still be in other studies at MCG if I meet their standards.

I read this paper. They will explain it to me. I will have the chance to ask questions. They will answer the questions so that I can understand. If I have more questions, my parents or I can call Dr. Savoca at (706) 721-5426. I will be in the study.
Subject's Name: _______________________

Subject's Name (print) _______________________

Subject's Signature _______________________

Date _______________________

* Parent or Guardian’s Name (print) _______________________

*Parent or Guardian’s Signature _______________________

Date _______________________

*The individual above verifies that he/she is the natural parent and/or legal guardian of _______________________

and as such has the legal authority to consent to the study outlined above.

Witness’ Name (print) _______________________

Signature of Witness _______________________

Date _______________________

to the informed consent process and to the
signature of the subject and/or subject’s
parent and/or legal guardian

INVESTIGATOR’S STATEMENT:
I acknowledge that I have discussed the above study with this participant and answered all of his/her questions. They have voluntarily agreed to participate. I have documented this action in the subject’s medical record or source document. A copy of this signed document will be placed in the subject’s medical record or source document. A copy of this document will be given to the subject or the subject’s legally authorized representative.

Printed name of investigator obtaining consent _______________________

Signature of investigator obtaining consent _______________________

Date _______________________

Version Date: 4/1/04

HAC FILE #: 04-04-345

HAC APPROVED INFORMED CONSENT DOCUMENT
APPROVAL FROM 5/10/04 TO 4/25/01

THIS DOCUMENT IS NO LONGER VALID TO ENROLL SUBJECTS AFTER THIS DATE.
APPENDIX D. MOTHER INTERVIEW

I appreciate the opportunity to talk with you. Understanding the views about health of mothers and their young adult children is the purpose of this research. The best way I know to learn about people’s experiences and views is to hear it in their own words. We want to provide people who are trying to improve the health of young adults with an honest view of how young adults and their parents view high blood pressure or hypertension and their lifestyle behaviors, such as exercise and diet. Our goal is to ensure that when doctors and other health educators provide advice, they base it on what you tell us - not what they think goes on in your life or your family.

The interview will last about one hour. I will be asking you questions about hypertension, your daily activities, as well as your views about daily activities that can affect your health. There are no right or wrong answers. This is not a test of what you know about hypertension or health habits. We just want you to share your own opinions, ideas, and experiences.

Each of you will be asked similar questions. Based upon your answers, I may ask you additional questions that will help me to better understand what you are telling me. If at any time you don’t feel comfortable answering something just let me know and we will move to another question. If you have thoughts that you think are important for me to know, I encourage you to share these with me.

I will tape record our session so that I can do a better job of listening to you. I will use the tapes only to review our conversation and record your answers. You will not be identified by name in our database only by ID number. I will destroy the tapes after I complete collecting and analyzing data. If at any time, you have concerns about the taping let me know and I will turn off the recorder. This recording will not be shared with your parent (child) or any other researcher. The only people who will listen to these tapes are me and the research assistant who is working with me.

Do you have any questions or concerns about the interview or taping?

I want to thank you in advance for your time and effort to help with this important work.
In the first part of the interview, I'll ask you some questions about hypertension. Remember this is not a test. I just want your honest answers to these questions.

Hypertension

1. What do you think hypertension or high blood pressure is? What do the numbers mean to you?
2. What do you believe causes it? Are there any symptoms that people have with hypertension?
3. What do think may happen to people who have hypertension?
4. How is hypertension usually treated? Do you think it can be cured?
5. Do you think there is anything that can prevent it?
6. Why do you think it is that some people get it and some do not?

Family History

1. We will be asking this question again but I'd like you to tell me if anyone in your family has hypertension? How old were they when they found out they had hypertension?
2. How has (or did) hypertension affected them?
3. Were their daily habits changed because they had hypertension?
4. Has anyone else who you know well had hypertension? How have their experiences compared to those of your family members?
5. Do you think anyone else in your family is at risk for hypertension? Why or why not?

If Mother has Hypertension

7. When were you diagnosed with hypertension? What was going on that lead to your diagnosis?
8. How did you react to the diagnosis?
9. Have you changed anything about your daily life because you have hypertension?
10. How easy do you think it is to control your blood pressure?
Doctor Information

1. How often do you visit the doctor?
2. What usually is the reason that you see a doctor?
3. Do you mind seeing doctor?
4. Has the number of doctor’s visits changed over time?
5. Do you ask question when you visit the doctor?
6. How often does your child visit the doctor?
7. Do you talk to the doctor with your child?
8. How are your doctor’s bills paid for? Health insurance?
9. How are your child’s health bills paid for? Health Insurance?
10. Is health coverage something that you are concerned about?

Other sources of health information

1. Are there other ways that you receive information about your health?
2. Where do you learn about health and conditions like hypertension?
3. Where would you go if you wanted to know more about health or had any questions about your health?
4. Any ideas on how to provide health education to young people? Or their mothers?

*Before we move on to other questions, do you have any other thoughts on hypertension or anything else you would like to share that I may not have asked?*
Part II (MOTHER): Health and Lifestyle: Behaviors and Influences

Any questions so far about the interview so far?

Overall Health

Now I would like to find out more about how you feel about your own health as well as learn more about your daily activities.

1. Do you have any concerns about your health today?
2. How do you feel most days?
3. Do you have any concerns about health conditions that might appear as you get older?
4. Are you taking any medications either regularly or as needed?
5. Do you have any concerns about your child’s health or the health of any members of your immediate family (e.g. husband, children, parents)

Now we will talk about your daily activities.

Household makeup

To help us learn how these activities fit into your everyday habits, tell me who lives in your household. Has this changed in the past few years?

Eating

Eating is our first topic. We will ask you more questions following the interview about what you eat. Now we will talk about eating in a more general way.

1. Tell me how you eat during a typical weekday. That is when and where you eat and generally what you would have. Beginning with the first thing you eat in the morning and going through to the last time you eat each day. Ask “What kind of beverages do you normally drink and why?”
2. What did you have for dinner last night?
3. Does your eating differ on the weekends?
4. How many meals would you usually eat at home? Who usually eats at home?
5. Who shops and prepares the meals at home? Do you shop with a list?
6. How often do you eat out? What are the places where you most frequently eat out?
7. What affects how and what you eat?
8. People are always interested in hearing about how and why people eat vegetables. What do you consider a vegetable? Tell me about it and how you include vegetables in meals.

9. Do you like vegetables? Have you always?

10. What kinds of eating habits do you think are healthy? Which habits are not?

11. Does your child cook for him or herself?

12. How much does your child know about foods and cooking? Where did he/she learn this?

13. How did you learn how to cook?

**Physical Activity**

*Now we'll talk about being active. I'd like to talk about all types of activity, not just exercise.*

1. How active are you during the day? When are you most active? When are you the least active?

2. Does work require you to be very active?

3. How much time do you spend watching TV, playing video games, or working on a computer at home?

4. Do you exercise on a regular basis? How often do you exercise? What do you like to do when you exercise?

5. Is exercising something you like to do?

6. What causes you to have more or less physical activity?

7. Was there a time when you were more or less active than you are today?

8. Is exercise or physical activity something that is important to you?

9. What kinds of physical activity habits do you think are healthy?
Sleeping

My next questions are about sleeping.

1. How much sleep do you get each weekday night or weekend?
2. What affects how much you sleep?
3. What kinds of sleep habits do you think are healthy? Which habits are not?

Smoking

Now I’d like to ask you about smoking.

1. Have you ever smoked cigarettes? Dipped or chewed? Do you now?
2. When did you start? Why do you think you started smoking?
3. How many cigarettes do you smoke in a day, month, or week? What affects how often you smoke?
4. Have you ever tried to quit?
5. Are your friends smokers?
6. Did either of your parents smoke?

Stress

Finally, I’d like to get an idea if you feel your life is stressful.

1. Do you feel you have a great deal of stress in your life? How about compared to other people you know?
2. Does stress affect you or your activities? How so?
3. What causes the stress in your life?
4. Are there things that you could do to reduce your stress?
5. Do you think that stress has an effect on health? If so, how so.
General Questions

I have some general questions about all of these areas.

