

Walden University

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Walden University
2025

Abstract

Lived Experiences of Obese Women in Mississippi Concerning the Role of Psychosocial
Factors in the Development of Obesity

by

Temitope Olabode

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health Dissertation

Walden University

November 2025

Abstract

One of the highest rates of obesity in the United States is in Mississippi, where middle-aged obese women deal with a variety of social, cultural, and personal issues, including shame, discrimination, and stigma based on weight, mental anguish, cultural norms, financial limitations, and restricted access to healthcare. This study investigated the psychosocial factors that contribute to obesity in women aged 40- 60 years, and the effects of obesity on body image, self-esteem, health behaviors, and quality of life. A qualitative phenomenological study using the social ecological model (SEM) framework looked at the individual, interpersonal, and policy levels of the phenomenon. Twelve major themes emerged from a thematic analysis of in-depth interviews. These included internalized weight stigma, cultural body size expectations, institutional healthcare hurdles, socioeconomic limitations that limit access to healthy food and exercise options, emotional eating as a coping mechanism, and the supportive role of social networks such as churches and communities. The primary psychosocial stressors, which were influenced by Mississippi's cultural and economic context, were caregiving strain, mourning, and economic demands. In addition, adoption of healthy behaviors was hampered by low self-efficacy, time constraints, and fear of being judged, but was encouraged by self-compassion and social support. The findings provide a basis for multi-level interventions that incorporate structural obstacle elimination, weight control, mental health assistance, and culturally specific health promotion. The adoption of such interventions would result in substantial positive social change.

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Chapter 1: Introduction to the Study

Introduction

Obesity continues to be a critical global public health issue, carrying substantial ramifications for communities, healthcare systems, and individuals. Examining the lived experiences of obese women in Mississippi concerning the influence of psychosocial factors on obesity development is the purpose of this research. Particularly in rural and marginalized communities, the high prevalence of obesity and associated health disparities in Mississippi render the state an ideal setting for this investigation (Cosby et al., 2019). Obesity arises from a complex interplay of factors, which include but are not restricted to inactivity, inadequate nutrition, a sedentary way of life, genetic susceptibility, socioeconomic standing, cultural impacts, and environmental determinants (Miller & Vasan, 2021). It is critical to comprehend the intricate dynamics among these elements in order to formulate efficacious interventions and strategies to tackle the obesity epidemic (Dwyer-Lindgren et al., 2017).

The research population consists of obese women who are residents of Mississippi. They represent a diverse demographic, which includes individuals of Hispanic, American Indian, White, and African American descent. Women are disproportionately impacted by obesity, as evidenced by its higher prevalence rates in comparison to men. As a result, research and intervention efforts must prioritize women (James et al., 2018). In collaboration with local healthcare facilities, community organizations, and academic institutions in Mississippi, this research will be carried out.

Collaborations of this nature are critical in order to facilitate data collection, guarantee access to participants, and effectively communicate research outcomes to pertinent stakeholders.

The urgency to address the obesity epidemic and its associated health disparities, particularly among vulnerable populations such as rural women, justifies the conduct of this research. This research endeavors to provide insights into the psychosocial determinants of obesity and the lived experiences of obese women. Its ultimate goal is to contribute to the development of targeted interventions, policy initiatives, and healthcare practices that are designed to prevent and manage obesity, not only in Mississippi but also in other regions. The study has the capacity to generate significant social ramifications that transcend individual, communal, and societal boundaries. Through providing insights into the personal experiences of obese women and clarifying the influence of psychosocial factors on the development of obesity, this study possesses the capacity to contribute to the development of more comprehensive and individual-focused strategies for preventing and managing obesity.

Background

The persistent problem of obesity prevalence continues to be a substantial worldwide public health concern, carrying far-reaching consequences for both physical and mental health, as well as healthcare systems on a global scale. The development and maintenance of obesity are influenced by various factors. However, there is growing acknowledgement of the significance of psychosocial factors, which include social, psychological, and environmental influences, in comprehending this intricate matter

(Dabas et al., 2024). It is crucial, especially in the state of Mississippi, where obesity rates are among the highest in the country, to comprehend the viewpoints and lived experiences of obese women regarding the influence of psychosocial factors on the development of obesity.

Mississippi, commonly known as the "Magnolia State," is confronted with enduringly elevated levels of obesity that surpass the national mean. The economic disparities, cultural heritage, and extensive historical background of the state all contribute to the complexity of the issues surrounding the prevalence of obesity. The prevalence of obesity among women in Mississippi was estimated to be around 43.1% in 2021, according to data from the Centers for Disease Control and Prevention (CDC). Significantly, the prevalence of obesity among African American adults in Mississippi exhibited a disproportionate increase, peaking at approximately 50% in 2022 (Mendy et al., 2017). These statistics emphasize the critical nature of investigating the experiences of obese women in Mississippi, specifically in regards to the psychosocial determinants of obesity.

Psychosocial variables comprise an extensive array of elements, such as socioeconomic status, cultural norms, mental health, and interpersonal relationships, all of which influence the attitudes and behaviors of individuals with regard to body image, diet, and exercise (Qobadi & Payton, 2017). However, the voices and perspectives of obese women themselves, particularly in the specific context of Mississippi, have received minimal attention. The multifaceted nature of obesity is underscored by its intricate connection to a variety of health issues, such as cardiovascular disease, Type 2

diabetes, and psychological distress (World Health Organization, 2015). Rural areas, including those that are prevalent in Mississippi, encounter unique obstacles as a result of restricted healthcare accessibility and elevated morbidity and mortality rates (Health Resources & Services Administration, 2021). In addition, health disparities are most pronounced in the state's rural regions, especially in the Mississippi Delta, which has the highest mortality rates and the shortest life expectancy in the nation (Miller & Vasan, 2021).

Although numerous factors have been identified in research as contributing to health inequalities in Mississippi, such as racial disparities, limited access to primary care, and poverty, there is a scarcity of comprehensive analyses that specifically examine the experiences of obese women and the psychosocial influences on their health behaviors (Coleman-Jensen et al., 2021). The aforementioned knowledge vacuum highlights the criticality of conducting research that investigates the interaction between psychosocial factors and obesity in the specific context of Mississippi (Segal et al., 2016). While existing research has acknowledged the myriad factors contributing to health disparities in Mississippi, such as poverty, limited healthcare access, and racial inequities, there persists a notable gap in understanding the nuanced experiences of obese women and the psychosocial determinants shaping their health behaviors (Coleman-Jensen et al., 2021). Specifically, the subjective perspectives, feelings, and narratives of low-income, obese women aged 40 to 60 remain underexplored, particularly within the intersectionality of race and socioeconomic status.

Obese women in Mississippi, particularly those from low-income backgrounds, grapple with a multitude of psychosocial challenges, including low self-esteem, stigma, discrimination, and poor body image. Despite the profound impact of these factors on individuals' lives, there has been limited attention paid to comprehensively examining how they intersect and exacerbate one another's effects in this population (Segal et al., 2016). Therefore, this research aims to address this critical gap by delving into the intersectionality of psychosocial factors among white and African American obese women, specifically within the context of low-income communities in Mississippi. By meticulously analyzing the intricate interplay between socioeconomic difficulties and psychosocial variables, this study seeks to uncover the underlying mechanisms driving health behaviors and outcomes among this vulnerable population. Ultimately, elucidating the complex dynamics between psychosocial factors and obesity within the Mississippi context is imperative for developing targeted interventions and support programs tailored to the unique needs of low-income, obese women. By amplifying their voices and experiences, this research endeavors to inform more effective strategies for addressing health disparities and promoting holistic well-being in Mississippi and beyond.

This study sheds more light into the challenges faced by obese women aged from 40-60 in Mississippi hence; it has huge significance in the society. Obesity is when an individual has a body mass index (BMI) - $\text{body weight (kg)} / \text{height (m}^2\text{)}$ - that is equal to or greater than 30 (Lin & Li, 2021). As a health issue, obesity is not just a debilitating physical condition; obese women also face psychological and social challenges that affect their body image, their self-esteem and mental health, and their access to healthcare

(Qobadi & Payton, 2017). This study seeks to provide insights into support programs and targeted interventions that are specifically designed to address the needs of obese women in Mississippi by amplifying their voices and experiences. Through addressing the psychosocial determinants of obesity, the ultimate objective is to enhance the health and quality of life of the obese population in Mississippi.

Problem Statement

The complex and widespread obstacles encountered by obese women in Mississippi, specifically those between the ages of 40 and 60, emphasize the urgent requirement to further examine the interplay of psychosocial elements within this population. These women face numerous psychosocial stressors and obstacles, such as discrimination, stigma, and negative body image perceptions. These challenges are further intensified by societal and cultural standards that promote optimal body standards. Notwithstanding the profound ramifications that these factors have on the lives of individuals, a substantial knowledge deficit persists regarding the intricate nuances of struggles and determinants of resilience among obese women in the context of Mississippi.

The objective of this study was to find out the experiences of obese women aged 40 to 60 that include their weight loss experiences and resisting or accepting their obesity status in relation to policy factors, psychosocial factors, psychological factors, social factors, and personal experiences in Mississippi. This will enable the development of interventions and support programs that are more efficacious and customized to address their unique requirements.

As the multifaceted nature of obesity and its pervasive effects on the physical and mental health of individuals become increasingly apparent, the importance and relevance of this research issue are further emphasized. The significance of psychosocial factors in influencing the attitudes and behaviors of individuals with respect to body image, exercise, and nutrition has been emphasized in recent scholarly works (Qobadi & Payton, 2017). Moreover, the significant incidence of obesity among women in Mississippi, specifically those hailing from economically disadvantaged backgrounds, emphasizes the critical nature of comprehending the intricate dynamics between psychosocial factors and obesity in this demographic (Coleman-Jensen et al., 2021). Through a critical examination of prior research and a constructive critique, this study endeavors to enhance comprehension regarding the psychosocial intricacies of obesity in Mississippi.

