Development of a questionnaire to assess knowledge, attitudes, and behaviors in American Indian children\textsuperscript{1,3}

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**ABSTRACT** One aim of the Pathways study is to improve the knowledge, attitudes, and behaviors of American Indian children in grades 3–5 regarding physical activity and diet in. This article describes the development of a culturally sensitive, age-appropriate questionnaire to assess these variables. The questionnaire was designed to be administered in the classroom in two 30-min sessions. Questions were developed to assess 4 key areas: physical activity, diet, weight-related attitudes, and cultural identity. Potential questions were written after review of relevant literature and existing questionnaires. Numerous and extensive revisions were made in response to input from structured, semistructured, and informal data collection. Questions were pretested in 32 children in grades 3–5 by using semistructured interviews. Test-retest reliability and the internal consistency of scales were examined in 371 fourth-grade children and subsequently in 145 fourth-grade children. Questions were reviewed by American Indians from the communities involved in the Pathways study several times during the developmental process. The process described here serves as one model for the development of a culturally appropriate tool to assess knowledge, attitudes, and behaviors in American Indian children. *Am J Clin Nutr* 1999;69(suppl):773S–81S.

**KEY WORDS** American Indians, attitudes, behaviors, children, knowledge, Pathways, schools, questionnaire development, reliability

**INTRODUCTION**

Pathways is a multicenter obesity-prevention trial that includes 6 American Indian tribes: Pima-Maricopa, Tohono O’odham, Navajo, White Mountain Apache, Oglala Lakota, and Sicangu Lakota. The objective of Pathways is to prevent obesity in American Indian children through a culturally appropriate, elementary school– and family-based intervention that promotes healthful eating behavior and increased physical activity. Several measures will be collected to determine the effect of the Pathways intervention, including a questionnaire designed to assess the effect of the intervention on knowledge, attitudes, and behaviors (KAB) related to diet and physical activity.

Previous school-based nutrition and physical activity intervention studies in grade-school children have relied on self-reported measures to assess changes in KAB targeted by the intervention. For example, in the Child and Adolescent Trial for Cardiovascular Health (CATCH) (1), intended food choices, knowledge, and self-efficacy regarding healthful eating among children in grades 3–5 were measured by using a classroom-administered questionnaire. Postintervention healthy-food-choice scores were significantly higher in intervention than in control schools (1). Subsequent work corroborated these findings in children in grades 6–9 and showed that self-reported intentions are consistent over time (2, 3). These findings indicate that this type of questionnaire is sensitive to the effects of a school-based intervention, and can be used successfully in an ethnically and socioeconomically diverse student population such as that targeted by CATCH (1). The results from CATCH suggested that self-report classroom-administered questionnaire measures of behaviors and attitudes would be appropriate for use in the Pathways study.

Cross-sectional studies have shown that food consumption and physical activity are influenced by a variety of psychologic, social, cultural, and environmental factors in addition to biologic and developmental factors (4, 5). These factors undoubtedly interact, although the importance of each factor and the nature of the interactions are not known because studies of multiple categories of factors are rare. In addition, there has been no systematic research across different age and ethnic groups. Thus, the relative importance of different factors for different groups and at different developmental periods is not known. The Pathways
Most commonly studied environmental factor, is strongly correlated with obesity (18), possibly because it replaces more active leisure-time pursuits.

Previous studies have shown an association between physical self-perception and level of participation in physical activities and organized athletics (18, 19) as well as other fitness indicators (20, 21). Physical self-perception in specific domains has also been shown to differ between individuals engaged in various types of physical activities. For example, participation in ball sports is associated with high self-perception in sports skills for male and female young adults (18). Physical self-perception has been reported to change with participation in physical activities, such as aerobics classes and Outward Bound programs (21, 22). In contrast, physical activity and fitness indicators do not appear to be associated with nonphysical domains of self-perception (20).