1. Have you changed your daily habits (eating, physical activity, exercise, smoking, sleep, and stress) as you’ve gotten older? How have things changed?

2. Do you think these habits need to be different depending on your age?

3. Which of these areas is most important as far as maintaining or improving health?

4. Are there any habits you would like to change or improve?

5. Do think there is anything that would help you to improve your habits or activities?

6. Briefly, how do you think your child would answer these questions about these activities for herself, such as -
   a. eating
   b. exercise
   c. sleep habits
   d. smoking
   e. stress

7. What influence do you think your child’s friends have on his/her habits?

8. Are there any of her activities that you wish he/she would change?

9. How much influence do you have over your child’s health habits? Has it changed over the years?

10. Do your children have any influence over your health habits?

Closing

Any other thoughts on any of the questions we have covered?

You have been a great help. Thank you so much for your time and interest answering these questions.
Introduction to the Interview

I appreciate the opportunity to talk with you. Understanding the views about health of mothers and their young adult children is the purpose of this research. The best way I know to learn about people's experiences and views is to hear it in their own words. We want to provide people who are trying to improve the health of young adults with an honest view of how young adults and their parents view high blood pressure or hypertension and their lifestyle behaviors, such as exercise and diet. Our goal is to ensure that when doctors and other health educators provide advice, they base it on what you tell us - not what they think goes on in your life or your family.

The interview will last about one hour. I will be asking you questions about hypertension, your daily activities, as well as your views about daily activities that can affect your health. There are no right or wrong answers. This is not a test of what you know about hypertension or health habits. We just want you to share your own opinions, ideas, and experiences.

Each of you will be asked similar questions. Based upon your answers, I may ask you additional questions that will help me to better understand what you are telling me. If at any time you don't feel comfortable answering something, just let me know and we will move to another question. If you have thoughts that you think are important for me to know, I encourage you to share these with me.

I will tape record our session so that I can do a better job of listening to you. I will use the tapes only to review our conversation and record your answers. You will not be identified by name in our database only by ID number. I will destroy the tapes after I complete collecting and analyzing data. If at any time, you have concerns about the taping let me know and I will turn off the recorder. This recording will not be shared with your parent (child) or any other researcher. The only people who will listen to these tapes are me and the research assistant who is working with me.

Do you have any questions or concerns about the interview or taping?

I want to thank you in advance for your time and effort to help with this important work.
Part I (CHILD): Hypertension: Views and Experiences

In the first part of the interview, I’ll ask you some questions about hypertension. Remember this is not a test. I just want your honest answers to these questions. There are no right or wrong answers.

Hypertension

1. What do you think hypertension or high blood pressure is? What do the numbers mean?
2. What do you believe causes it?
3. Are there any symptoms that people with hypertension have?
4. What do think may happen to people who have hypertension?
5. How is hypertension usually treated? Do you think it can be cured?
6. Do you think there is anything that can prevent it?
7. Why do you think it is that some people get hypertension some do not?

Family History

1. We will be asking this question again but I’d like you to tell me if anyone in your family has hypertension? How old were they when they found out they had hypertension?
2. How has (or did) hypertension affected them?
3. Were their daily habits changed because they had hypertension?
4. Has anyone else who you know well had hypertension? How have their experiences compared to those of your family members?
5. Do you think anyone else in your family is at risk for hypertension? Why or why not?
Doctor Information

1. How often do you visit the doctor?
2. What usually is the reason that you see a doctor?
3. What kind of doctor do you go to see? Pediatrician?
4. Has this changed over time?
5. Do you mind seeing doctor?
6. Do you ask question when you visit the doctor?
7. Does your mother talk to the doctor with you?
8. How are your doctor bills paid for? Health insurance?

Other sources of health information

1. Are there other ways that you receive information about your health?
2. Where do you learn about health and conditions like hypertension?
3. Where would you go if you wanted to know more about health or had any questions about your health?
4. Any ideas on how to provide health education to young people? Or their mothers?

Before we move on to other questions, do you have any other thoughts on hypertension or anything else you would like to share that I may not have asked?
Any questions so far about the interview so far?

Overall Health

Now I would like to find out more about how you feel about your own health as well as learn more about your daily activities.

1. Do you have any concerns about your health today?
2. How do you feel most days?
3. Do you have any concerns about health conditions that might appear as you get older?
4. Are you taking any medications either regularly or as needed?

Now we will talk about your daily activities.

Household Makeup

To help us learn how these activities fit into your everyday habits, tell me about who lives in your household. Has this changed in the past few years?

Probe the relationship with their father, if he hasn’t been mentioned.

Find out if they are working, in school, between jobs, etc.

Eating

Eating is our first topic. We will ask you more questions following the interview about what you eat. Now we will talk about eating in a more general way.

1. Tell me how you eat during a typical weekday. That is when and where you eat and generally what you would have. Beginning with the first thing you eat in the morning and going through to the last time you eat each day. *Ask what kind of beverages do you normally drink and why if not mentioned.*
2. What did you have for dinner last night?
3. Does your eating differ on the weekends?
4. How many meals would you usually eat at home? Who usually eats at home?
5. Who shops and prepares the meals at home? Do you know if there is meal planning?
6. How often do you eat out? What are the places where you most frequently eat out?
7. Do you ever cook for yourself? How did you learn how to cook?

8. What affects how and what you eat?

9. People are always interested in hearing about how and why people eat vegetables. What do you consider a vegetable? Tell me if and how you include vegetables in meals.

10. Do you like vegetables? Have you always?

11. What kinds of eating habits do you think are healthy? Which habits are not?

12. How do your friends influence how you eat?

Physical Activity

Now we’ll talk about being active. I’d like to talk about all types of activity not just exercise.

1. How active are you during the day? When are you the most active? When are you the least active?

2. Does work or school require you to be very active?

3. How much time do you spend watching TV, playing video games, or working on a computer at home?

4. Do you exercise on a regular basis? How often do you exercise? What do you like to do when you exercise?

5. Is exercising something you like to do?

6. What causes you to have more or less physical activity?

7. Was there a time when you were more or less active than you are today?

8. Is exercise or physical activity something that is important to you?

9. How much influence do your friends have on your physical activity?
Sleeping

My next questions are about sleeping.

1. How much sleep do you get each weekday night or weekend?
2. What affects how much you sleep?
3. What kinds of sleep habits do you think are healthy?

Smoking

Now I'd like to ask you about smoking.

1. Have you ever smoked cigarettes? Dipped or chewed? Do you now?
2. When did you start? Why do you think you started smoking?
3. How many cigarettes do you smoke in a day, or week? Does anything affect how often you smoke?
4. Have you ever tried to quit?
5. Are your friends smokers?
6. Do either of your parents smoke?

Stress

Finally, I'd like to get an idea if you feel your life is stressful.

1. Do you feel you have a great deal of stress in your life? How about compared to other people you know?
2. Does stress affect you or your activities? How so?
3. What causes the stress in your life?
4. Do your friends have an effect on your stress level?
5. Are there things that you could do to reduce your stress?
6. Do you think that stress has an effect on health? If so, how so.
General Questions

I have some general questions about all of these areas.

1. Have you changed your daily habits (eating, physical activity, exercise, smoking, sleep, and stress) as you’ve gotten older? How have things changed?

2. Which of these areas is most important as far as maintaining or improving health?

3. Are there any habits you would like to change or improve?

4. Do think there is anything that would help you to improve your habits or activities?

5. Briefly, how do you think your mother would answer these questions about these activities for herself, such as -
   a. eating
   b. exercise
   c. sleep habits
   d. smoking
   e. stress for herself

6. Are there any of her activities that you wish she would change?

7. How much influence does your mother have over your health habits? Has it changed over the years?

8. Do you have any influence over your mother’s health habits?

Closing

Any other thoughts about any of the questions I have asked today?

You have been a great help. Thank you so much for your time and interest answering these questions.
# APPENDIX F. NATIONAL INSTITUTES OF HEALTH DIET HISTORY QUESTIONNAIRE

## GENERAL INSTRUCTIONS

- Answer each question as best you can. Estimate if you are not sure. A guess is better than leaving a blank.
- Use only a No. 2 pencil.
- Be certain to completely blacken each of the answers.
- Erase completely if you make any changes.
- Do not make any stray marks on this form.
- If you blacken NEVER or NO for a question, please follow any arrows or instructions that direct you to the next question.