Purpose of the Study

Through a comprehensive examination of the viewpoints and experiences of obese women residing in Mississippi, I endeavored in this study to shed light on the significance of psychosocial factors in the progression of obesity. The objective was to explore the personal experiences, sentiments, and subjective accounts of individuals who are obese in order to illuminate concerns including stigma, self-esteem, negative body image, and discrimination, in addition to the overall impact on quality of life. Through an exploration of the effects of obesity stigma, self-stigma, and weight bias on the lives of obese individuals, this study's aim was to provide a more comprehensive understanding of their implications for health outcomes, social identities, healthcare accessibility, and participation in health-promoting activities.

In addition, the purpose of this research was to increase knowledge of the psychosocial dynamics associated with obesity among obese women between the ages of 40 and 60 in Mississippi. Through the identification of distinctive experiences and determinants of resilience within this demographic, the study contributes to the formulation of intervention and support initiatives customized to address their particular psychological requirements. I utilized qualitative research methods which are suitable for this inquiry due to their capacity to facilitate an in-depth comprehension of human realities and experiences via extended engagement with participants in their authentic environments (Renjith et al., 2021). In contrast to quantitative methodologies, which center on precise temporal, substantive, and spatial aspects of decision-making, qualitative inquiry seeks to examine, explicate, and clarify events in order to grasp the intricate essence of reality.

Phenomenology, a qualitative research method that investigates a phenomenon from the perspective of those who have firsthand experience, was employed in the research strategy (Teherani et al., 2015). Phenomenology investigates both the content and manner in which an experience transpires in an effort to ascertain its significance. In particular, a hermeneutic phenomenological approach was utilized to interpret the lived experiences of individuals in the context of their sociocultural environment (Tuffour, 2017). This method is consistent with the research's aim of comprehending the psychosocial intricacies of obesity within various demographics of women residing in Mississippi.

The incorporation of phenomenology is crucial to this study in order to capture the participants' nuanced experiences and interpretations of obesity. Through the application of phenomenological methodology, I sought to reveal the fundamental nature of the participants' experiences, thereby illuminating the complex interaction of individual, societal, and cultural elements that influence their attitudes and conduct in regard to obesity. By employing this methodology, the research endeavors to produce comprehensive and detailed information that will enhance comprehension of the psychosocial aspects of obesity in the state of Mississippi.

Research Questions

The research question for this research study was:

What is the lived experience of obesity among obese women aged 40 to 60 in Mississippi?

The sub-questions were the following:

- SRQ1: What is the lived experience of obese women about how psychosocial factors contribute to obesity?
- SRQ2: What is the lived experience of obese women about how discrimination and stigma are related to obesity?
- SRQ3: What is the lived experience of obese women about how body image dissatisfaction influences self-esteem and overall quality of life?
- SRQ4: What is the lived experience of obese women about the role of psychosocial factors in shaping health-promoting behaviors?

Theoretical and Conceptual Framework for the Study

Theoretical Framework

The study was grounded in the social ecological model (SEM), a framework established by Urie Bronfenbrenner in the 1970s. This model offers a holistic perspective on health behaviors and outcomes, situating them within the intricate web of environmental influences. Individual, interpersonal, community, and societal factors are all taken into account by the SEM, which emphasizes the dynamic interactions that occur between these levels (Kilanowski, 2017).

The SEM postulates that various levels of influence exert an impact on health behaviors and outcomes. These levels include societal factors, interpersonal relationships, individual characteristics, and community environments (Patel et al., 2016). The model emphasizes the interdependence and dynamic relationships between different levels of influence, implying that modifications at one level may trigger a series of consequences that impact individual behaviors and health outcomes (Roux et al., 2016). In contrast to interventions that exclusively concentrate on individual-level variables, those that target multiple spheres of influence demonstrate greater efficacy in promoting health outcomes, as indicated by the SEM (Kilanowski, 2017).

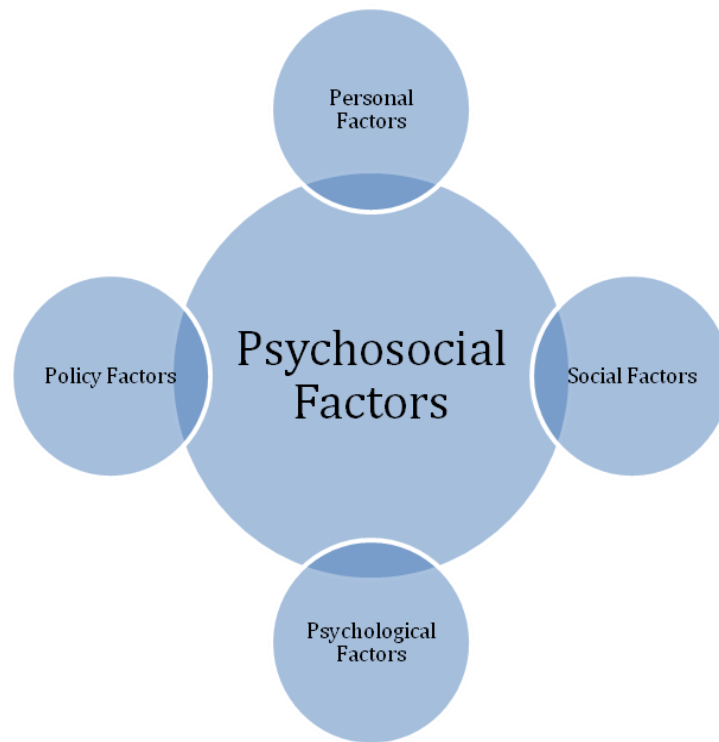
The SEM has been extensively applied and adapted in numerous disciplines—including public health, psychology, and sociology—to comprehend the relationship between environmental influences and health behaviors and outcomes. Although the exact origins of this concept remain obscure, it has emerged as a paradigm for understanding the intricate nature of matters pertaining to health (Patel et al., 2016). The

utilization of the SEM in this study is highly compatible with the qualitative research design implemented, as it facilitates an all-encompassing investigation into the complex interplay of personal, social, community, and societal elements that impact the onset and persistence of obesity among women residing in Mississippi (Roux et al., 2016). The study seeks to reveal the subjective experiences and viewpoints of obese women through the use of a phenomenological methodology. It situates their narratives within the wider socio-ecological framework established by the SEM (Korom et al., 2023).

The SEM guided the design of the interview questions, data collection, and data analysis by investigating factors at multiple levels of influence. By employing qualitative research methods, including interviews, the study will amass comprehensive and detailed descriptive data in order to investigate the ways in which personal, communal, and societal elements influence the lived experiences of obese women residing in Mississippi. Following this, the data will be analyzed in order to discern recurring themes and patterns at various levels of impact, thereby illuminating the intricate interrelation of elements that contribute to obesity among this demographic (Register-Mihalik et al., 2017).

Conceptual Framework

Supported by personal, psychosocial, psychological, societal, and policy factors, the conceptual framework for this study identifies key phenomena and concepts associated with obesity among women in Mississippi. These variables interact in a dynamic manner, influencing the attitudes, behaviors, and health outcomes of individuals (see Figure 1).

Figure 1**Conceptual Framework**

Personal factors such as body image, self-esteem, and attitudes toward food influence the dietary practices and weight management strategies utilized by obese women. Cultural practices and prior experiences with food significantly shape these beliefs, particularly in a region like Mississippi where traditional Southern gastronomy is universally acknowledged. Cultural norms and stress may both contribute to emotional eating, which may result in weight gain and the exacerbation of unhealthy eating habits. Genetic factors exert an influence on both obesity and depression, thereby emphasizing the criticality of early detection and integrated treatment approaches (Mendy & Vargas, 2015).

Anxiety and depression, which are part of psychological and psychosocial factors, are prevalent among adults in Mississippi and have a strong correlation with adiposity. The presence of bidirectional relationships between obesity and depression highlights the complex interrelationships that exist between somatic, psychological, and physiological pathways. Poor health practices, biological disturbances, and psychological determinants all contribute to the co-occurrence of these conditions. Significant impact is exerted by body image perceptions on dietary habits and approaches to weight management (Amare et al., 2017). The body dissatisfaction and low self-esteem of obese women can be attributed to various social and cultural influences, particularly those associated with ideals of thinness and attractiveness (Kim et al., 2023).

Social factors encompass a range of elements that impact the experiences of obese women residing in Mississippi. These elements comprise familial dynamics, social support networks, and cultural conventions that are specific to body image and diet. Traditional Southern cuisine and familial expectations have the potential to reinforce unhealthy dietary practices. Conversely, social occasions that center around food may pose challenges to the adherence to a healthy diet. Body image-related attitudes and behaviors are influenced by cultural norms and value differences between ethnic groups (Connell et al., 2019). Although the embrace of larger body sizes by certain ethnic groups might mitigate the social stigma linked to obesity, it could potentially hinder the adoption of healthy lifestyle habits. Physical inactivity among obese women can be attributed to structural factors such as caregiving obligations and limited availability of secure outdoor areas. While social support networks undeniably offer invaluable assistance, they may

also reinforce cultural norms and values pertaining to nutrition and body image (Walsh et al., 2019).

The global obesity epidemic has been further intensified by changes in dietary patterns, food accessibility, and affordability that have been induced by the process of globalization, which are policy-related factors. To advance the cause of nutritious eating, food policies must consider the social, familial, and individual factors that influence food consumption. The participation of regional and national administrations is critical for the formulation and implementation of food policies. It is imperative that these policies endeavor to modify the accessibility, financial feasibility, and societal acceptance of nutritious food alternatives across various contexts. To address the obesity epidemic through the implementation of high-leverage policies, environments that promote healthy behaviors and target underlying structures must be created. In order to achieve effective implementation, policies must interact synergistically with administrative oversight and enforcement mechanisms, which originate from diverse systems (Zhang et al., 2014).

The conceptual framework, which underscores the interconnectedness of personal, psychological, societal, and policy elements that influence obesity among women in Mississippi, exerts an influence on the study design and research inquiries. Qualitative research methods, such as interviews and observations, enable an exhaustive examination of the aforementioned variables and their impact on individuals' experiences and behaviors. Instrument Development, which identifies fundamental concepts and phenomena to be investigated through qualitative data collection methods, is also guided by the conceptual framework. Through the identification of themes and patterns linked to

personal beliefs, psychological factors, societal influences, and policy implications, this framework will additionally provide guidance for data analysis. As a result, the data analysis will illuminate the complex interrelation of variables that contribute to the high prevalence of obesity among women in Mississippi.