The choice of specific factors to measure was based on the strength of the reported associations between physical activity and its correlates, the nature of the planned intervention, and the acceptability of the items in all of the American Indian communities involved in Pathways. Four broad categories were chosen for this section of the questionnaire: physical activity self-efficacy, social support for physical activity, perceived barriers to activity, and physical self-perception. Other potential predictors of activity, including body composition and physical environment factors, such as actual availability and proximity of television watching and of play areas, facilities, and programs, were evaluated elsewhere in the study.

**Diet**

Children’s eating behavior can be examined by looking at individual, behavioral, and environmental factors (23). Individual factors are personality dispositions, cognitions, or affective domains that increase or decrease the likelihood of engaging in a given behavior and include self-efficacy, knowledge, functional meanings of food, and perceived body image. Behavioral factors are those that affect actions directly and include one’s behavioral repertoire, behavioral intentions, and skills. Environmental factors are those aspects of the environment that support, permit, encourage, or discourage engagement in a particular behavior and include family and peer influences, social support, social norms, and specific opportunities (23). To change eating patterns successfully, interventions must aim to modify all 3 factors.

Over the past decade, several nutrition-related programs have focused their intervention efforts on these 3 factors (5, 24–26). Outcome evaluation in these programs followed the intervention model and measured specific behaviors, knowledge, attitudes, and intentions as well as physiologic outcomes. Outcomes were generally favorable in terms of knowledge, attitudes, and intentions, and were less so in terms of behavior and physiologic change on nutrition-related measures (25, 26). Recent findings from the CATCH study showed significant improvements in dietary intentions, usual food choices, knowledge, and self-efficacy for eating lower-fat and lower-sodium foods in third-grade children in intervention compared with control schools (24). These findings support theory-based and combined individual and environmental interventions for changing health-related risk behaviors in children. Most of the nutrition education programs that resulted in behavior change used teaching strategies based on social learning theory. In such programs, increasing student knowledge is only one of many objectives. The relation between nutrition knowledge and behavior is weak (5, 25). It is well doc-
umerated that although nutrition knowledge is essential, knowl-
edge alone does not enable young persons to adopt healthy eat-
ing behaviors. Thus, behaviorally centered approaches (ie, goal 
setting, behavioral skill building, and efficacy-enhancing experi-
ences) are needed (5). Furthermore, behavioral changes may not 
be maintained unless the school environment supports the 
changes and the home environment reinforces the intentions.

The diet measures chosen for assessment in the Pathways 
KAB questionnaire were based on specific constructs derived 
from social learning theory that are considered to be determi-
nants of behaviors underlying obesity-related risk factors. The 
diet measures were also based on the concepts emphasized in the 
Pathways intervention, specifically, reducing consumption of 
dietary fat and sugared beverages and increasing consumption of 
healthful lower-fat foods. Student outcomes targeted for assess-
ment included knowledge of high-fat foods, self-efficacy to 
to make healthy food choices, perceived social support for eating 
healthful foods, intentions to choose healthful foods, and self-
reported behaviors.

Weight-related attitudes and behaviors

Frequent dieting and exaggerated concern about body weight 
are common in this country. National data collected in 1990 from 
11 467 high school students as part of the Youth Risk Behavior 
Survey (27, 28) estimated that 34% of female students and 15% of 
males considered themselves overweight. Forty-four percent of female students and 15% of male students reported that 
they were trying to lose weight. Students trying to lose 
weight had used several methods in the 7 d preceding the survey, 
including skipping meals (49% of females, 18% of males), tak-
ing diet pills (4% of females, 2% of males), and vomiting (3% of 
females and 1% of males). Few studies have examined weight-
related attitudes and behaviors in preadolescent children. Mellin 
et al (29) surveyed middle-class girls in California and found 
that controlled eating was reported by 45% of third-grade and 
80% of fourth- and fifth-grade girls. Inappropriate methods of 
weight control (vomiting, taking diet pills or laxatives, or skip-
ning meals to lose weight) were reported by 10% of the 9- and 
10-y-old girls examined.