## BEFORE TURNING THE PAGE, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

### Today's date:

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN</td>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>FEB</td>
<td></td>
<td>2003</td>
</tr>
<tr>
<td>MAR</td>
<td>3</td>
<td>2004</td>
</tr>
<tr>
<td>APR</td>
<td>4</td>
<td>2005</td>
</tr>
<tr>
<td>MAY</td>
<td>5</td>
<td>2006</td>
</tr>
<tr>
<td>JUN</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>JUL</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>AUG</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>SEP</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>OCT</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>NOV</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>DEC</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

### In what month were you born?

- JAN
- FEB
- MAR
- APR
- MAY
- JUN
- JUL
- AUG
- SEP
- OCT
- NOV
- DEC

### In what year were you born?

- 19

### Are you male or female?

- Male
- Female

---

**PLEASE DO NOT WRITE IN THIS AREA**

---

**SERIAL #**
1. Over the past 12 months, how often did you drink tomato juice or vegetable juice?

- NEVER (GO TO QUESTION 2)
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week

1a. Each time you drank tomato juice or vegetable juice, how much did you usually drink?

- Less than ¾ cup (6 ounces)
- ¾ to 1 ½ cups (6 to 10 ounces)
- More than 1 ½ cups (10 ounces)

2. Over the past 12 months, how often did you drink orange juice or grapefruit juice?

- NEVER (GO TO QUESTION 3)
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week

2a. Each time you drank orange juice or grapefruit juice, how much did you usually drink?

- Less than ¾ cup (6 ounces)
- ¾ to 1 ½ cups (6 to 10 ounces)
- More than 1 ½ cups (10 ounces)

3. Over the past 12 months, how often did you drink other 100% fruit juice or 100% fruit juice mixtures (such as apple, grape, pineapple, or others)?

- NEVER (GO TO QUESTION 4)
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week

3a. Each time you drank other fruit juice or fruit juice mixtures, how much did you usually drink?

- Less than ¾ cup (6 ounces)
- ¾ to 1 ½ cups (6 to 12 ounces)
- More than 1 ½ cups (12 ounces)

Over the past 12 months...

4. How often did you drink other fruit drinks (such as cranberry cocktail, Hi-C, lemonade, or Kool-Aid, diet or regular)?

- NEVER (GO TO QUESTION 5)
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week

4a. Each time you drank fruit drinks, how much did you usually drink?

- Less than 1 cup (8 ounces)
- 1 to 2 cups (8 to 16 ounces)
- More than 2 cups (16 ounces)

4b. How often were your fruit drinks diet or sugar-free drinks?

- Almost never or never
- About ½ of the time
- About ¾ of the time
- Almost always or always

5. How often did you drink milk as a beverage (NOT in coffee, NOT in cereal)? (Please include chocolate milk and hot chocolate.)

- NEVER (GO TO QUESTION 6)
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week

5a. Each time you drank milk as a beverage, how much did you usually drink?

- Less than 1 cup (8 ounces)
- 1 to 1 ½ cups (8 to 12 ounces)
- More than 1 ½ cups (12 ounces)

5b. What kind of milk did you usually drink?

- Whole milk
- 2% fat milk
- 1% fat milk
- Skim, nonfat, or 1/2% fat milk
- Soy milk
- Rice milk
- Other

Question 4 appears in the next column.

Question 6 appears on the next page.
Over the past 12 months...

6. How often did you drink meal replacement, energy, or high-protein beverages such as instant Breakfast, Ensure, SlimFast, Suscatal or others?
   - NEVER (GO TO QUESTION 7)
   - 1 time per month or less
   - 2–3 times per month
   - 1–2 times per week
   - 3–4 times per week
   - 5–6 times per week

5a. Each time you drank meal replacement beverages, how much did you usually drink?
   - Less than 1 cup (8 ounces)
   - 1 to 1½ cups (8 to 12 ounces)
   - More than 1½ cups (12 ounces)

5b. How often did you drink meal replacement beverages?
   - NEVER
   - 1 time per month or less
   - 2–3 times per month
   - 1–2 times per week
   - 3–4 times per week
   - 5–6 times per week

7a. How often did you drink soft drinks, soda, or pop IN THE SUMMER?
   - NEVER
   - 1 time per month or less
   - 2–3 times per month
   - 1–2 times per week
   - 3–4 times per week
   - 5–6 times per week

7b. How often did you drink soft drinks, soda, or pop DURING THE REST OF THE YEAR?
   - NEVER
   - 1 time per month or less
   - 2–3 times per month
   - 1–2 times per week
   - 3–4 times per week
   - 5–6 times per week

7c. Each time you drank soft drinks, soda, or pop, how much did you usually drink?
   - Less than 12 ounces or less than 1 can or bottle
   - 12 to 16 ounces or 1 can or bottle
   - More than 16 ounces or more than 1 can or bottle

7d. How often were these soft drinks, soda, or pop diet or sugar-free?
   - Almost never or never
   - About 1/4 of the time
   - About 1/2 of the time
   - About 3/4 of the time
   - Almost always or always

7e. How often were these soft drinks, soda, or pop caffeine-free?
   - Almost never or never
   - About 1/4 of the time
   - About 1/2 of the time
   - About 3/4 of the time
   - Almost always or always

8. Over the past 12 months, did you drink beer?
   - NO (GO TO QUESTION 9)
   - YES

8a. How often did you drink beer IN THE SUMMER?
   - NEVER
   - 1 time per month or less
   - 2–3 times per month
   - 1–2 times per week
   - 3–4 times per week
   - 5–6 times per week

8b. How often did you drink beer DURING THE REST OF THE YEAR?
   - NEVER
   - 1 time per month or less
   - 2–3 times per month
   - 1–2 times per week
   - 3–4 times per week
   - 5–6 times per week

8c. Each time you drank beer, how much did you usually drink?
   - Less than a 12-ounce can or bottle
   - 1 to 3 12-ounce cans or bottles
   - More than 3 12-ounce cans or bottles
Over the past 12 months...

12a. How often was the cold cereal you ate some other bran or fiber cereal (such as Cheerios, Shredded Wheat, Raisin Bran, Bran flakes, Grape-Nuts, Granola, Wheaties, or Healthy Choice)?
   ○ Almost never or never
   ○ About ¼ of the time
   ○ About ½ of the time
   ○ About ¾ of the time
   ○ Almost always or always

12b. How often was the cold cereal you ate any other type of cold cereal (such as Corn Flakes, Rice Krispies, Frosted Flakes, Special K, Froot Loops, Cap’n Crunch, or others)?
   ○ Almost never or never
   ○ About ¼ of the time
   ○ About ½ of the time
   ○ About ¾ of the time
   ○ Almost always or always

12c. Was milk added to your cold cereal?
   ○ NO (GO TO QUESTION 13)
   ○ YES

12g. What kind of milk was usually added?
   ○ Whole milk
   ○ 2% fat milk
   ○ 1% fat milk
   ○ Skim, nonfat, or 1/2% fat milk
   ○ Soy milk
   ○ Rice milk
   ○ Other

12h. Each time milk was added to your cold cereal, how much was usually added?
   ○ Less than ½ cup
   ○ ½ to 1 cup
   ○ More than 1 cup

13. How often did you eat applesauce?
   ○ NEVER (GO TO QUESTION 14)
   ○ 1–6 times per year
   ○ 7–11 times per year
   ○ 1 time per month
   ○ 2–3 times per month
   ○ 1 time per week
   ○ 2 or more times per day

13a. Each time you ate applesauce, how much did you usually eat?
   ○ Less than 1/2 cup
   ○ 1/2 to 1 cup
   ○ More than 1 cup

14. How often did you eat apples?
   ○ NEVER (GO TO QUESTION 15)
   ○ 1–6 times per year
   ○ 7–11 times per year
   ○ 1 time per month
   ○ 2–3 times per month
   ○ 1 time per week
   ○ 2 or more times per day

14a. Each time you ate apples, how many did you usually eat?
   ○ Less than 1 apple
   ○ 1 apple
   ○ More than 1 apple

15. How often did you eat pears (fresh, canned, or frozen)?
   ○ NEVER (GO TO QUESTION 16)
   ○ 1–6 times per year
   ○ 7–11 times per year
   ○ 1 time per month
   ○ 2–3 times per month
   ○ 1 time per week
   ○ 2 or more times per day

15a. Each time you ate pears, how much did you usually eat?
   ○ Less than 1 pear
   ○ 1 pear
   ○ More than 1 pear

16. How often did you eat bananas?
   ○ NEVER (GO TO QUESTION 17)
   ○ 1–6 times per year
   ○ 7–11 times per year
   ○ 1 time per month
   ○ 2–3 times per month
   ○ 1 time per week
   ○ 2 or more times per day

Question 17 appears on the next page.
Over the past 12 months...