The comprehensive conceptual framework provides a methodical approach to examining the intricate attributes of obesity and the factors that contribute to it. The methodology and analysis of the study are guided by this framework, which ultimately produces significant findings that can contribute to the development of policies and interventions.

Nature of the Study

This qualitative study explored the personal experiences of obese women in Mississippi with regard to the psychological and social determinants of obesity. A comprehensive understanding of the viewpoints and experiences of the participants was acquired for this study through interviews (Renjith et al., 2021). In order to enhance thorough examination and understanding of complex phenomena, the research study utilizes a qualitative research design. To achieve the research aim of understanding the lived experiences of overweight women in Mississippi in relation to obesity and psychosocial determinants, qualitative investigation allows for the exploration of subjective experiences and the importance that individuals attribute to them (Matua, 2015).

The primary focus of this study was the impact of psychosocial and psychological factors on the development and perpetuation of obesity among women in Mississippi.

This requires an examination of the intricate interplay between individual beliefs, societal norms, cultural influences, and mental well-being in relation to the emergence of obesity-related issues. The participants in this study were obese women from Mississippi. The sample size I sought to have for interviews in this qualitative study was 15 to 20 participants, with the exact number determined iteratively during data collection until saturation was achieved (Bekele & Ago, 2022). In order to examine the ways in which psychological and social determinants influence the experiences of specific participants who are affected by obesity, an extensive series of interviews was conducted. The narratives and perspectives of the participants were solicited through open-ended inquiries (Kerver et al., 2020).

The recruitment of participants for the interviews were conducted using purposive sampling. The participant selection procedure was conducted in accordance with pre-established criteria (Palinkas et al., 2015). The inclusion criteria were the following: domicile in Mississippi, self-identification as female, self-reported obesity status, adults between the ages of 40 and 60, any race, and prior participation in support organizations that focus on weight loss or obesity. Qualitative data analysis was employed to analyze the data gathered via interviews. The process involves a systematic analysis of the data with the purpose of identifying trends, themes, and importance (Gomes et al., 2023). Following the thematic analysis principles, the analysis process was ongoing and iterative. In order to ascertain the adequacy of the sample size, an assessment of data saturation was conducted (Worku et al., 2023).

The qualitative research employed interviews to examine the perspectives and actual experiences of participants. Its objective was to acquire substantial insights into the psychological and social dimensions of obesity among women in Mississippi. In this research, I aimed to generate a comprehensive understanding of the complex factors that contribute to obesity in this specific population through the use of purposive sampling and rigorous qualitative data analysis.

Definitions

Body Image:

Body image encompasses an individual's cognitive, affective, and perceptual evaluations of their physical form, dimensions, and overall presentation. Body image is a psychological construct that is substantially impacted by societal ideals, cultural norms, personal experiences, and personal experiences; it influences self-esteem and weight management behaviors (Mendy & Vargas, 2015).

Cultural Norms:

Cultural norms encompass a set of mutually accepted beliefs, values, customs, and behaviors that serve to define an entire society or group. Attitudes regarding health, physical activity, food, and body image are all impacted by cultural norms, which can differ among ethnic and cultural groups (Kim et al., 2023).

Data Saturation:

Data saturation is a conceptual milestone in qualitative research that is achieved when further data collection ceases to yield any novel insights or themes, signifying the attainment of theoretical saturation. This indicates that the researcher has amassed an

adequate quantity of data to comprehensively comprehend the phenomenon being investigated, and it is improbable that additional data collection will produce substantial novel insights. In qualitative research studies, data saturation is a crucial criterion for determining the appropriate sample size (Gomes et al., 2023).

Genetic Factors:

Genetic factors encompass hereditary characteristics and DNA variations that may impact an individual's vulnerability to obesity and associated medical conditions. The risk of obesity may be influenced by a combination of genetic, environmental, and behavioral factors (Łojko & Rybakowski, 2017).

Obesity:

Obesity is a pathological state distinguished by the excessive buildup of adipose tissue on the body, to the degree that it potentially impairs one's well-being. Typically, body mass index BMI, which is computed by dividing weight in kilograms by the square of height in meters (kg/m^2), is utilized for this purpose. A multitude of health complications are associated with obesity, such as diabetes, cardiovascular disease, and specific forms of cancer (World Health Organization, 2022).

Personal Factors:

Personal factors encompass attributes, convictions, stances, and encounters that are inherent to an individual and exert an impact on health outcomes and behavior. Personal factors may include emotional coping mechanisms, genetic predispositions, self-perceptions, and cultural beliefs regarding food and body image (Kim et al., 2023).

Psychological Factors:

Psychological factors encompass cognitive processes, experiences, and behaviors that exert an impact on the thoughts, emotions, and actions of an individual. Cognitive processes, affective states, personality attributes, and coping mechanisms are examples of such variables. Psychological factors may play a role in the development of eating disorders, anxiety, and depression, among other mental health conditions, in the context of obesity (Luck-Sikorski et al., 2018).

Psychosocial Factors:

Psychosocial factors encompass the intricate interplay between social and psychological elements that exert an impact on the mental health, conduct, and general welfare of an individual. Social support, familial dynamics, cultural beliefs, socioeconomic status, and individual psychological characteristics such as coping mechanisms, personality traits, and stress are among these numerous elements. They significantly influence body image, dietary behaviors, physical activity levels, and adherence to weight management programs (Wiss & Brewerton, 2020).

Purposive Sampling:

Purposive sampling, alternatively referred to as judgmental or selective sampling, is a non-random sampling method in which participants are deliberately chosen according to particular attributes or criteria that are pertinent to the objectives of the research. In qualitative research, this sampling technique is frequently employed to enlist participants who possess direct experience or specialized knowledge pertaining to the subject under investigation. (Palinkas et al., 2015) Purposive sampling guarantees that participants will

be able to offer comprehensive insights and perspectives regarding the phenomenon being studied.

Social Factors:

Social factors comprise elements of the social milieu in which an individual is situated. These elements consist of socioeconomic status, social norms, cultural influences, and social support networks. These variables have the capacity to influence opportunities, behaviors, and attitudes concerning health and well-being. Social determinants may impact dietary patterns, levels of physical activity, healthcare accessibility, and societal norms regarding body image with respect to obesity (Connell et al., 2019).

Support Networks:

Support networks comprise community organizations, friends, family, and other individuals who are in need of resources, encouragement, and assistance. The impact of support networks on obesity management resources, coping mechanisms, and health behaviors has been documented (Connell et al., 2019).

Thematic Analysis:

Determining meanings, patterns, and themes within the data is the objective of thematic analysis, a qualitative data analysis method. Qualitative data analysis entails the methodical arrangement and interpretation of such information in order to reveal recurring themes, concepts, or experiences that are pertinent to the research inquiries. Interview transcripts are frequently analyzed using thematic analysis (Ayre & McCaffery, 2022).

Assumptions

A foundational assumption of this research was that the experiences and viewpoints of the participants, as they self-report, are faithful representations of their actual circumstances concerning obesity and the psychosocial factors that influence it. This presumption was essential due to the research's reliance on qualitative data collection techniques, including interviews, which place emphasis on the subjective narratives provided by participants regarding their experiences. Although researchers endeavor to establish a nurturing and unbiased setting wherein participants feel comfortable revealing their experiences, ascertaining the preciseness or comprehensiveness of the narratives provided by participants is inherently challenging. This premise is essential due to the fact that qualitative research endeavors to elicit comprehensive and nuanced accounts of the experiences, emotions, and viewpoints of individuals using their own language. Researchers can extract valuable insights and interpretations from the collected data by presuming that the self-report of participants offer authentic perspectives on their experiences with obesity and the psychosocial factors associated with it. Neglecting to make this presupposition would undermine the credibility and interpretability of the qualitative results, as it would be impossible for researchers to believe that the participants' testimonies were genuine.

In addition, establishing rapport and trust between researchers and participants is contingent upon the premise that participants' self-reports faithfully depict their experiences. In order to evoke candid and truthful responses from participants, it is critical to establish trust, particularly when addressing delicate subjects like weight, body

image, and mental health. Insufficient trust among participants may impede their willingness to candidly disclose their experiences, thereby introducing the possibility of obtaining biased or incomplete data.

Scope and Delimitations

Understanding the lived experiences of obese women in Mississippi with regard to the psychological and social determinants of obesity is the precise objective of this research endeavor. By directing attention to this particular aspect, the necessity for a more profound comprehension of the intricate relationship between psychosocial factors and obesity in this demographic was acknowledged. The study's objective was to offer contextually pertinent insights by focusing on obese women in Mississippi. These insights can then be utilized to develop targeted interventions and policies that specifically target obesity in this demographic.

The study's boundaries encompass populations that satisfy the participant selection criteria specified in the sampling section. For instance, they had to consist of self-identified female residents of Mississippi between the ages of 40 and 60 who self-report being obese and have prior experience participating in support groups that specifically target weight loss or obesity. Populations that are excluded may consist of members who do not fall within the designated inclusion criteria or who do not meet the demographic criteria that are mentioned.

Unexplored theoretical frameworks that are most pertinent to the field of study may comprise sociological or psychological theories of health behavior on a broader scale, such as the SEM or theories of health behavior change. Although these frameworks

offer valuable insights into the wider context of obesity and health behavior, the primary objective of this research is to capture the subjective experiences and perspectives of obese women residing in Mississippi. The examination of particular theoretical constructs is not the focus of this study.

When considering the prospective transferability of the study's findings, it is crucial to recognize the contextual specificity of them. Although the knowledge acquired from this study could be beneficial in comprehending the struggles of overweight women in Mississippi, its applicability to different populations or geographic areas may be limited. Diverse healthcare systems, cultural norms, and socioeconomic disparities are a few of the context-specific elements that can affect the manifestation of obesity and its psychosocial determinants

The study duly recognizes and endeavors to mitigate the potential for participant coercion, difficulties associated with BMI measurements, and time constraints through the research design and implementation processes. Ethical considerations and strategies for emotional distancing are employed in order to minimize potential hazards to the welfare of participants. Furthermore, it is acknowledged that the research findings cannot be universally applied, underscoring the necessity for additional investigations to delve into the intricacies of obesity and psychosocial determinants across various populations and contexts.