We know of no similar data from American Indian children of 
this age. However, studies in older children and adults indicate 
that attitudes toward dieting and body size are similar in whites 
and American Indians (30), and that the use of inappropriate 
weight-loss strategies may be as prevalent or even more preva-
 lent among American Indians than among whites. Smith and 
Krejci (31) administered the Eating Disorder Inventory and the 
Bulimic Test to American Indian, Hispanic, and white high 
school students (n = 545; mean age: 15.2 y). They found that the 
129 American Indian students consistently scored the highest on 
each of the 7 items testing for disturbed eating behaviors and 
attitudes. Story et al (32) reported using national survey data 
from American Indian and Alaska Native children aged 12–18 y. 
Most participants, particularly girls, were dissatisfied with their 
weight and were worried about being overweight. Unhealthy 
weight-control practices were not uncommon.

Some voluntary control of food intake or attention to the 
selection of foods is appropriate; however, preoccupation with 
weight and extreme practices such as fasting and vomiting to 
lose weight are inappropriate at any age and are especially unde-
sirable in children. In the Pathways study we developed ques-
tions to assess children’s perceived and ideal body size, concern 
about body size, and prevalence of dieting practices. Our 
hypothesis is that the Pathways intervention will not be associ-
ated with negative changes in children’s body image, nor will it 
increase the prevalence of dieting.

Cultural identity

An ethnic identity scale was developed based on the recom-
endation of American Indian collaborators in the study. The 
Pathways intervention was carefully designed to be culturally 
sensitive, but some measure of cultural identity was required so 
that we could assess whether the intervention was equally effec-
tive in children who identified more or less strongly with their 
American Indian culture. Measurement of cultural identity in 
Pathways provided the opportunity to gain information about 
and insights into the impact of cultural issues on the effective-
ness of an intervention in this group.

Ethnic identity is known to be related to the concept of self-
estee (33–35). Phinney (36) remarked that “a positive self-con-
cept may be related to the process of identity formation—that is, 
to the extent to which people have come to an understanding and 
acceptance of their ethnicity.” Ethnic identity was found in some 
early studies to be related to the level of acculturation to mainstream 
values and behaviors (37–40). These interrelations were of cen-
tral concern to this study. Greater ethnic identity and self-esteem 
may be related to a decreased adoption of dominant American 
lifestyle attributes in American Indian children.

The only existing literature on developing ethnic identity scales 
for US children focuses primarily on white ethnic groups and 
African Americans; there is no such literature on American Indian 
children. Phinney (36) wrote an excellent review of ethnic iden-
tity, but focused on adults and adolescents rather than on children. 
In fact, the measurement of ethnic identity in children is a difficult 
proposition considering current models. Many models today con-
sider ethnic identity to be a developmental process, in which indi-
viduals go through various life stages. For instance, the Racial 
Identity Attitude Scale developed by Parham and Helms (41) 
describes changes in attitudes during the stages of preencounter, 
encounter, immersion, and internalization. Young children have 
not been measured with use of these models because they are 
not old enough to have moved through these stages.

CREATION, ADMINISTRATION, AND REVISION OF THE 
KAB QUESTIONNAIRE

Creation and selection of questions

Responsibility for the creation and selection of potential ques-
tions within each concept area was divided among the members 
of the working group. After a review of existing questionnaires 
and deliberations with several experts, the first draft of the ques-
tionnaire was constructed by collating all proposed questions. 
This initial draft contained 248 questions, which were reduced to 
170 after review by the teams in charge of curriculum design and 
by field coordinators.

Initial tests with children

To help determine validity of the questionnaire, a subset of 64 
questions was pretested with 32 American Indian children by 
using semistructured interviews. The children were in the third, 
fourth, or fifth grade. Trained American Indian staff members 
conducted most of these interviews at the field site. In individual
interviews, children were asked each question on the questionnaire. Follow-up probes included, “What do you think this question is asking?,” “Does this question make sense to you?,” and “Does this question seem important?”