20c. Each time you ate cantaloupe, how much did you usually eat?
- Less than 1/4 cup or less than 1/2 cup
- 1/4 cup or 1/2 to 1 cup
- More than 1/4 cup or more than 1 cup

21. Over the past 12 months, did you eat melon, other than cantaloupe (such as watermelon or honeydew)?
- NO (GO TO QUESTION 22)
- YES

21a. How often did you eat fresh melon, other than cantaloupe, (such as watermelon or honeydew) WHEN IN SEASON?
- NEVER
- 1–6 times per season
- 7–11 times per season
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

21b. How often did you eat fresh or frozen melon, other than cantaloupe (such as watermelon or honeydew) DURING THE REST OF THE YEAR?
- NEVER
- 1–6 times per year
- 7–11 times per year
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

21c. Each time you ate melon other than cantaloupe, how much did you usually eat?
- Less than 1/2 cup or 1 small wedge
- 1/2 to 2 cups or 1 medium wedge
- More than 2 cups or 1 large wedge

22. Over the past 12 months, did you eat strawberries?
- NO (GO TO QUESTION 23)
- YES

22a. How often did you eat fresh strawberries WHEN IN SEASON?
- NEVER
- 1–6 times per season
- 7–11 times per season
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

22b. How often did you eat fresh or frozen strawberries DURING THE REST OF THE YEAR?
- NEVER
- 1–6 times per year
- 7–11 times per year
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

22c. Each time you ate strawberries, how much did you usually eat?
- Less than 1/4 cup or less than 3 berries
- 1/4 to 1/2 cup or 3 to 6 berries
- More than 1/2 cup or more than 6 berries

23. Over the past 12 months, did you eat oranges, tangerines, or tangelos?
- NO (GO TO QUESTION 24)
- YES

23a. How often did you eat fresh oranges, tangerines, or tangelos WHEN IN SEASON?
- NEVER
- 1–6 times per season
- 7–11 times per season
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

Question 22 appears on the next column.
23b. How often did you eat oranges, tangerines, or tangelos (fresh or canned) DURING THE REST OF THE YEAR?

☐ NEVER
☐ 1-6 times per year
☐ 7-11 times per year
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 or more times per day

23c. Each time you ate oranges, tangerines, or tangelos, how many did you usually eat?

☐ Less than 1 fruit
☐ 1 fruit
☐ More than 1 fruit

24. Over the past 12 months, did you eat grapefruit?

☐ NO (GO TO QUESTION 25)
☐ YES

24a. How often did you eat fresh grapefruit WHEN IN SEASON?

☐ NEVER
☐ 1-6 times per season
☐ 7-11 times per season
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 or more times per day

24b. How often did you eat grapefruit (fresh or canned) DURING THE REST OF THE YEAR?

☐ NEVER
☐ 1-6 times per year
☐ 7-11 times per year
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 or more times per day

24c. Each time you ate grapefruit, how much did you usually eat?

☐ Less than ½ grapefruit
☐ ½ grapefruit
☐ More than ½ grapefruit

Question 25 appears in the next column.

25. How often did you eat other kinds of fruit?

☐ NEVER (GO TO QUESTION 26)
☐ 1-6 times per year
☐ 7-11 times per year
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 or more times per day

25a. Each time you ate other kinds of fruit, how much did you usually eat?

☐ Less than ¼ cup
☐ ¼ to ¾ cup
☐ More than ¾ cup

26. How often did you eat COOKED greens (such as spinach, turnip, collard, mustard, chard, or kale)?

☐ NEVER (GO TO QUESTION 27)
☐ 1-6 times per year
☐ 7-11 times per year
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 or more times per day

26a. Each time you ate COOKED greens, how much did you usually eat?

☐ Less than ½ cup
☐ ½ to 1 cup
☐ More than 1 cup

27. How often did you eat RAW greens (such as spinach, turnip, collard, mustard, chard, or kale)? (We will ask about lettuce later.)

☐ NEVER (GO TO QUESTION 28)
☐ 1-6 times per year
☐ 7-11 times per year
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 or more times per day

27a. Each time you ate RAW greens, how much did you usually eat?

☐ Less than ½ cup
☐ ½ to 1 cup
☐ More than 1 cup
Over the past 12 months...

33b. How often did you eat corn (fresh, canned, or frozen) during the rest of the year?
- NEVER
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

33c. Each time you ate corn, how much did you usually eat?
- Less than 1 cup or less than 1/2 cup
- 1/2 cup to 1 cup
- More than 1 cup or more than 1 1/2 cup

34. Over the past 12 months, how often did you eat broccoli (fresh or frozen)?
- NEVER (GO TO QUESTION 36)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

34a. Each time you ate broccoli, how much did you usually eat?
- Less than 1/4 cup
- 1/4 to 1 cup
- More than 1 cup

35. How often did you eat cauliflower or Brussels sprouts (fresh or frozen)?
- NEVER (GO TO QUESTION 36)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

35a. Each time you ate cauliflower or Brussels sprouts, how much did you usually eat?
- Less than 1/4 cup
- 1/4 to 1/2 cup
- More than 1/2 cup

36. How often did you eat mixed vegetables?
- NEVER (GO TO QUESTION 37)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

36a. Each time you ate mixed vegetables, how much did you usually eat?
- Less than 1/2 cup
- 1/2 to 1 cup
- More than 1 cup

37. How often did you eat onions?
- NEVER (GO TO QUESTION 38)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

37a. Each time you ate onions, how much did you
- Less than 1 slice or less than 1 tablespoon
- 1 slice or to 1 1/2 tablespoons
- More than 1 slice or more than 4 tablespoons

38. Now think about all the cooked vegetables you ate in the past 12 months and how they were prepared. How often were your vegetables COOKED WITH some sort of fat, including oil spray? (Please do not include potatoes.)
- NEVER (GO TO QUESTION 39)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

Question 39 appears on the next page.
Over the past 12 months...

39a. Which fats were usually added to your vegetables DURING COOKING? (Please do not include potatoes. Mark as many as apply.)

- Margarine (including low-fat)
- Butter (including low-fat)
- Lard, fatback, or bacon fat
- Olive oil
- Corn oil
- Canola or rapeseed oil
- Oil sour, such as Palm or others
- Other kinds of oils
- None of the above

39. Now, thinking again about all the cooked vegetables you ate in the past 12 months, how often was some sort of fat, sauce, or dressing added AFTER COOKING OR AT THE TABLE? (Please do not include potatoes.)

- NEVER (GO TO QUESTION 40)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3 or more times per week

39b. Which fats, sauces, or dressings were usually added AFTER COOKING OR AT THE TABLE? (Please do not include potatoes. Mark as many as apply.)

- Margarine (including low-fat)
- Salad dressing
- Butter (including low-fat)
- Cheese sauce
- Lard, fatback, or bacon fat
- White sauce
- Other

39c. If margarine, butter, lard, fatback, or bacon fat was added to your cooked vegetables AFTER COOKING OR AT THE TABLE, how much did you usually add?

- Did not usually add these
- Less than 1 teaspoon
- 1 to 3 teaspoons
- More than 3 teaspoons

40. Over the past 12 months, how often did you eat sweet peppers (green, red, or yellow)?

- NEVER (GO TO QUESTION 41)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

40a. Each time you ate sweet peppers, how much did you usually eat?