Limitations

Limitations of the study related to design and methodological weaknesses include that the use of purposive sampling may introduce bias by selecting participants based on

predetermined characteristics, potentially excluding individuals with different perspectives or experiences related to obesity and psychosocial factors. This could limit the generalizability of the findings to the broader population of obese women in Mississippi. Reliance on self-reported data for variables such as obesity status and psychological experiences may introduce response bias, as participants may underreport or over report certain information due to social desirability or recall biases. This could affect the accuracy and reliability of the study findings (Schwartz et al., 2017).

In addition, the time-intensive nature of qualitative data collection and analysis, including conducting interviews, may limit the depth and breadth of the study. Time constraints could affect the researcher's ability to thoroughly explore all relevant themes and perspectives related to obesity and psychosocial factors. The researcher's own biases or preconceived notions about obesity and psychosocial factors could influence study outcomes, such as through the framing of interview questions or interpretation of data. Awareness of researcher bias and efforts to maintain reflexivity throughout the research process are necessary to minimize its impact on the study (Dahlke & Stahlke, 2020).

To address these limitations, reasonable measures can be implemented. To have more understanding of this research, triangulation of the data sources will be utilized with the interviews, this approach helps with reducing the limitations of self-reported data. Engaging in peer debriefing sessions with other researchers or experts in qualitative research methods can help identify and address potential biases in study design, data collection, and analysis. Peer debriefing involves discussing and reflecting on key decisions and interpretations throughout the research process to enhance rigor and

credibility. Providing participants with opportunities to review and validate the findings, known as member checking, can enhance the trustworthiness of the study outcomes. By soliciting feedback from participants on the accuracy and relevance of the findings, researchers can ensure that their perspectives are accurately represented and interpreted. By implementing these measures, researchers can enhance the credibility, dependability, and transferability of the study findings, thereby address limitations and strengthen the overall quality of the research.

Significance

This research is significantly relevant to the improvement of the understanding of the interrelation/relationship between psychosocial factors and obesity as well as policy and practice. Through the examination of experiences of obese women in Mississippi, further knowledge was derived from this research study of the complex interactions of societal, environmental, psychological, psychosocial, and personal factors that lead to obesity. The employment of qualitative analysis of participants' narratives' subtle facets unveils from this research, implicit mechanisms that are often disregarded by quantitative approaches. The comprehension that is more profound builds up the theoretical underpinnings of obesity research and upcoming investigations that are directed into therapies and interventions. The result of this qualitative study guides the formation of regulations and focused treatments that holistically tackle obesity.

Health Practitioners and policymakers develop more successful treatment, prevention, and management methods by understanding the psychological determinants of obesity. For instance, interventions could improve communication skills, support

healthy family dynamics, or promote behavior modification. Laws and policies governing sugar-sweetened beverage regulations, standards of nutrition in schools, and food marketing to minors may be shaped by the knowledge acquired from this study. This could result in evidence-based strategies that combat obesity broadly.

Additionally, this study looked at how familial dynamics and societal influences impact individual behavior adjustment and how it leads to social change that is beneficial. With the encouragement of healthy behaviors and family communication, this study improved the quality of life and the health of life of obese women. Furthermore, this research study impacts policy choices and public health campaigns that support programs that address the stigma associated with obesity, it establishes surroundings that encourage healthy living, and improve wholesome food availability. This study deals with both systematic and individual determinants of health to effectively tackle obesity.

Summary

Throughout this chapter, the fundamental components of the research investigation were centered on understanding the psychosocial determinants that impact obesity among women residing in Mississippi. The initial step involved the development of a conceptual framework that outlined fundamental ideas, including psychosocial variables, psychological factors, personal factors, societal factors, and policy factors. By conducting a comprehensive analysis of the available scholarly works, the intricate dynamics were elucidated among these variables and their joint impact on the onset and maintenance of obesity. The nature and scope of the study were elaborated upon by providing specifics regarding the research design, methodology, and population being

examined. The justification for employing purposive sampling to select participants was based on its congruence with the qualitative nature of the research and its objective of encompassing a wide range of experiences associated with obesity. Exhaustive descriptions were provided of the data collection method, which included interviews. Emphasis was placed on fostering a supportive and nonjudgmental atmosphere that encouraged participants to openly share their experiences.

To promote terminology clarity and consistency throughout the study, definitions of important concepts and constructs were furnished. The researcher clarified the assumptions that formed the basis of the study, recognizing the conviction in specific elements that are not amenable to empirical verification but are considered essential for substantial investigation. Delimitations and scope were specified in order to establish the parameters of the research, encompassing the excluded and included populations, in addition to the theories and frameworks that were not examined. The study acknowledged certain limitations pertaining to its design, methodology, and biases. Efforts were made to rectify these constraints in order to augment the study's rigor and dependability. Emphasizing the prospective contributions of the study to the advancement of knowledge, practice, and policy in the domain of obesity research, its significance was emphasized. The study seeks to provide insights for interventions and policies that ameliorate obesity-related outcomes and foster positive social change by situating individual experiences in the larger framework of societal and environmental influences. In Chapter 2, there is a more thorough examination of the extant body of literature concerning obesity and psychosocial determinants. By synthesizing pertinent

studies, a comprehensive comprehension of the research terrain was attained and formulated well-founded research inquiries.

Chapter 2: Literature Review

Introduction

Globally, obesity is still a major public health concern that has a huge impact on people's physical and mental health as well as healthcare systems. Although there are many variables that lead to the onset and maintenance of obesity, the importance of psychosocial factors—such as social, psychological, and environmental influences—is becoming more widely acknowledged as crucial to comprehending the complexities of this complicated problem (Dabas et al., 2024). The lived experiences of obese women and their perspectives on the importance of psychosocial variables in the development of obesity are crucial to understand, especially in Mississippi, where obesity rates are among the highest in the nation.

Mississippi, sometimes called the "Magnolia State," has obesity rates that constantly above the national average. The magnolia is also the state flower and the state tree of Mississippi. The intricate interplay between historical legacies, rich traditions, and economic inequality in the state adds to the challenges associated with managing obesity prevalence. In 2021, women with obesity in Mississippi are approximately 43.1% (Centers for Disease Control and Prevention (CDC), 2021). Approximately 50% of African American adults in Mississippi were obese in 2022. Joint strain caused by obesity-related excess weight can contribute to the development of osteoarthritis. This statistic illustrates the adult obesity rates by race and ethnicity in Mississippi in 2022. In women, the prevalence of obesity and extreme obesity increased significantly (Annual Percentage Change, 2.5%; 95% Confidence Interval [CI], 1.9% to 3.2%) and 1.1% to

4.0%, respectively (Mendy et al., 2017). To address the underlying psychological factors of obesity and design customized therapies and support systems, it is imperative to comprehend the lived experiences of obese women in this setting (Halfacre et al., 2022).

Complex interactions exist between psychosocial variables and obesity, emphasizing the role that mental health, interpersonal relationships, cultural norms, and socioeconomic status play in influencing people's attitudes and behaviors regarding food, exercise, and body image (Qobadi & Payton, 2017). Nonetheless, the opinions and voices of obese women themselves have received little attention, especially in the unique setting of Mississippi.

Literature Search Strategy

To find literature relevant to this study, I searched the following databases: Science direct, PubMed Central, Google scholar, PMC free article search, PloS one, JSTOR.

Keywords used in this searches included: obesity, weight loss, women's health, psychosocial factors, emotional experiences, qualitative research, thematic analysis, weight management, health disparities, Mississippi, body image, social support, healthcare access, stigma, weight maintenance, cultural influences, personal narratives, and health behavior.

Theoretical Foundation

Social-Ecological Model

Urie Bronfenbrenner's ecological systems theory, which was first created in the 1970s, is the foundation of the SEM. In particular, the SEM became a paradigm for

comprehending health outcomes and behaviors within the framework of intricate environmental impacts. Public health, psychology, and sociology are just a few of the fields that have widely used and modified the SEM, even if its precise origins may not be able to be traced to a single source.

Major Theoretical Propositions and Research Based Analysis

According to the SEM, a variety of factors at different levels, from societal structures to individual traits, might affect health behaviors and results (Kilanowski, 2017). The following are the main theoretical propositions and hypotheses of the SEM: Multilevel Influence on Health Behavior: According to the SEM, a variety of factors acting at different levels of influence health behaviors and results. Among these levels are the following:

Individual (Intrapersonal) Level

Personal qualities including health-related knowledge, attitudes, beliefs, self-efficacy, and behaviors comprise the Individual (Intrapersonal) level of the SEM. Critical determinants of health-related behavior are fundamental personal attributes such as motivation, self-esteem, and health literacy (Kilanowski, 2017). An example of a factor that substantially impacts an individual's health outcomes is their level of confidence and understanding regarding health practices. This is consistent with the intrapersonal level of the SEM, which emphasizes the influence of distinct personal characteristics and experiences on health-related behaviors. To effectively promote healthy behaviors, these studies emphasize the significance of individualized interventions that take into account disparities.

Interpersonal Level

Social interactions and connections with peers, family, and friends are included in this level. Peer pressure, social norms, and social support are important variables affecting health-related behaviors. Having relatives or friends who are encouraging, for instance, might motivate people to develop healthy habits (Patel et al., 2016). The study investigates how program members' health practices are shaped by family dynamics and peer support. That's in line with the SEM's interpersonal level, which takes connections and social networks into account when analyzing health outcomes (Korom et al., 2023).

Community Level

People live, work, and socialize in communities, which offer the necessary physical and social surroundings. A community's health habits are influenced by a number of factors, including social cohesiveness, community norms, healthcare access, and the availability of resources (such as parks and recreational centers). Interventions at the community level could center on fostering conditions that encourage the promotion of health (Kilanowski, 2017).