**Input from the American Indian members of the Pathways team**

Feedback from American Indian colleagues in Pathways was obtained during a 2-d meeting attended by 16 Pathways staff members, 8 of whom were American Indian. The purpose of each section of the questionnaire was reviewed and then items were examined one by one. As a result, 40 more questions were eliminated and the remaining 130 were revised extensively. At the suggestion of some of the American Indians in attendance, the cultural identity section was added to the questionnaire.

After the questionnaire was approved by the Pathways Study Steering Committee, approval was obtained from all 5 tribes without further revisions.

**Selection of protocols for administrators**

The working group decided to administer the questionnaire in school classrooms by using a protocol patterned after that of the CATCH study (42) that was age appropriate and accommodated differences in reading level. The children marked their own answers to questions, but a trained test administrator read the questions to the class. This dictated that the questionnaire format had to be simple and easy to understand, with no embedded items. Illustrative pictures were included wherever appropriate. A standardized instruction manual for administration of the questionnaire was developed that oriented the administrator to the purpose of the questionnaire and provided detailed, step-by-step instructions on how to administer the questionnaire. The protocol called for 2 staff members to administer the questionnaire in the classroom, one to read the questions aloud and the other to act as proctor, circulating throughout the room to answer questions and keep the children on task. To accommodate differences in reading level it was decided that questions would be read twice to third- and fourth-grade children and once to fifth-grade children. Brief activities (≤5 min) that engaged the children were included in the protocol to break up lengthy testing sessions. The test administrator distributed letters explaining the questions and protocol to the teachers before the start of the test session.

**Pretesting in the classroom**

The 130-item draft of the questionnaire was pretested in 2 classrooms at one of the field centers. It was given by an administrator and a proctor with 1 other staff member present to observe. The questionnaire was administered in 3 sections, each ~30 min in length, over 2–3 d. The children’s general reactions to the questionnaire and their observed comfort level upon completion of the questionnaire were positive. Several modifications were made as a result of this testing. This process yielded version 1.0 of the questionnaire.

**Description of version 1.0 of the questionnaire**

The reading level of the questionnaire was evaluated as second-grade level (grade 2.4) by the RIGHT WRITER (43) and fifth grade level (grade 5.6) by the FLESCH GRADE LEVEL (44) software programs. Each section of the questionnaire is described below.

**Physical activity**

Scales were developed or adapted to assess the following constructs thought to be mediators or correlates of physical activity: social support, self-efficacy, perceived barriers, and self-perception. The Physical Self-Perception Profile (PSPP) (18) was chosen as the instrument on which to base the physical self-perception portion of the KAB questionnaire. The PSPP is widely used (18), psychometrically sound (17, 45, 46), and has been adapted for use with younger adolescents (45) and children, including fourth and fifth graders (46). In version 1.0 of the KAB, 2 subscales from the Harter (47) Self-Perception Profile for Children (scholastic competence and social acceptance) were also included. This is the best known and most widely used of the general multidimensional self-perception instruments and has good-to-excellent psychometric properties with children as young as third-grade age (48). The domains included from the Harter profile were those most likely to be associated with obesity or to change as a result of participation in a regular physical activity program.

**Diet**

The specific diet-related psychosocial constructs measured by the KAB questionnaire included dietary self-efficacy, social support for lower-fat food choices, dietary intentions and expectations, dietary-fat knowledge, and reported food consumption. All measures, with the exception of food consumption, were based on the health behavior questionnaire used in the CATCH study (1). These measures have been used in previous work including Hearty Heart (49) and Go for Health (50) or were developed specifically for CATCH (1). Although the KAB diet-related scales were derived from these measures, the questions, food items, and response categories were changed. The specific food items included in the KAB questionnaire were chosen on the basis of the results of a formative assessment of foods commonly consumed by American Indian children.

**Weight-related attitudes and behaviors**

Questionnaires to measure weight-related attitudes and behaviors in a variety of populations were available from previous studies (28, 50–60). Some questions in this section were used intact from these existing questionnaires; however, most were modified to simplify the language to make the questionnaire more suitable for third- to fifth-grade children. The concepts assessed included body image, concerns about weight, and attempts at weight loss. As a measure of perceived actual, ideal, and healthy body size, children were asked to select from 8 line drawings of children that ranged from very thin to obese. These drawings were conceptually similar to those previously created for use in adults (52). In this section, as in other sections dealing with weight-related attitudes and behaviors, some questions were included to provide balance. For instance, to balance “Would you like to be skinnier than you are now?” we included “Would you like to be chubbier than you are now?”