- Less than 1/8 pepper
- 1/8 to 1/4 pepper
- More than 1/4 pepper

41. Over the past 12 months, did you eat fresh tomatoes (including those in salads)?

- NO (GO TO QUESTION 42)
- YES

41a. How often did you eat fresh tomatoes (including those in salads) WHEN IN SEASON?

- NEVER
- 1-6 times per season
- 7-11 times per season
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

41b. How often did you eat fresh tomatoes (including those in salads) DURING THE REST OF THE YEAR?

- NEVER
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

41c. Each time you ate fresh tomatoes, how much did you usually eat?

- Less than 1/4 tomato
- 1/4 to 1/2 tomato
- More than 1/2 tomato
42. How often did you eat lettuce salads (with or without other vegetables)?
- NEVER (GO TO QUESTION 43)
  - 1-6 times per year
  - 7-11 times per year
  - 1 time per month
  - 2-3 times per month
  - 1 time per week
  - 2 or more times per day

42a. Each time you ate lettuce salads, how much did you usually eat?
  - Less than 1/4 cup
  - 1/4 to 1/2 cup
  - More than 1 1/2 cups

43. How often did you eat salad dressing (including low-fat) on salads?
- NEVER (GO TO QUESTION 44)
  - 1-6 times per year
  - 7-11 times per year
  - 1 time per month
  - 2-3 times per month
  - 1 time per week
  - 2 or more times per day

43a. Each time you ate salad dressing on salads, how much did you usually eat?
  - Less than 2 tablespoons
  - 2 to 4 tablespoons
  - More than 4 tablespoons

44. How often did you eat sweet potatoes or yams?
- NEVER (GO TO QUESTION 45)
  - 1-6 times per year
  - 7-11 times per year
  - 1 time per month
  - 2-3 times per month
  - 1 time per week
  - 2 or more times per day

44a. Each time you ate sweet potatoes or yams, how much did you usually eat?
  - 1 small potato or less than 1/4 cup
  - 1 medium potato or 1/4 to 1/2 cup
  - 1 large potato or more than 1 1/2 cups

45. How often did you eat French fries, home fries, hash browned potatoes, or tater tots?
- NEVER (GO TO QUESTION 46)
  - 1-6 times per year
  - 7-11 times per year
  - 1 time per month
  - 2-3 times per month
  - 1 time per week
  - 2 or more times per day

45a. Each time you ate French fries, home fries, hash browned potatoes, or tater tots, how much did you usually eat?
  - Less than 10 fries or less than 1/2 cup
  - 10 to 25 fries or 1/2 to 1 cup
  - More than 25 fries or more than 1 cup

46. How often did you eat potato salad?
- NEVER (GO TO QUESTION 47)
  - 1-6 times per year
  - 7-11 times per year
  - 1 time per month
  - 2-3 times per month
  - 1 time per week
  - 2 or more times per day

46a. Each time you ate potato salad, how much did you usually eat?
  - Less than 1/2 cup
  - 1/2 to 1 cup
  - More than 1 cup

47. How often did you eat baked, boiled, or mashed potatoes?
- NEVER (GO TO QUESTION 48)
  - 1-6 times per year
  - 7-11 times per year
  - 1 time per month
  - 2-3 times per month
  - 1 time per week
  - 2 or more times per day

47a. Each time you ate baked, boiled, or mashed potatoes, how much did you usually eat?
  - 1 small potato or less than 1/2 cup
  - 1 medium potato or 1/2 to 1 cup
  - 1 large potato or more than 1 cup
Over the past 12 months...

47b. How often was sour cream (including low-fat) added to your potatoes, EITHER IN COOKING OR AT THE TABLE?

- Almost never or never (GO TO QUESTION 47d)
- About 1/6 of the time
- About 1/3 of the time
- About 1/2 of the time
- Almost always or always

47d. Each time sour cream was added to your potatoes, how much was usually added?

- Less than 1 tablespoon
- 1 to 3 tablespoons
- More than 3 tablespoons

47c. How often was margarine (including low-fat) added to your potatoes, EITHER IN COOKING OR AT THE TABLE?

- Almost never or never
- About 1/4 of the time
- About 1/3 of the time
- About 1/2 of the time
- Almost always or always

47e. How often was butter (including low-fat) added to your potatoes, EITHER IN COOKING OR AT THE TABLE?

- Almost never or never
- About 1/4 of the time
- About 1/3 of the time
- About 1/2 of the time
- Almost always or always

47f. Each time margarine or butter was added to your potatoes, how much was usually added?

- Never added
- Less than 1 teaspoon
- 1 to 3 teaspoons
- More than 3 teaspoons

47g. How often was cheese or cheese sauce added to your potatoes, EITHER IN COOKING OR AT THE TABLE?

- Almost never or never (GO TO QUESTION 48)
- About 1/6 of the time
- About 1/3 of the time
- About 1/2 of the time
- Almost always or always

47h. Each time cheese or cheese sauce was added to your potatoes, how much was usually added?

- Less than 1 tablespoon
- 1 to 3 tablespoons
- More than 3 tablespoons

48. How often did you eat salsa?

- NEVER (GO TO QUESTION 49)
- 1–6 times per year
- 7–11 times per year
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

48a. Each time you ate salsa, how much did you usually eat?

- Less than 1 tablespoon
- 1 to 3 tablespoons
- More than 3 tablespoons

49. How often did you eat catsup?

- NEVER (GO TO QUESTION 50)
- 1–6 times per year
- 7–11 times per year
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

49a. Each time you ate catsup, how much did you usually eat?

- Less than 1 teaspoon
- 1 to 6 teaspoons
- More than 6 teaspoons

50. How often did you eat stuffing, dressing, or dumplings?

- NEVER (GO TO QUESTION 51)
- 1–6 times per year
- 7–11 times per year
- 1 time per month
- 2–3 times per month
- 1 time per week
- 2 or more times per day

50a. Each time you ate stuffing, dressing, or dumplings, how much did you usually eat?

- Less than 1/2 cup
- 1/2 to 1 cup
- More than 1 cup

Question 48 appears on the next column.
Over the past 12 months...

61. Each time cream cheese was added to your bagels or English muffins, how much was usually added?
   - Less than 1 tablespoon
   - 1 to 2 tablespoons
   - More than 2 tablespoons

The next questions ask about your intake of breads other than bagels or English muffins. First, we will ask about bread you ate as part of sandwiches only. Then we will ask about all other bread you ate.

62. How often did you eat breads or rolls as part of sandwiches (including burger and hot dog rolls)?
   - NEVER (GO TO QUESTION 63)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per week

62a. Each time you ate breads or rolls as part of sandwiches, how many did you usually
   - 1 slice or 1/2 roll
   - 2 slices or 1 roll
   - More than 2 slices or more than 1 roll

62b. How often were the breads or rolls that you used for your sandwiches while bread (including burger and hot dog rolls)?
   - Almost never or never
   - About 1/4 of the time
   - About 1/2 of the time
   - About 3/4 of the time
   - Almost always or always

62c. How often was mayonnaise or mayonnaise-type dressing (including low-fat) added to your sandwich bread or rolls?
   - Almost never or never (GO TO QUESTION 62a)
   - About 1/4 of the time
   - About 1/2 of the time
   - About 3/4 of the time
   - Almost always or always

62d. Each time mayonnaise or mayonnaise-type dressing was added to your sandwich bread or rolls, how much was usually added?
   - Less than 1 teaspoon
   - 1 to 3 teaspoons
   - More than 3 teaspoons

62e. How often was margarine (including low-fat) added to your sandwich bread or rolls?
   - Almost never or never
   - About 1/4 of the time
   - About 1/2 of the time
   - About 3/4 of the time
   - Almost always or always

62f. How often was butter (including low-fat) added to your sandwich bread or rolls?
   - Almost never or never
   - About 1/4 of the time
   - About 1/2 of the time
   - About 3/4 of the time
   - Almost always or always

62g. Each time margarine or butter was added to your sandwich breads or rolls, how much was usually added?
   - Never added
   - Less than 1 teaspoon
   - 1 to 2 teaspoons
   - More than 2 teaspoons

63. How often did you eat breads or dinner rolls, NOT as part of sandwiches?
   - NEVER (GO TO QUESTION 64)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per week

63a. Each time you ate breads or dinner rolls, NOT as part of sandwiches, how much did you usually eat?
   - 1 slice or 1 dinner roll
   - 2 slices or 2 dinner rolls
   - More than 2 slices or 2 dinner rolls
Over the past 12 months...