Societal Level

Social, economic, and political systems that influence health-related behavior and results are collectively referred to as societal influences. These consist of structural disparities, legislation, socioeconomic position, and cultural norms. Social variables affect how opportunities, resources, and power relationships affect health-related behaviors and results (Patel et al., 2016). Through the use of the SEM, this study will obtain a thorough grasp of the many levels of variables that influence the health and

wellness results of obese women in Mississippi. This framework facilitates a comprehensive examination of the interplay of personal conduct, interpersonal relationships, local assets, and wider cultural factors. Furthermore, by focusing on various spheres of influence, it offers a theoretical framework for developing treatments and policies that address health inequities within the Latinx community.

Similar research methods have been used using the SEM as described in Lusmägi and Aavik's (2021) work "Developing a Social-Ecological Model for Promoting Physical Activity Among Older Adults Based on the Experiences of 50+ Adults". Using the SEM framework as a guiding theoretical lens, the authors of this study examine the meanings associated with physical activity (PA) and involvement in PA among older individuals in Estonia. The SEM highlights the dynamic relationships and connections among various impact levels. A change at one level can affect individual behaviors and health outcomes by cascading over other levels. For instance, adding bike lanes or altering community-level rules might encourage physical exercise and have an impact on people's behavior (Kilanowski, 2017). According to the model, treatments that focus on several spheres of influence have a greater impact on health outcomes than those that just address individual-level variables. Interventions can provide synergistic effects and promote long-lasting behavior change by targeting numerous variables at once. A thorough obesity prevention program, for example, can incorporate community-level activities like encouraging healthy food alternatives and improving neighborhood walkability with education at the individual level.

Multi-Level Approach

Individual, interpersonal, institutional, community, and public policy elements are only a few of the layers of impact that the SEM highlights on health behavior. Likewise, the investigation explores diverse degrees of impact on physical activity in senior citizens, recognizing the interdependence of these elements in molding conduct (Register-Mihalik et al., 2017). By taking into account both individual and an environmental factor, the SEM enables an interdisciplinary view of health behavior. Similarly, the research combines knowledge from public health, psychology, and sociology to investigate the intricate processes pertaining to older individuals' participation in PA (Zubala et al., 2017). Although environmental elements were not specifically included in initial SEM formulations, later modifications have acknowledged the significance of environmental context in influencing behavior. In a similar vein, the Estonian study recognizes that older persons' PA behaviors are influenced by their physical and social surroundings (Lusmägi & Aavik, 2021). The SEM offers a framework for creating interventions that attempt to create settings that are supportive of changes in health-related behavior at various levels of influence. In a similar vein, the study makes suggestions based on knowledge gleaned from the SEM framework for encouraging PA among older individuals in Estonia (Zubala et al., 2017).

The SEM offers a thorough framework for comprehending the intricate interactions between personal, social, community, and societal factors that lead to the emergence and maintenance of obesity in Mississippian women, especially in those from a variety of ethnic backgrounds. Researchers and policymakers may acquire a

comprehensive understanding of how health outcomes are shaped by examining the larger socio-environmental factors that go beyond individual actions by implementing the SEM framework. SEM allows for a detailed analysis of psychological elements that affect obesity on an individual basis, including self-worth, body image, and personal habits (Patel et al., 2016). Mississippi's obese women may struggle with low self-esteem and unfavorable body image views that are made worse by social pressures and cultural conventions. SEM makes it possible to comprehend how these internalized attitudes and beliefs affect food decisions, levels of physical activity, and weight control techniques on a deeper level (Kilanowski, 2017).

SEM emphasizes how crucial social networks and interpersonal connections are in influencing health outcomes and behaviors. Family dynamics, social support networks, and contacts with healthcare professionals are important factors in the context of obesity among women in Mississippi. Through examining the ways in which friends, family, and medical professionals impact attitudes on food, activity, and body image, structural equation modeling offers valuable insights into the social determinants of obesity and possible paths for intervention (Roux et al., 2016). SEM assesses the resources, opportunities, and obstacles that exist in Mississippi communities and have an influence on the prevalence of obesity among women. This includes having access to good dietary selections, chances for physical activity, and healthcare services. SEM examines structural determinants of obesity, which disproportionately affect marginalized communities, by looking at community-level variables such as food deserts, a lack of recreational facilities, and socioeconomic inequality (Kim et al., 2023). SEM analyzes a

wider range of society variables, such as socioeconomic disparities, public health regulations, and cultural norms. SEM provides insights into how structural variables sustain differences in obesity rates among women in Mississippi, a state where historical legacies and cultural traditions coexist with modern issues. SEM provides insight into policy measures that attempt to promote health equality and lower the incidence of obesity by addressing systemic concerns including poverty, discrimination, and poor access to healthcare.

Rationale for Using SEM

Due to its applicability to the goals and research issues of the study, the SEM was chosen to examine obesity among Mississippian women. There are many variables that affect obesity at varying degrees, making it a complicated public health issue. When analyzing how social, environmental, political, and human variables interact to influence health outcomes and behaviors, the SEM provides a thorough framework. Since obesity and its factors are complex, this all-encompassing approach offers a solid basis for a thorough analysis of the problem (Roux et al., 2016). A variety of personal, societal, and environmental variables, as well as individual behaviors and genetics, contribute to obesity inequalities. By using the SEM, researchers may investigate how these factors are related to one another and how their combined effects affect the prevalence of obesity. Finding the underlying reasons of Mississippi's obesity inequalities among women may be accomplished through this study by taking into account the interactions between individual traits, social networks, community resources, and policy contexts (Kilanowski, 2017).

Women are disproportionately affected by Mississippi's high obesity incidence, which is among the highest in the country. To effectively create interventions and policies, it is imperative to comprehend the social and environmental causes of obesity in this group. Examining the ways in which structural elements, like access to healthful foods, socioeconomic status, and built environments, contribute to obesity inequalities is made easier with the help of the SEM (Roux et al., 2016). The SEM highlights how environmental and policy changes might influence health outcomes and behaviors. The study can facilitate the development of evidence-based policy recommendations that are customized to the requirements of Mississippian women by identifying policy levers that impact obesity, such as rules pertaining to healthcare, urban planning, and food access. This supports the goal of the study, which is to identify systemic factors contributing to obesity and offering workable strategies for treatment.

Conceptual Framework

Personal factors are distinct individual characteristics that have the potential to impact the risk of developing obesity (Wiss et al., 2020). These include demographic factors, including but not limited to age, gender, ethnicity, heredity, and biological predispositions. Personal factors are significantly influenced by lifestyle factors, including but not limited to dietary patterns, levels of physical activity, sleep hygiene, and stress management.

Social factors comprise the interpersonal and societal influences that contribute to obesity. This classification encompasses elements pertaining to socioeconomic status, cultural practices, social norms, peer influences, and family dynamics. Social variables

investigate the influence of societal structures and relationships on the weight status and health behaviors of an individual (Rinaldo et al., 2022).

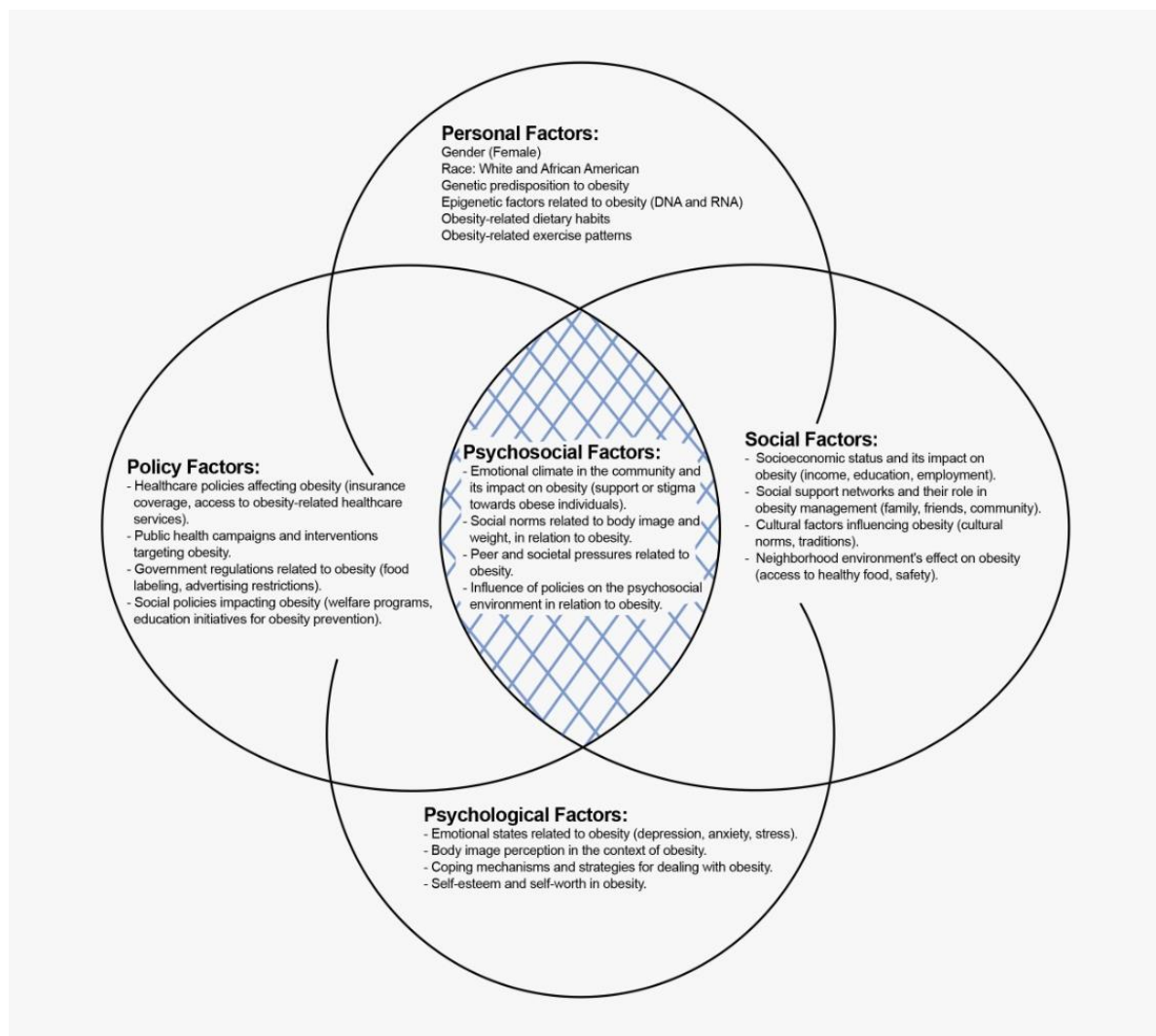
Psychosocial factors encompass the psychological and emotional determinants that exert an impact on obesity. Mental health conditions such as anxiety, melancholy, tension, and body image dissatisfaction fall under this category (Godoy-Izquierdo et al., 2021). Additionally, coping mechanisms, self-esteem, emotional eating patterns, and cognitive-behavioral factors that influence weight management and eating behaviors are taken into account (Poulsen et al., 2019). Societal factors pertain to the tangible, constructed, and societal surroundings that influence the health-related decisions and behaviors of individuals. Access to healthful foods, availability of recreational facilities, neighborhood safety, transportation options, urban design, food marketing practices, and food policies are all included in this category. This also evaluate the extent to which one's circumstances impact dietary habits, levels of physical activity, and overall health results (Wiss et al., 2020).