**Cultural identity**

The literature indicates that there are 4 potential components of ethnic identity: ethnic self-identification (the label you give yourself), sense of belonging to a particular ethnic group, positive and negative attitudes toward one’s own ethnic group, and ethnic involvement (participation in social and cultural practices) (36). We found that the wording used to measure ethnic
identity by “sense of belonging” and “positive or negative attitudes” was too complex for third-grade children. Therefore, our scale of ethnic identity included only those components that relate to self-identification and ethnic involvement. In particular, the ethnic involvement component focused on concrete behaviors, such as language spoken and activities practiced.

Test and retest of version 1.0

Test-retest reliability was assessed for version 1.0 of the KAB questionnaire by administering the questionnaire twice to the same fourth-grade children with an interval of 3–6 wk between tests. Fourth-grade children were chosen because they would give an intermediate view of what could be expected in terms of comprehension and performance from children in the third, fourth, and fifth grades. Questionnaire administrators and proctors were trained in a 3-h meeting during which instructions were reviewed and administrators were required to rehearse in front of the group.

The questionnaire was administered in 2 schools at each of 4 sites. Three separate sessions (separated by ≥1 h) were conducted over a 2- or 3-d interval. An average of ≈70 min was required to administer the entire questionnaire. The paper forms were mailed to the coordinating center and all data were entered centrally. A total of 371 fourth-grade children from the 4 study sites took part in the reliability testing; 18% of the questionnaires were incomplete (a questionnaire was considered incomplete if ≥3 questions were not answered). This relatively high level of incomplete data was due to student absences and student participation in special programs during one or more of the 3 scheduled test times.

Qualitative feedback was requested from each center regarding problems that arose during the test-retest administration. Overall, these reports indicated that the test was well accepted. However, the body-image questions with the graded body shapes were felt to be insensitive, and teasing of overweight children was a problem at some sites. It was also noted that some children in special education programs were unable to keep up with the rest of the class and may not have provided valid data.

Statistics were calculated for each of the study questions as an estimate of repeatability (61). Cronbach’s (62) α statistics were calculated as measures of internal consistency of the scales and correlation coefficients were used to estimate the repeatability of scales (63). The following 8 scales had a Cronbach’s α and test-retest r ≥ 0.5: barriers to physical activity, knowledge of high-fat foods, diet self-efficacy, diet behaviors, food frequency, body image, attempts at weight loss, and cultural identity.

Revisions based on reliability data

The questionnaire was revised on the basis of the results of the first reliability testing. Some questions were dropped and others were added. In some cases, new response options were created and tested in an effort to improve repeatability. Selected examples of changes are presented below.

For the physical self-perception section, each subscale contained only 2 items, so internal consistency could not be assessed. To address this problem, the working group decided to include more items to assess each dimension. The scholastic competence and social acceptance scales were judged to be of little relevance to the central aims of the Pathways study and were eliminated. The response format was revised from that of the original PSPP to a Likert (64) format, consistent with the format used in the first KAB testing. Question wording was also revised to improve clarity. The revised version of the self-perception section of the KAB contained six 4-item subscales consisting of questions adapted from the original PSPP.

Neither the physical activity nor the diet social support scales performed adequately. A new 4-point response format (most of the time, sometimes, once in a while, and almost never) was developed and pilot tested that replaced the original 3-choice response set (most of the time, sometimes, and never or almost never). The food-frequency scale was modified because it appeared that children had difficulty conceptualizing the time frame associated with usual intake. In the revised version of the KAB questionnaire, specific foods were presented and children were asked to circle the picture if they had eaten the food the day before; thus, the time frame was more limited and concrete.