63b. How often were the breads or rolls you ate white bread?
- Almost never or never
- About 1/8 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

63c. How often was margarine (including low-fat) added to your breads or rolls?
- Almost never or never
- About 1/8 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

63d. How often was butter (including low-fat) added to your breads or rolls?
- Almost never or never
- About 1/8 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

63e. Each time margarine or butter was added to your breads or rolls, how much was usually added?
- Never added
- Less than 1 teaspoon
- 1 to 2 teaspoons
- More than 2 teaspoons

63f. How often was cream cheese (including low-fat) added to your breads or rolls?
- Almost never or never (GO TO QUESTION 64)
- About 1/8 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

63g. Each time cream cheese was added to your breads or rolls, how much was usually added?
- Less than 1 tablespoon
- 1 to 2 tablespoons
- More than 2 tablespoons

64. How often did you eat jam, jelly, or honey on bagels, muffins, bread, rolls, or crackers?
- NEVER (GO TO QUESTION 65)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

64a. Each time you ate jam, jelly, or honey, how much did you usually eat?
- Less than 1 teaspoon
- 1 to 3 teaspoons
- More than 3 teaspoons

65. How often did you eat peanut butter or other nut butter?
- NEVER (GO TO QUESTION 66)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

65a. Each time you ate peanut butter or other nut butter, how much did you usually eat?
- Less than 1 tablespoon
- 1 to 2 tablespoons
- More than 2 tablespoons

66. How often did you eat roast beef or steak in SANDWICHES?
- NEVER (GO TO QUESTION 67)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

66a. Each time you ate roast beef or steak in SANDWICHES, how much did you usually eat?
- Less than 1 slice or less than 2 ounces
- 1 to 2 slices or 2 to 4 ounces
- More than 2 slices or more than 4 ounces
Over the past 12 months...

67. How often did you eat turkey or chicken cold cuts (such as loaf, luncheon meat, turkey ham, turkey salami, or turkey pastrami)? (We will ask about other turkey or chicken later.)

- NEVER (GO TO QUESTION 88)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

67a. Each time you ate turkey or chicken cold cuts, how much did you usually eat?

- Less than 1 slice
- 1 to 3 slices
- More than 3 slices

68. How often did you eat luncheon or deli-style ham?

(We will ask about other ham later.)

- NEVER (GO TO QUESTION 69)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

68a. Each time you ate luncheon or deli-style ham, how much did you usually eat?

- Less than 1 slice
- 1 to 3 slices
- More than 3 slices

68b. How often was the luncheon or deli-style ham you ate light, low-fat, or fat-free?

- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

69. How often did you eat other cold cuts or luncheon meats (such as bologna, salami, corned beef, pastrami, or others, including low-fat)? (Please do not include ham, turkey, or chicken cold cuts.)

- NEVER (GO TO QUESTION 70)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

69a. Each time you ate other cold cuts or luncheon meats, how much did you usually eat?

- Less than 1 slice
- 1 to 3 slices
- More than 3 slices

69b. How often were the other cold cuts or luncheon meats you ate light, low-fat, or fat-free cold cuts or luncheon meats? (Please do not include ham, turkey, or chicken cold cuts.)

- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

70. How often did you eat canned tuna (including in salads, sandwiches, or casseroles)?

- NEVER (GO TO QUESTION 71)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

70a. Each time you ate canned tuna, how much did you usually eat?

- Less than 1/4 cup or less than 2 ounces
- 1/4 to 1/2 cup or 2 to 3 ounces
- More than 1/2 cup or more than 3 ounces

70b. How often was the canned tuna you ate water-packed tuna?

- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always
70c. How often was the canned tuna you ate prepared with mayonnaise or other dressing (including low-fat)?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

71. How often did you eat GROUND chicken or turkey? (We will ask about other chicken and turkey later.)
- NEVER (GO TO QUESTION 72)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

71a. Each time you ate GROUND chicken or turkey, how much did you usually eat?
- Less than 2 ounces or less than 1/2 cup
- 2 to 4 ounces or 1/2 to 1 cup
- More than 4 ounces or more than 1 cup

72. How often did you eat beef hamburgers or cheeseburgers?
- NEVER (GO TO QUESTION 73)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

72a. Each time you ate beef hamburgers or cheeseburgers, how much did you usually eat?
- Less than 1 patty or less than 2 ounces
- 1 patty or 2 to 4 ounces
- More than 1 patty or more than 4 ounces

72b. How often were the beef hamburgers or cheeseburgers you ate made with lean ground beef?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

73. How often did you eat ground beef in mixtures (such as meatballs, casseroles, chili, or meatloaf)?
- NEVER (GO TO QUESTION 74)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

73a. Each time you ate ground beef in mixtures, how much did you usually eat?
- Less than 3 ounces or less than 1/2 cup
- 3 to 8 ounces or 1/2 to 1 cup
- More than 8 ounces or more than 1 cup

74. How often did you eat hot dogs or frankfurters? (Please do not include sausages or vegetarian hot dogs.)
- NEVER (GO TO QUESTION 75)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

74a. Each time you ate hot dogs or frankfurters, how many did you usually eat?
- Less than 1 hot dog
- 1 to 2 hot dogs
- More than 2 hot dogs

74b. How often were the hot dogs or frankfurters you ate light or low-fat hot dogs?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always
Over the past 12 months...

75. How often did you eat beef mixtures such as beef stew, beef pot pie, beef and noodles, or beef and vegetables?

   - NEVER (GO TO QUESTION 78)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per day

75a. Each time you ate beef stew, beef pot pie, beef and noodles, or beef and vegetables, how much did you usually eat?

   - Less than 1 cup
   - 1 to 2 cups
   - More than 2 cups

76. How often did you eat roast beef or pot roast? (Please do not include roast beef or pot roast in sandwiches.)

   - NEVER (GO TO QUESTION 77)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per day

76a. Each time you ate roast beef or pot roast (including in mixtures), how much did you usually eat?

   - Less than 2 ounces
   - 2 to 5 ounces
   - More than 5 ounces

77. How often did you eat steak (beef)? (Do not include steak in sandwiches)

   - NEVER (GO TO QUESTION 78)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per day

77a. Each time you ate steak (beef), how much did you usually eat?

   - Less than 3 ounces
   - 3 to 7 ounces
   - More than 7 ounces

77b. How often was the steak you ate lean steak?

   - Almost never or never
   - About 1/4 of the time
   - About 1/2 of the time
   - Almost always or always

78. How often did you eat pork or beef spare ribs?

   - NEVER (GO TO QUESTION 79)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per day

78a. Each time you ate pork or beef spare ribs, how much did you usually eat?

   - Less than 4 lbs
   - 4 to 12 lbs
   - More than 12 lbs

78b. How often did you eat roast turkey, turkey cutlets, or turkey nuggets (including in sandwiches)?

   - NEVER (GO TO QUESTION 80)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per day

79a. Each time you ate roast turkey, turkey cutlets, or turkey nuggets, how much did you usually eat? (Please note: 4-8 turkey nuggets = 3 ounces.)

   - Less than 2 ounces
   - 2 to 4 ounces
   - More than 4 ounces

80. How often did you eat chicken as part of salads, sandwiches, casseroles, stews, or other mixtures?

   - NEVER (GO TO QUESTION 81)
   - 1-6 times per year
   - 7-11 times per year
   - 1 time per month
   - 2-3 times per month
   - 1 time per week
   - 2 or more times per day

Question 76 appears in the next column.

Question 81 appears on the next page.
Over the past 12 months...