In psychological factors, studies have demonstrated that depression results in weight gain. Serotonin secretion in the brain appears to influence appetite and mood. It is suggested that depression indirectly contributes to obesity by means of actions such as reduced physical activity and emotional eating behaviors. The reduction of excessive carbohydrate intake in response to the necessity to enhance mood has been achieved through pharmacologic interventions that enhance serotonin neurotransmission. The likelihood of adult women gaining weight increases as a result of shorter sleep duration (Jang et al., 2020).

Policy factors consist of the regulations, guidelines, and interventions implemented by governmental and organizational entities with the objective of tackling obesity on a population-wide scale. This category comprises educational programs, public health policies, food and nutrition policies, urban planning policies, healthcare policies, and workplace wellness initiatives. Policy variables investigate the effects of legislative and regulatory measures on strategies for the prevention, treatment, and management of obesity (Taghizadeh & Farhangi, 2020). By examining various determinants of obesity through the lens of each category, a comprehensive strategy can be devised to devise efficacious interventions and policies aimed at mitigating this public health concern.

Figure 2

The Conceptual Framework



Literature Review Related to Key Variables and Concepts

Psychosocial Factors

Research indicates that chronic stress—that is, stress that lasts for more than a month—can cause depression in people who are vulnerable, despite the fact that the link between psychosocial stress and depression is complicated and may even be bidirectional

(Khan & Khan, 2017). Long-term stress exposure raises cortisol levels and lowers serotonin and dopamine levels, which have been connected to depression (Isasi et al., 2015). Although this physiologically appropriate stress reaction is not uncommon, prolonged exposure to this condition might cause depression in certain individuals. In fact, a wealth of research suggests that depression may be brought on by ongoing stress (Sims et al., 2016). Moreover, it is possible to speculate that stress not only directly causes obesity through physiological mechanisms like elevated cortisol, but also indirectly through depression, which has also been positively linked to obesity, particularly in women (Jantaratnotai et al., 2017). From a behavioral standpoint, eating habits may be the mechanism by which stress influences weight change. Food consumption may have a role in the relationship between stress and obesity. According to studies, people may turn to comfort or binge eating as a coping mechanism for psychosocial stress in an effort to feel better about themselves (Flegal et al., 2016). Stress raises hunger (Flegal et al., 2016) and is linked to preferences for meals that are easier to eat—higher fat, energy dense, sweet, and salty snacks—as well as for more appealing foods (Molina et al., 2021). All of these factors add up to an excess of calories.

Psychosocial Stress and Obesity

Psychosocial stress, which includes a range of elements including anxiety, depression, and traumatic experiences, has a significant impact on obesity by altering eating patterns and raising the risk of developing disordered eating behaviors (Ouakinin et al., 2018). This complex link highlights the complex interactions that exist between physical and mental health. Changes brought on by stress might cause people to adopt

unhealthy coping mechanisms; including overindulging in meals high in fat and sugar, which eventually causes weight gain (Grami, 2017). While eating these comfort foods might temporarily reduce stress, it can also set off an unhealthy cycle of emotional eating that result in weight gain (Cohen et al., 2018).

Furthermore, stressful events in infancy and adulthood can have a significant negative effect on the body's stress response system by disrupting hormonal pathways that control metabolism and hunger (Wiss & Brewerton, 2020). Traumatized individuals may turn to disordered eating patterns, such binge eating, as a coping strategy for their intense feelings of discomfort. Understanding the critical role that psychological stress plays in obesity is essential to creating successful therapies that target the root causes of weight-related problems. Adopting healthy behaviors and lowering the risk of obesity can be achieved by programs that address stresses and offer adequate support and coping skills.

Psychological Factors

In 2021, 42.7% of adults in Mississippi reported symptoms of anxiety or depression, and 21.1% were unable to get needed counseling or therapy (Centers for Disease Control and Prevention (CDC), 2022). One source for these two conditions is obesity. According to Luck-Sikorski et al. (2018), obesity and depression both have significant somatic and psychological symptoms, and share epidemiological, clinical and biological pathways in a bidirectional manner (Milaneschi et al., 2019). In prospective studies, depression has been shown to increase the risk of obesity, and obesity has been shown to increase the risk of depression (Wurtman & Wurtman, 2018). The emergence of

depression and obesity are frequently associated with childhood trauma, poor health habits, metabolic disturbances (e.g., low-grade inflammation, HPA axis dysfunction, neuroendocrine disorders, brain disorders, gut-brain microbiota axis troubles; Amare et al., 2017), and common psychological origins (e.g., early trauma, deprived environment, or inadequate coping strategies; Ambrósio et al., 2018). Furthermore, there are several good reasons for the medical community to concentrate on these two debilitating conditions due to the long-term physical, psychological, and social effects of obesity and depression, including cardiometabolic disorders, comorbid psychiatric disorders, poor social outcomes, and significant stigma (Jantaratnotai et al., 2017).

Bidirectional Relationship between Depression and Obesity

Obesity and depression rates showed a strong positive link that suggested a regional overlap (Łojko & Rybakowski, 2017). According to the statement, there is a significant positive link between the prevalence rates of depression and obesity in Mississippi. This association implies that there is a proportional rise in the incidence of depression along with the prevalence of obesity, and vice versa. This suggests a spatial overlap, whereby regions with high obesity rates also typically have high depression rates. This regional overlap highlights the relationship between depression and obesity and raises the possibility that these two illnesses have similar underlying causes or impacts in Mississippi. There might be a number of reasons for the observed link, including socioeconomic position, healthcare access, cultural norms, environmental stresses, and lifestyle choices. For instance, because of the pressures connected to both

disorders, areas with financial difficulties or limited access to healthful dietary alternatives may have greater incidences of obesity and depression.

There is a complex and multifaceted association between obesity and depression that is impacted by a number of factors. Studies have demonstrated a mutual relationship between the two disorders, indicating that elevated BMI is associated with elevated depressive severity and vice versa (O'Brien et al., 2017). This suggests that people with higher BMIs could be more likely to experience depression, and that those who are depressed might be more likely to become obese. Emotional eating, or overindulging in food as a reaction to unpleasant feelings like stress, worry, or despair, is one element that contributes to this association (Michopoulos et al., 2015). Emotional eating has the potential to exacerbate depression symptoms by increasing calorie consumption and weight gain, which in turn exacerbates obesity. The relationship between depression and obesity is further influenced by increasing weight stigma and societal prejudice against overweight people (Michopoulos et al., 2015). Social isolation, psychological anguish, and low self-esteem are all risk factors for depression, and they can all be exacerbated by the stigma attached to obesity.

Furthermore, the association between obesity and depression may be mediated by a number of demographic variables, including sex and level of education. There are subtle differences depending on socioeconomic level, even though a favorable association between the two diseases is typically seen. For example, studies in poor socioeconomic groups have shown a negative link between depression and BMI, indicating that the relationship may differ based on individual circumstances (Choi,

2019). In order to successfully manage both obesity and depression, public health initiatives must take into account the geographical overlap between the two illnesses. By identifying areas where depression and obesity co-occur, policymakers, medical professionals, and community stakeholders may more effectively target treatments and resources.

Interventions may be customized to fit the unique requirements of communities experiencing this regional overlap by addressing common risk factors and supporting holistic approaches to health and well-being. This will eventually improve the overall health outcomes and quality of life for impacted persons. In order to address the complicated association between obesity and depression, the study emphasizes the necessity for customized health interventions in underprivileged communities (Chauvet-Gelinier et al., 2019).

Evidence from prospective research supports the connection between depression and obesity, represented by bidirectional arrows suggesting their mutual link. Common biological problems like low-grade inflammation and neuroendocrine disorders, together with unhealthy behaviors and common psychological causes like early trauma and insufficient coping mechanisms, surround the essential components. Obesity and depression both develop and worsen as a result of these common pathways and contributing variables. This conceptual framework highlights the need of taking into account both physical and psychological variables in understanding and treating these two common medical diseases by providing a visual representation of the intricate interactions between obesity and depression.

Emotional Eating and Obesity

The complex phenomenon known as "emotional eating" refers to the act of eating in reaction to unpleasant feelings like stress, worry, or despair. This unhealthy coping strategy can have serious effects on managing weight and general health. It frequently results from persistent emotional pain; many studies have shown that emotional eating and weight problems such as obesity and overweight are strongly correlated (e.g., Frayn et al., 2018). Emotional eating is typically activated by stress and hormones, namely cortisol, which controls hunger especially for tasty and high-calorie meals (Michopoulos et al., 2015).

For more than a century, emotions and feelings have been the focus of extensive study in a variety of fields, and there are several ideas and disagreements regarding the nature and purposes of emotions and feelings (Weatherell, 2014). However, there is consensus on a few points: Emotion is a psychophysical reaction to a stimulus. Emotions are significant because they influence our thoughts and actions, and they are now widely acknowledged as significant data in qualitative studies of people and societies in a variety of disciplines, including neuroscience, education, health science, and economics. It might be difficult to gauge someone's emotional state or how a community "feels" about a particular scenario or idea, though. Emotions flow and alter in intricate, multi-layered patterns that are essentially constant (Schwab & Margaritis, 2020).