To identify the sources of incomplete questionnaires, procedures were put into place to identify children in special education programs, a protocol was written for obtaining data from children who were absent for a portion of the test, and a form was developed to collect information on the amount of effort required to produce higher rates of completion. On the basis of time logs from the first test and retest, it was decided to administer the test in 2 sessions rather than 3 to reduce the staff-assOCIated costs of the administration.

Review of revised questionnaire

The revised questionnaire was sent out to the American Indian members of the Pathways team for review. After approval by that group and the Pathways Steering Committee, the revised questionnaire, version 2.0, was reviewed and approved by the participating tribes.

Test and retest of version 2.0

Sample questions from each section of version 2.0 of the KAB questionnaire are shown in Table 1. This version was tested for repeatability between October and December of 1995. Training of the administrators and proctors was conducted in a 2-h conference call. Data were entered at the site rather than centrally for version 2.0, and an additional 2-h conference call was held to train field staff to enter the KAB data at the site. The completion rate of the questionnaires was > 95% because Pathways staff members revisited schools to obtain missing data. The test was completed in ≈80 min in 2 sessions.

The number of questions and the average χ statistic by section are shown in Table 2, as well as the number of questions, Cronbach’s α, and χ for repeatability for each scale. The correlation is the appropriate statistic to use for the assessment of the repeatability of scales; however, the average χ of the questions as used in the scales is also shown for descriptive purposes (61, 63). Because one of the goals of the testing was to produce a more concise questionnaire, efforts were made to reduce the number of items in some scales. The mean χ and Cronbach’s α statistics were recalculated after deleting poorly performing or unnecessary questions or after collapsing response options. Six of the 8 scales with both a Cronbach’s α and test-retest r > 0.5 in the first version performed equally well in the second version (barriers to physical activity, knowledge of high-fat foods, diet self-efficacy, diet behaviors, body image, and attempts at weight loss). The repeatability and internal consistency of the physical activity self-efficacy scale improved such that the internal consistency and repeatability tests met the > 0.5 criterion value. However, the performance of the food-frequency and cultural-identity scales declined and no longer met this criterion. Generally, the modifi-
None of the subscales in the physical activity self-perception portion of the questionnaire met our criteria for repeatability and internal consistency. This was due in part to the fact that children had particular difficulty with items that were negatively worded.

**FUTURE DIRECTIONS AND LESSONS LEARNED**

**Readiness of children**

The ability of fourth-grade children to answer the questions on the KAB questionnaire reliably varied considerably. Separating the children in special education programs for individualized testing will likely improve repeatability. There are no other studies using a similar questionnaire in children of the age and ethnicity studied here on which to form a basis for the expected level of repeatability. Because the food self-efficacy scale and the mode of administration used here were patterned after CATCH, some indication of the expected level of repeatability can be gained from an examination of the CATCH results. In the 14-item food self-efficacy scale tested in CATCH, the Cronbach’s α was 0.84 and the test-retest r was 0.63 (60). In Pathways, the respective results were 0.76 and 0.59 for the 12-item scale tested. More research is needed on methods of questionnaire administration in children of this age.

**TABLE 1**

Sample questions in version 2.0 of the Pathways knowledge, attitudes, and behaviors questionnaire