92f. How often were the soups you ate tomato or vegetable soups?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

92g. How often were the soups you ate broth soups (including chicken) with or without noodles or rice?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

93. How often did you eat pizza?
- NEVER (GO TO QUESTION 94)
  - 1–6 times per year
  - 7–11 times per year
  - 1 time per month
  - 2–3 times per month
  - 1 time per week
  - 2 or more times per day

93a. Each time you ate pizza, how much did you usually eat?
- Less than 1 slice or less than 1 mini pizza
- 1 to 3 slices or 1 mini pizza
- More than 3 slices or more than 1 mini pizza

93b. How often did you eat pizza with pepperoni, sausage, or other meat?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

94. How often did you eat crackers?
- NEVER (GO TO QUESTION 95)
  - 1–6 times per year
  - 7–11 times per year
  - 1 time per month
  - 2–3 times per month
  - 1 time per week
  - 2 or more times per day

94a. Each time you ate crackers, how many did you usually eat?
- Fewer than 4 crackers
- 4 to 10 crackers
- More than 10 crackers

95. How often did you eat corn bread or corn muffins?
- NEVER (GO TO QUESTION 99)
  - 1–6 times per year
  - 7–11 times per year
  - 1 time per month
  - 2–3 times per month
  - 1 time per week
  - 2 or more times per day

95a. Each time you ate corn bread or corn muffins, how much did you usually eat?
- Less than 1 piece or muffin
- 1 to 2 pieces or muffins
- More than 2 pieces or muffins

96. How often did you eat biscuits?
- NEVER (GO TO QUESTION 97)
  - 1–6 times per year
  - 7–11 times per year
  - 1 time per month
  - 2–3 times per month
  - 1 time per week
  - 2 or more times per day

96a. Each time you ate biscuits, how many did you usually eat?
- Fewer than 1 biscuit
- 1 to 2 biscuits
- More than 2 biscuits

97. How often did you eat potato chips, tortilla chips, or corn chips (including low-fat, fat-free, or low-salt)?
- NEVER (GO TO QUESTION 98)
  - 1–6 times per year
  - 7–11 times per year
  - 1 time per month
  - 2–3 times per month
  - 1 time per week
  - 2 or more times per day

Question 98 appears on the next page.
### Over the past 12 months...

102a. Each time you ate yogurt, how much did you usually eat?
- Less than 1/2 cup or less than 1 container
- 1/2 to 1 cup or 1 container
- More than 1 cup or more than 1 container

103. How often did you eat cottage cheese (including low-fat)?
- NEVER (GO TO QUESTION 104)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

103a. Each time you ate cottage cheese, how much did you usually eat?
- Less than 1/4 cup
- 1/4 to 1 cup
- More than 1 cup

104. How often did you eat cheese (including low-fat; including on cheeseburgers or in sandwiches or subs)?
- NEVER (GO TO QUESTION 105)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

104a. Each time you ate cheese, how much did you usually eat?
- Less than 1/2 ounce or less than 1 slice
- 1/2 to 1 ounce or 1 slice
- More than 1 1/2 ounces or more than 1 slice

104b. How often was the cheese you ate light or low-fat cheese?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

104c. How often was the cheese you ate fat-free cheese?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

105. How often did you eat frozen yogurt, sorbet, or ices (including low-fat or fat-free)?
- NEVER (GO TO QUESTION 106)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

105a. Each time you ate frozen yogurt, sorbet, or ices, how much did you usually eat?
- Less than 1/2 cup or less than 1 scoop
- 1/2 to 1 cup or 1 to 2 scoops
- More than 1 cup or more than 2 scoops

106. How often did you eat ice cream, ice cream bars, or sherbet (including low-fat or fat-free)?
- NEVER (GO TO QUESTION 107)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

106a. Each time you ate ice cream, ice cream bars, or sherbet, how much did you usually eat?
- Less than 1/2 cup or less than 1 scoop
- 1/2 to 1 1/2 cups or 1 to 2 scoops
- More than 1 1/2 cups or more than 2 scoops

106b. How often was the ice cream you ate light, low-fat, or fat-free ice cream or sherbet?
- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always
Over the past 12 months...

107. How often did you eat cake (including low-fat or fat-free)?

- NEVER (GO TO QUESTION 108)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

107a. Each time you ate cake, how much did you usually eat?

- Less than 1 medium piece
- 1 medium piece
- More than 1 medium piece

107b. How often was the cake you ate light, low-fat, or fat-free cake?

- Almost never or never
- About ¼ of the time
- About ½ of the time
- About ¾ of the time
- Almost always or always

108. How often did you eat cookies or brownies (including low-fat or fat-free)?

- NEVER (GO TO QUESTION 109)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

108a. Each time you ate cookies or brownies, how much did you usually eat?

- Less than 2 cookies or 1 small brownie
- 2 to 4 cookies or 1 medium brownie
- More than 4 cookies or 1 large brownie

108b. How often were the cookies or brownies you ate light, low-fat, or fat-free cookies or brownies?

- Almost never or never
- About ¼ of the time
- About ½ of the time
- About ¾ of the time
- Almost always or always

109. How often did you eat doughnuts, sweet rolls, Danish, or pop-tarts?

- NEVER (GO TO QUESTION 110)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

109a. Each time you ate doughnuts, sweet rolls, Danish, or pop-tarts, how much did you usually eat?

- Less than 1 piece
- 1 to 2 pieces
- More than 2 pieces

110. How often did you eat sweet muffins or dessert breads (including low-fat or fat-free)?

- NEVER (GO TO QUESTION 111)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

110a. Each time you ate sweet muffins or dessert breads, how much did you usually eat?

- Less than 1 medium piece
- 1 medium piece
- More than 1 medium piece

110b. How often were the sweet muffins or dessert breads you ate light, low-fat, or fat-free sweet muffins or dessert breads?

- Almost never or never
- About ¼ of the time
- About ½ of the time
- About ¾ of the time
- Almost always or always

111. How often did you eat fruit crisp, cobbler, or strudel?

- NEVER (GO TO QUESTION 112)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per day

Question 109 appears in the next column.

Question 112 appears on the next page.
Over the past 12 months...

112a. Each time you ate fruit crisp, cobbler, or strudel, how much did you usually eat?
- Less than 1/2 cup
- 1/2 to 1 cup
- More than 1 cup

112b. How often were the pies you ate fruit pie (such as apple, blueberry, others)?
- Almost never or never
- About 1/8 of the time
- About 1/4 of the time
- About 3/4 of the time
- Almost always or always

112c. How often were the pies you ate cream, pudding, custard, or meringue pie?
- Almost never or never
- About 1/8 of the time
- About 1/4 of the time
- About 3/4 of the time
- Almost always or always

112d. How often were the pies you ate pumpkin or sweet potato pie?
- Almost never or never
- About 1/8 of the time
- About 1/4 of the time
- About 3/4 of the time
- Almost always or always

112e. How often were the pies you ate pecan pie?
- Almost never or never
- About 1/8 of the time
- About 1/4 of the time
- About 3/4 of the time
- Almost always or always

113a. Each time you ate chocolate candy, how much did you usually eat?
- Less than 1 average bar or less than 1 ounce
- 1 average bar or 1 to 2 ounces
- More than 1 average bar or more than 2 ounces

113b. How often were the pies you ate chocolate candy?
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

113c. Each time you ate chocolate candy, how much did you usually eat?
- Less than 1 average bar or less than 1 ounce
- 1 average bar or 1 to 2 ounces
- More than 1 average bar or more than 2 ounces

115. How often did you eat eggs, egg whites, or egg substitutes (NOT counting eggs in baked goods and desserts)? (Please include eggs in salads, quiches, and soufflés.)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week

116. How often did you eat other candy?
- Never (Go to Question 115)
- 1-6 times per year
- 7-11 times per year
- 1 time per month
- 2-3 times per month
- 1 time per week
- 2 or more times per week
Over the past 12 months...