Furthermore, psychological issues like boredom or melancholy may motivate emotional eating. People may eat to console themselves or divert their attention from upsetting feelings. Nevertheless, this coping mechanism may culminate in a vicious cycle

of emotional eating, wherein eating reduces unpleasant emotions momentarily but eventually brings on feelings of shame, guilt, or further emotional pain (Michopoulos et al., 2015). Recurrent episodes of emotional eating have the potential to cause weight gain and excessive calorie consumption over time. This is especially concerning in the context of today's obesogenic surroundings, when attractive, high-calorie meals are widely accessible and aggressively promoted. The development and maintenance of obesity may be facilitated by the cumulative impact of emotional eating on energy balance (Cohen et al., 2018).

Anxiety and Obesity

There are many different ways to view the complex association between anxiety and obesity in the scientific literature. While some research indicates that there is a positive relationship (Amiri & Behnezhad, 2019) between BMI and anxiety, other research suggests a more complex relationship with non-linear patterns, such as U-shaped or inverted U-shaped connections (DeJesus et al., 2016). The link between anxiety and BMI may not be linear, as suggested by the idea of a U-shaped or inverted U-shaped relationship. Rather, it implies that a healthy BMI may be linked to ideal anxiety levels, and that variations from these optimal levels may result in changes in one's weight status. For instance, persons who experience extremely high or very low anxiety levels may be more likely to become obese than others who experience intermediate anxiety levels (Haghighi et al., 2016).

According to DeJesus et al. (2016) and Haghighi et al. (2016), the association between anxiety and obesity is further complicated by confounding variables such age,

ethnicity, and socioeconomic position. The relationship between anxiety and BMI can be influenced by variations in certain demographic characteristics, which can cause disparities in research results among various population groups.

Personal Factors

Eating Habits

The eating habits and weight control techniques of obese women in Mississippi are greatly influenced by individual level factors, such as personal beliefs about food, body image, and self-esteem. This is especially true for women from diverse ethnic backgrounds, including African American, Hispanic, American Indian, and White women. Personal food beliefs include attitudes, tastes, and perceptions about the nutritional content, flavor, and function of food in one's life. These ideas may be influenced by cultural customs, financial standing, and prior eating experiences for obese women. Obese women in Mississippi may believe that cultural authenticity and flavor are more important than nutritional value since the state's traditional Southern food frequently consists of calorie-dense dishes that are heavy in fat, sugar, and salt. Furthermore, the dearth of reasonably priced healthy food alternatives in many low-income regions may serve to further perpetuate the notion that bad eating habits are inescapable or inevitable (Kim et al., 2023). Personal convictions regarding food as a comfort or a reward system might support unhealthful eating patterns, which can result in weight gain and make it harder to maintain a healthy weight. Furthermore, meal habits and portion sizes may be influenced by cultural norms surrounding food, which can lead to overeating and health problems connected to weight (Mendy & Vargas, 2015).

Genetic Inheritance

According to Łojko and Rybakowski (2017), certain genotypes appear to be associated with atypical symptoms of depression and an elevated susceptibility to obesity and overweight. This indicates that, in order to prevent prevalence of obesity condition, additional focus should be placed on the correlation between obesity and depression. The presence of clinical and biological connections suggests that, at least for substantial clinical subgroups, the two diseases might benefit from a combined approach to early detection and therapeutic synergies. Nevertheless, a significant proportion of public health endeavors fail to establish uniform protocols or initiate autonomous campaigns in an effort to address the issues of obesity and mood disorders (Milaneschi et al., 2017).

Body Image and Self-Esteem

The term "body image" describes how someone feels, thinks, and perceives their own body, including its form, size, and appearance. Mississippi's obese women's perceptions of their bodies can be greatly impacted by social pressures, cultural standards of beauty, and individual experiences of weight stigma. Obese women may internalize negative views about their bodies in a society that frequently idealizes thinness and associates beauty with a specific body size, which can result in low self-esteem and body dissatisfaction (Mendy & Vargas, 2015). Furthermore, views of the ideal physical size may vary depending on the cultural norms among ethnic groupings. African American and Hispanic cultures, for instance, can value other characteristics like curves and fullness more than thinness. Even Nevertheless, there could still be pressure in these

societies to adhere to particular body ideals—even if they deviate from popular culture (Kim et al., 2023).

An individual's eating habits and weight management techniques can be significantly impacted by body image issues. In an attempt to achieve an idealized body form, obese women who have a poor body image may resort to improper weight management methods, restricted diets, or excessive exercise. On the other hand, emotional eating and a lack of drive to make good living choices might result from body dissatisfaction. Self-esteem is the total assessment of one's own ability and value. Many variables, such as body image, social interactions, and perceived societal judgments regarding weight, might impact the self-esteem of obese women. Studies reveal that compared to their non-obese peers, obese people—especially women—may have worse self-esteem because of internalized stigma and discrimination based on weight (Mendy & Vargas, 2015).

Poor self-esteem might make it difficult to follow weight-management plans and adopt healthy lifestyle habits. Women who are obese and have low self-esteem may believe that they are not deserving of self-care or that they are unable to reach their health objectives (Connell et al., 2019). Furthermore, it might be difficult to maintain long-term improvements in eating patterns and physical activity levels when negative self-talk and self-criticism undermine resilience and drive.

Social Factors

The Role of Culture

The lived experiences of obese women in Mississippi are greatly influenced by inter relationship issues, especially when it comes to women from varied ethnic backgrounds such as African American, Hispanic, American Indian, and White women. The aforementioned aspects, which greatly impact food practices, levels of physical activity, and attitudes toward weight control, include family dynamics, social support networks, and cultural norms surrounding body image (Connell et al., 2019). The family dynamics seen in Mississippi's different ethnic populations can have a big influence on the attitudes and behaviors of obese women when it comes to their health. Food is associated with more than just nourishment in many cultures; it is frequently a part of festivities, family customs, and acts of affection. In this situation, moms and grandparents in particular are frequently the main figures influencing eating choices. Obese women may find it difficult to establish better eating habits in homes where traditional, calorie-dense Southern cuisine is the norm because of cultural norms and familial expectations surrounding food (Milaneschi et al., 2017).

Relationships within Family

Family relationships can also affect how active a person is physically. Obese women may be discouraged from exercising regularly if they have limited access to safe outdoor areas or recreational facilities, particularly if their families are lower income. Moreover, caregiving obligations, which are frequently borne disproportionately by women in minority groups, might further obstruct chances for exercise and self-care

(Walsh et al., 2019). Friends, family, and community groups are examples of social support networks that are important in influencing the health and well-being of obese women. Adopting healthy living behaviors can benefit from the accountability, encouragement, and hands-on help that positive social support can offer. However, different ethnic groups and socioeconomic backgrounds may have different social support systems and their availability. Social support networks may be a great source of both practical and emotional support in close-knit communities like the African American and Hispanic neighborhoods in Mississippi, but they can also reinforce cultural norms related to food and body image. For instance, social events centered around food may be frequent, which makes it difficult for obese women to follow diet plans or resist peer pressure to overindulge (Qobadi & Payton, 2017).

Ethnic differences in cultural norms and values about body image can have a substantial impact on how obese women perceive and behave. For example, there could be a cultural desire for fuller figures among African American and Hispanic populations, which helps lessen the stigma attached to obesity. However, there may be less social pressure to adopt healthy living behaviors and less perception of the need for weight management therapies as a result of this cultural acceptance of bigger body proportions. Conversely, obese women may experience more social stigma and internalized guilt about their weight in mainstream American culture, which frequently idealizes thinness. In an attempt to meet unattainable beauty standards, this might result in disordered eating practices, such as binge eating or restrictive dieting (Walsh et al., 2019). Furthermore, obese women may experience worsening body image issues as a result of conventional

gender norms that place a strong emphasis on femininity and beauty. This is especially true for minority-affiliated women who may experience overlapping kinds of discrimination based on weight, race, and gender.

According to Fryar et al. (2021), the National Health and Nutrition Survey (NHANES) 2017–2018 estimated the prevalence of overweight (BMI: 25.0–29.9 kg/m²), obesity (BMI: 30.0 kg/m²), and severe obesity (BMI: 40.0 kg/m²) among adults in the United States to be 31%, 42%, and 9%, respectively. A disproportionate number of African Americans are obese. The complete understanding of the factors contributing to this gender disparity in weight gain remains elusive; however, it could be attributed to the wider range of life stages through which women are more likely than men to experience weight gain (e.g., during pregnancy, menarche, and menopause), in conjunction with cultural norms regarding the ideal body size (Kronenfeld et al., 2017). African American women report less acceptance of larger body sizes and internalized weight stigma than white women (Himmelstein et al., 2017; Kronenfeld et al., 2017). Furthermore, research suggests that among African Americans, the correlation between structural racism and elevated body mass index (BMI) is more pronounced among women than men (Dougherty et al., 2020). Although additional research is required, it is noteworthy to mention that the increased prevalence of obesity among African American women is not a recent development. An investigation examining the fluctuations in body mass index (BMI) readings from 1959 to 2006, stratified by sex and race, among adults born in the United States between 1882 and 1986, revealed that rises in BMI were already evident

among the birth cohorts of the early 20th century. African American women experienced the most rapid rate of increase (Lofton et al., 2023).

One plausible explanation for the existing discrepancy in obesity rates among self-identified races is that race merely serves as an indicator of social class; groups with higher income or educational achievement generally have a lower prevalence of obesity (Wong et al., 2014). Conversely, there are racial disparities in the incidence of obesity among women who belong to higher-income and/or education-level groups, indicating that race may not be directly correlated with weight status. At all levels of educational achievement, African American women have a higher BMI than their White counterparts; the discrepancy is most pronounced among those who have completed higher education than high school (Ogden et al., 2017). Regarding African Americans, the correlation between adiposity and income differs by gender. The prevalence of obesity among African American women is not influenced by socioeconomic status (Ogden et al., 2017).

Complications such as cardiovascular disease, Type 2 diabetes, and nonalcoholic fatty liver disease are more prevalent in individuals who are obese (Garvey et al., 2016). African Americans exhibit a higher incidence of various complications, such as hypertension, diabetes, and stroke, in comparison to the White population. Nevertheless, dyslipidemia and myocardial infarction are less prevalent among African Americans in comparison to the White population (Lofton et al., 2023). Weight reduction ranging from 5% to 15% has been shown to be associated with a substantial decrease in the risk of developing numerous conditions linked to obesity (Garvey et al., 2016).