<table>
<thead>
<tr>
<th>Section and scale or subsection</th>
<th>Question</th>
<th>Possible responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activity</td>
<td>I can play hard during most of recess.</td>
<td>I know I can</td>
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<tr>
<td></td>
<td></td>
<td>I think I can</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I’m not sure I can</td>
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<tr>
<td></td>
<td></td>
<td>I don’t think I can</td>
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<tr>
<td>Social support</td>
<td>My friends play hard.</td>
<td>Most of the time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once in a while</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Almost never</td>
</tr>
<tr>
<td>Barriers</td>
<td>The weather is too bad to play sports or active games.</td>
<td>Almost never</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once in a while</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Most of the time</td>
</tr>
<tr>
<td>Self-perception</td>
<td>Some kids wish they could feel better about themselves physically.</td>
<td>Just like me</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A little like me</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not much like me</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all like me</td>
</tr>
<tr>
<td>Diet</td>
<td>Which has more fat?</td>
<td>Hot dog</td>
</tr>
<tr>
<td>Knowledge of high-fat foods</td>
<td></td>
<td>Turkey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I don’t know</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>I can put less butter on my tortilla bread.</td>
<td>I know I can</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I think I can</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I’m not sure I can</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I don’t think I can</td>
</tr>
<tr>
<td>Social support</td>
<td>The adults in my house eat fruits and vegetables.</td>
<td>Most of the time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once in a while</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Almost never</td>
</tr>
<tr>
<td>Intentions</td>
<td>Which would you pick for a snack?</td>
<td>Potato chips</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pretzels</td>
</tr>
<tr>
<td>Food frequency</td>
<td>Did you drink fruit juice yesterday?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Weight-related attitudes</td>
<td>Do you think you are:</td>
<td>Too skinny</td>
</tr>
<tr>
<td>Body image</td>
<td></td>
<td>About right</td>
</tr>
<tr>
<td>Concern regarding weight</td>
<td>How do you feel about your weight?</td>
<td>Happy</td>
</tr>
<tr>
<td></td>
<td>Are you:</td>
<td>Unhappy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I never think about it</td>
</tr>
<tr>
<td>Attempts at weight loss</td>
<td>Are you trying to lose weight?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Cultural identity</td>
<td>Can you speak your tribal language?</td>
<td>Yes, I can speak easily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes, I can speak a few words</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I do not belong to any tribe</td>
</tr>
</tbody>
</table>
As noted above, an interesting problem emerged for items that required reverse scoring, apparently because they were negatively worded. A negatively worded item is one in which a negative response is keyed positively (65). For example, “Some kids do not like the way their body looks” is a negatively worded item from the KAB questionnaire. Such items are included in psychosocial questionnaires to guard against a tendency to answer affirmatively to all items. Children completing version 2.0 of the KAB questionnaire responded to such items as though they were positively worded (eg, “Some kids like the way their body looks”). Previous literature suggests similar problems when administering some psychologic questionnaires to children in this age group (66). Taken together with the present results, these findings suggest that negatively worded items may not be appropriate for use in the Pathways study and that other strategies for reducing response-set bias should be investigated.

Cultural issues

The poor performance of the negatively worded questions was likely related to the young age of our sample, but cultural issues may also have contributed. Other questions we found to be problematic were those designed to ascertain information about attitudes or behaviors that could be termed undesirable. Because it is intrinsic to many American Indian cultures to think and speak in a positive way and to avoid thinking or speaking in a negative way (67), questions that elicit negative thinking are inappropriate. In traditional Navajo culture, it is held that thoughts and spoken words have the power to shape reality and to control events. Therefore, asking a question about negative feelings or behaviors is believed to potentially cause those negative feelings and behaviors. An additional culture-bound belief that made questionnaire development challenging was the tradition of avoiding comparisons between individuals. Rating or ranking individuals is considered unacceptable in several tribes. Thus, questions that required a comparison of oneself to others were not acceptable.

Over the course of the development of the questionnaire we gained an appreciation of the differences between individual opinion and group consensus in the area of cultural input. In the early phases of the study, the KAB working group responded to the suggestions of the individual American Indian members of the team. As time passed and the number of American Indian members on the team grew and the study experienced turnover in staff, it became obvious that there were differences in the culture-bound beliefs between different tribes and between individuals in tribes. We have found it very useful to request formal recommendations from the American Indians on the project as a group rather than individually. Also, we found that occasional face-to-face meetings were essential for discussions of cultural appropriateness.

Our experience underscores the importance of involvement of American Indian members of the Pathways team in every phase of development of the KAB questionnaire. This was important not only in ensuring that the questionnaire was properly worded and culturally appropriate, but in obtaining tribal approval. Too often, instruments are developed for majority children and used with children from different ethnic communities without adequate data on reliability and validity for use within that population, and without input from the community. The American Indian members of the KAB team not only helped to produce a more culturally appropriate instrument, but also facilitated acceptance of the instrument by the larger community.