127c. How often was the mayonnaise you ate fat-free mayonnaise?
   ○ Almost never or never
   ○ About 1/4 of the time
   ○ About 1/2 of the time
   ○ About 3/4 of the time
   ○ Almost always or always

128. Over the past 12 months, did you eat sour cream?
   ○ NO (GO TO QUESTION 129)
   ○ YES
      128a. How often was the sour cream you ate regular-fat sour cream?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

      128b. How often was the sour cream you ate light, low-fat, or fat-free sour cream?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

      129. Over the past 12 months, did you eat cream cheese?
   ○ NO (GO TO QUESTION 130)
   ○ YES
      129a. How often was the cream cheese you ate regular-fat cream cheese?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

      129b. How often was the cream cheese you ate light, low-fat, or fat-free cream cheese?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

130. Over the past 12 months, did you eat salad dressing?
   ○ NO (GO TO INTRODUCTION TO QUESTION 131)
   ○ YES
      130a. How often was the salad dressing you ate regular-fat salad dressing (including oil and vinegar dressing)?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

      130b. How often was the salad dressing you ate light or low-fat salad dressing?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

      130c. How often was the salad dressing you ate fat-free salad dressing?
         ○ Almost never or never
         ○ About 1/4 of the time
         ○ About 1/2 of the time
         ○ About 3/4 of the time
         ○ Almost always or always

The following two questions ask you to summarize your usual intake of vegetables and fruits. Please do not include salads, potatoes, or juices.

131. Over the past 12 months, how many servings of vegetables (not including salad or potatoes) did you eat per week or per day?
   ○ Less than 1 per week
   ○ 1-2 per week
   ○ 3-4 per week
   ○ 5-6 per week
   ○ 1 per day

132. Over the past 12 months, how many servings of fruits (not including fruit juice) did you eat per week or per day?
   ○ Less than 1 per week
   ○ 1-2 per week
   ○ 3-4 per week
   ○ 5-6 per week
   ○ 1 per day
Over the past 12 months...

137a. Over the past 12 months, did you take any vitamins, minerals, or other herbal supplements other than your multivitamin?

- NO

Thank you very much for completing this questionnaire! Because we want to be able to use all the information you have provided, we would greatly appreciate it if you would please take a moment to review each page making sure that you:
- Did not skip any pages,
- Completely blackened-in each answer, and
- Completely erased any changes you may have made.

- YES (GO TO INTRODUCTION TO QUESTION 138.)

These last questions are about the vitamins, minerals, or herbal supplements you took that are NOT part of a One-a-day-, Theragran-, or Centrum-type of multivitamin.

Please include vitamins taken as part of an antioxidant supplement.

138. How often did you take Beta-carotene (NOT as part of a multivitamin in Question 137)?

- NEVER (GO TO QUESTION 138)
- Less than 1 day per month
- 1–3 days per month
- 1–3 days per week
- 4–6 days per week
- Every day

138a. When you took Beta-carotene, about how much did you take in one day?

- Less than 10,000 IU
- 10,000–14,999 IU
- 15,000–19,999 IU
- 20,000–24,999 IU
- 25,000 IU or more
- Don’t know

138b. For how many years have you taken Beta-carotene?

- Less than 1 year
- 1–4 years
- 5–9 years
- 10 or more years

139. How often did you take Vitamin A (NOT as part of a multivitamin in Question 137)?

- NEVER (GO TO QUESTION 140)
- Less than 1 day per month
- 1–3 days per month
- 1–3 days per week
- 4–6 days per week
- Every day

139a. When you took Vitamin A, about how much did you take in one day?

- Less than 5,000 IU
- 5,000–9,999 IU
- 10,000–14,999 IU
- 15,000–24,999 IU
- 25,000 IU or more
- Don’t know

139b. For how many years have you taken Vitamin A?

- Less than 1 year
- 1–4 years
- 5–9 years
- 10 or more years

140. How often did you take Vitamin C (NOT as part of a multivitamin in Question 137)?

- NEVER (GO TO QUESTION 141)
- Less than 1 day per month
- 1–3 days per month
- 1–3 days per week
- 4–6 days per week
- Every day

140a. When you took Vitamin C, about how much did you take in one day?

- Less than 500 mg
- 500–999 mg
- 1,000–1,499 mg
- 1,500–1,999 mg
- 2,000 mg or more
- Don’t know

140b. For how many years have you taken Vitamin C?

- Less than 1 year
- 1–4 years
- 5–9 years
- 10 or more years
**Over the past 12 months...**

141. How often did you take Vitamin E (NOT as part of a multivitamin in Question 137)?

- NEVER (GO TO QUESTION 142)
- Less than 1 day per month
- 1-3 days per month
- 1-3 days per week
- 4-6 days per week
- Every day

141a. When you took Vitamin E, about how much did you take in one day?

- Less than 400 IU
- 400-799 IU
- 800-999 IU
- 1,000 IU or more
- Don't know

141b. For how many years have you taken Vitamin E?

- Less than 1 year
- 1-4 years
- 5-9 years
- 10 or more years

142. How often did you take Calcium or Calcium-containing antacids (NOT as part of a multivitamin in Question 137)?

- NEVER (GO TO QUESTION 143)
- Less than 1 day per month
- 1-3 days per month
- 1-3 days per week
- 4-6 days per week
- Every day

142a. When you took Calcium or Calcium-containing antacids, about how much elemental calcium did you take in one day? (If possible, please check the label for elemental calcium.)

- Less than 500 mg
- 500-599 mg
- 600-999 mg
- 1,000 mg or more
- Don't know

142b. For how many years have you taken Calcium or Calcium-containing antacids?

- Less than 1 year
- 1-4 years
- 5-9 years
- 10 or more years

The last two questions ask you about other supplements you took **more than once per week**.

143. Please mark any of the following single supplements you took **more than once per week** (NOT as part of a multivitamin in Question 137):

- B-6
- B-complex
- Brewer's yeast
- Cod liver oil
- Coenzyme Q
- Fish oil
- (Omega-3 fatty acids)
- Zinc
- Folic acid/dilute
- Glucosamine
- Hydroxykryptophan (HTP)
- Iron
- Niacin
- Selenium
- (Omega-3 fatty acids)

144. Please mark any of the following herbal or botanical supplements you took **more than once per week**

- Aloe Vera
- Astaxanthin
- Bilberry
- Camu Camu
- Cat's claw
- Cayenne
- Cranberry
- Dong Quai (Tan guk)
- Echinacea
- Evening primrose oil
- Feverfew
- Garlic
- Ginger
- Ginseng
- Ginseng (American or Asian)
- Goldenseal
- Grape seed extract
- Kava, kava
- Milk thistle
- Saw palmetto
- Siberian ginseng
- St. John's wort
- Valerian
- Other

Thank you very much for completing this questionnaire! Because we want to be able to use all the information you have provided, we would greatly appreciate it if you would please take a moment to review each page making sure that you:

- Did not skip any pages.
- Completely blackened-in each answer, and
- Completely erased any changes you may have made.
APPENDIX G. MOTHER DESCRIPTIVE QUESTIONNAIRE

Risk of HTN: Young Adult Lifestyles & Parental Influence

Mother Descriptive Information

"ID# ___________  Date: ___________
Age: _______  Comments: _________

Family History

<table>
<thead>
<tr>
<th>Condition</th>
<th>You</th>
<th>Child's Father</th>
<th>Your Mother</th>
<th>Your Father</th>
<th>Child's Father's Mother</th>
<th>Child's Father's Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease or High Cholesterol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack, if yes ask for age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (fill in)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Deceased

Cause of Death
Age at Death

Household Income

- < $10,000
- $10,000 - $20,000
- $20,000 - $30,000
- $30,000 - $50,000
- $50,000 - $75,000
- $75,000 or more

Highest Level of Education

- □ Less than high school
- □ High School
- □ Some College
- □ College Degree
- □ Post college education

Child's HS Performance

GPA or Letter Grade: ________
### Risk of HTN: Young Adult Lifestyles & Parental Influence

#### Young Adult Descriptive Information

<table>
<thead>
<tr>
<th>ID#</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Comments:</td>
</tr>
</tbody>
</table>

#### Family History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother</td>
</tr>
<tr>
<td>Heart Disease or High Cholesterol</td>
<td></td>
</tr>
<tr>
<td>Heart Attack, if yes ask for age</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>Other (fill in)</td>
<td></td>
</tr>
</tbody>
</table>

#### Child’s HS Performance

<table>
<thead>
<tr>
<th>GPA or Letter Grade:</th>
<th></th>
</tr>
</thead>
</table>

#### Number of people living in your household: |