### Table 2

Statistics from version 2.0 of the Pathways knowledge, attitudes, and behaviors questionnaire

<table>
<thead>
<tr>
<th>Section and scale or subsection</th>
<th>No. of questions</th>
<th>Average ( \kappa )</th>
<th>No. of questions in scale</th>
<th>Average ( \kappa ) of questions in scale</th>
<th>Cronbach’s ( \alpha )</th>
<th>( r^t )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical activity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-efficacy</td>
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<td>0.30</td>
<td>3</td>
<td>0.31</td>
<td>0.61</td>
<td>0.58</td>
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<tr>
<td>Social support</td>
<td>12</td>
<td>0.23</td>
<td>9</td>
<td>0.18</td>
<td>0.78</td>
<td>0.48</td>
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<tr>
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<td>10</td>
<td>0.21</td>
<td>10</td>
<td>0.22</td>
<td>0.56</td>
<td>0.52</td>
</tr>
<tr>
<td><strong>Self-perceptions</strong></td>
<td></td>
<td></td>
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<tr>
<td>Global</td>
<td>4</td>
<td>0.25</td>
<td>4</td>
<td>0.29</td>
<td>0.15</td>
<td>0.34</td>
</tr>
<tr>
<td>Global physical</td>
<td>4</td>
<td>0.25</td>
<td>4</td>
<td>0.25</td>
<td>0.30</td>
<td>0.56</td>
</tr>
<tr>
<td>Sports and skills</td>
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<td>0.24</td>
<td>4</td>
<td>0.16</td>
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<td>0.22</td>
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<tr>
<td>Fitness</td>
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<td>4</td>
<td>0.24</td>
<td>0.23</td>
<td>0.26</td>
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<tr>
<td>Body attractiveness</td>
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<td>4</td>
<td>0.25</td>
<td>0.02</td>
<td>0.32</td>
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<tr>
<td>Strength</td>
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<td>4</td>
<td>0.29</td>
<td>0.25</td>
<td>0.57</td>
</tr>
<tr>
<td>Social acceptance</td>
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<td>0.29</td>
<td>4</td>
<td>0.29</td>
<td>0.46</td>
<td>0.31</td>
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<td><strong>Diet</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of high-fat foods</td>
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<td>0.30</td>
<td>6</td>
<td>0.29</td>
<td>0.56</td>
<td>0.52</td>
</tr>
<tr>
<td>Self-efficacy</td>
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<td>0.26</td>
<td>12</td>
<td>0.26</td>
<td>0.76</td>
<td>0.59</td>
</tr>
<tr>
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<td>0.64</td>
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<tr>
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<td>11</td>
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<td>0.46</td>
<td>0.52</td>
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<tr>
<td><strong>Weight-related attitudes</strong></td>
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<td>5</td>
<td>0.41</td>
<td>0.57</td>
<td>0.64</td>
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<td>—</td>
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<td>—</td>
</tr>
<tr>
<td>Attempts at weight loss</td>
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<td>0.40</td>
<td>0.67</td>
<td>0.65</td>
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<td>0.43</td>
<td>4</td>
<td>0.44</td>
<td>0.41</td>
<td>0.49</td>
</tr>
</tbody>
</table>

*One or more of the questions in the scale may have been deleted or collapsed for this calculation (see text).*
Conclusion

In conclusion, the development of a questionnaire to measure knowledge, attitudes, and behaviors in American Indian children used many different types of information and expertise. The process has taken >2 y and is still ongoing. Our objective was to produce scales that were internally consistent and repeatable as indicated by Cronbach’s α and r values ≥0.6. The final questionnaire will be administered annually during the Pathways full-scale intervention trial. We look forward to learning more about the effect of the intervention in areas pertinent to the health of American Indian children.

REFERENCES

41. Parham T, Helms J. The influence of black student’s racial identity attitudes on preferences for counselor’s race. J Consult Psychol