Socioeconomic Factors and Obesity

The incidence of obesity and its effects on health are significantly influenced by socioeconomic variables, including marital status and level of education. Studies have repeatedly demonstrated that obesity is more common in those with lower levels of education than in people with greater levels of education (Wagner et al., 2018). Numerous factors, such as disparities in healthcare access, awareness of nutrition and good living practices, and socioeconomic possibilities, can be ascribed to this correlation. A plausible rationale for the association between obesity and lower educational achievement might be the unequal distribution of resources and chances for healthy habit adoption. Higher educated people frequently have easier access to knowledge on exercise, diet, and preventative healthcare practices, which can empower them to make better decisions and maintain a healthy weight (Cohen et al., 2018). Conversely, those with lower levels of education could encounter obstacles such restricted availability of wholesome, fresh food, less possibilities for physical activity, and more exposure to bad eating surroundings, all of which might raise the risk of obesity.

The incidence of obesity is also influenced by marital status, with married people frequently having greater rates of obesity than single people (Wagner et al., 2018). Numerous elements pertaining to the social and environmental settings of marriage may have an impact on this connection. Married couples, for instance, could share food habits and sedentary lifestyles, which over time could result in weight increase. Furthermore, stress related to marriage, routine adjustments, and caregiving duties within a marriage might affect a person's capacity to give priority to healthy lifestyle choices.

Policy Factors

As a result of globalization, which encompasses the advancement of economies and technologies, there has been an increase in the availability and affordability of food, significant changes in the way people live, and enhanced health conditions in numerous nations. Nevertheless, these modifications have also contributed to adverse outcomes, such as the proliferation of sedentary behaviors and unhealthy dietary habits, as well as the escalating worldwide pandemic of obesity and other non-communicable chronic diseases associated with lifestyle choices (Zhang et al., 2014).

Government Policies

Obesity arises from a positive energy balance, which is maintained when the amount of energy consumed (via food) surpasses the amount of energy expended (via physical activity and inactivity). There is ongoing debate regarding whether it would be simpler and more effective to assist individuals in reducing their energy intake rather than increasing their energy expenditure, as suggested by some research. In addition to international factors, such as global trade policies, numerous personal (e.g., food preference), familial (e.g., family income), and social (e.g., food availability and prices) determinants influence the food consumption of individuals. Diverse countries have implemented a variety of food policy alternatives that aim to encourage the adoption of healthful diets (Zhang et al., 2014). The NOURISHING framework offers a practical method for implementing food policies that encourage healthful diets. In order to promote healthier eating habits and mitigate the occurrence of obesity, pertinent food policies would seek to modify the accessibility, cost-effectiveness, and social acceptance

of nutritious (unhealthy) food options across multiple environments, including households, schools, workplaces, and communities.

Multiple factors influence the formulation and execution of food policies by national and regional governments. These factors encompass cultural norms, traditional practices, political structures, and the backing of diverse societal stakeholders. In order to effectively modify behavior, synergistic interactions and the interoperability of policies originating from diverse constituent systems are indispensable. An ideal policy framework should be implemented at every level, creating a cohesive system that focuses on individual conduct. The food milieu that individuals encounter on a daily basis should be modified in order to alter the context in which undesirable dietary patterns manifest. In order to establish a healthful food environment, endeavors to modify the food environment must confront the food system, which necessitates a comprehensive revision and reengineering. Ongoing education and training are essential for maintaining the intended modification in behavior. These programs should equip individuals with the knowledge and abilities required to effectively adjust to the new surroundings. In order to attain synergy among these various factors and policies, it is imperative that enforcement mechanisms be established and that local and national governments exercise administrative supervision (Tseng et al., 2018).

High-leverage Policies

The purpose of high-leverage policies is to alter underlying structures and establish an environment in which individuals are less likely to develop or sustain

undesirable behaviors. By restricting fast food options in school cafeterias, for instance, children may no longer have access to toxic food. Conversely, by implementing school policies that emphasize nutrition education, students can acquire a greater understanding of how to effectively manage their energy expenditure and consumption in a constantly changing food environment. In actuality, this dual approach strengthens children's resistance to adverse consumption environments as adults. However, the majority of policies fail to capitalize on the potential of more systemic policy adoptions, which could bring about more substantial changes in hazardous food environments, by focusing on a single aspect of the food environment.

Commercial Policies

Food environment is shaped by business activities and commercial policies. Product placement, dietary choices prices, methods of marketing, and behaviors are essential as they influence the food industry. Financial gain is one of the primary emphases of food industry, which frequently leads to the endorsement of processed, energy-dense food that often results to detrimental dietary habits, especially in susceptible demographics like youth and adults (Loh et al., 2023). Research has shown that the promotion of food and drink via advertisements has a significant impact on children's understanding of nutrition, their preferences, their purchase habits, and their consumption patterns (Meiksin et al., 2022). Specifically, Obesity and bad eating habits can be attributed to television advertising tends to mostly promote goods that are less healthful. These commercial activities may worsen diet and health disparities, since individuals from disadvantaged families are more likely to be exposed to adverts pushing

for high-calorie, low-nutrient foods, beverages high-fat, salt, and sugar (HFSS) products. These advertisements are delivered via various outdoor, recreational, and digital platforms (Backholer et al., 2020).

Food marketing refers to any kind of commercial promotion aimed at enhancing the awareness, attractiveness, and consumption of certain food items, brands, and services. In this context, food advertising plays a crucial role in connecting the production of food goods with the generation of demand for these products. Currently, food advertising mostly focuses on promoting highly processed food and beverage items that include high levels of lipids (namely saturated and trans fats), free sugars, and salt, which are known to be linked with a low-quality diet (Dixon et al., 2015). There is enough data indicating that this kind of advertising not only influences customers' tastes and buying habits but also leads to an increase in the consumption of promoted items.

Nevertheless, the promotion of low-nutrition, energy-dense foods and beverages is a prominent aspect of the present food landscape. Given the current food environment that promotes obesity, it is crucial to transition towards a "healthygenic" food environment. This involves implementing strategies throughout the food system that increase the availability, accessibility, and affordability of foods and food groups that provide necessary nutrients, prevent chronic diseases, and promote overall health (Folkvord & Hermans, 2020). To tackle these issues, it is crucial to enact policies through legislation that is targeted at equitable advertising practices to end the promotion of

unhealthy food, especially to susceptible populations. These may result to the reduction of the adverse effects of these adverts.

Nutrition Education

In order to promote healthy diets, including those intended to prevent obesity, and to facilitate positive health behavior changes, nutrition education is crucial. In the last twenty years, numerous nations have established dietary guidelines, with the United States taking the lead in this endeavor. Dietary guidelines of this nature serve to enhance public consciousness regarding nutritional requirements and promote nutrition instruction across various contexts and levels. More than 60 developed and developing nations on each continent have established their own national dietary guidelines as of this moment (Zhang et al., 2014).

Nutrition Assistance

To prevent obesity, policies that increase availability to nutrient-dense, high-calorie foods and decrease intake of high-calorie, low-nutrient meals must be put into place. This might entail taking steps like boosting financing for nutrition assistance programs, offering incentives for the establishment of supermarkets and farmers' markets in underprivileged areas, and putting rules in place for food marketing and labeling to encourage the purchase of healthier options. Policies that encourage physical exercise and active commuting can aid in the fight against sedentary behavior and aid in weight control. This could entail funding the construction of secure and convenient recreational spaces, encouraging the use of active transportation options like infrastructure for

bicyclists and walkers, and incorporating physical activity into the workplace and educational settings through initiatives like required workplace wellness programs and physical education classes (Olstad et al., 2017).

Addressing Obesity Disparities

Addressing obesity disparities requires expanding access to healthcare services, including preventative care and obesity treatment. Increasing Medicaid eligibility, financing community health centers and obesity prevention initiatives, and guaranteeing coverage for evidence-based obesity treatments like bariatric surgery and nutrition counseling are a few examples of policy approaches. It is imperative to tackle the fundamental socioeconomic determinants of health, including housing, education, and poverty, in order to minimize the inequalities in obesity that affect women in Mississippi. In order to establish supportive settings for healthy living, policy interventions may include putting anti-poverty programs into action, expanding access to high-quality education and employment opportunities, and funding efforts to revitalize neighborhoods and provide affordable housing (Kraak et al., 2019).

Cultural Competency and Diversity in Healthcare

The specific needs and experiences of various ethnic groups impacted by obesity may be addressed with the support of policies that foster cultural competency and diversity in healthcare delivery. Increasing diversity in the healthcare workforce, putting in place training programs for healthcare practitioners on cultural sensitivity and implicit prejudice, and guaranteeing access to obesity prevention and treatment programs that are

culturally appropriate are some of the steps that may be included in this. Public health campaigns and educational programs can help women in Mississippi understand the value of a nutritious diet, regular exercise, and weight control. Funding for school-based nutrition education programs, community-based health promotion programs, and media campaigns that support body positivity and healthy habits are a few examples of policy interventions (Freudenberg et al., 2015).

Warning Labels

One potential disclosure remedy that could place the greatest burden on food marketers is the requirement for warning labels to be placed on specific food products, meals, and/or in their advertising. A potential warning of this nature could apprise consumers that a particular product is excessive in calories and/or fat, in accordance with standardized disclosure of nutrition information pertaining to obesity that is both conspicuous and simplified. An alternative warning would apprise consumers of particular health-related repercussions. Although marketing that targets heavy users is generally accepted, the legally mandated duty of reasonable care may require a warning about the health consequences of obesity if the products pose a high risk for heavy users or if they are especially likely to sacrifice future health for more immediate attributes (e.g., palatability, price; Shankar, 2017). In accordance with this line of reasoning, cautionary statements would be established according to trigger levels of fat and/or caloric. For the purpose of informing consumers that sedentary or petite adults ought to consume 2000 calories daily, a meal comprising 1500 calories could be suitably labeled as providing 75% of the daily calorie requirement for a considerable number of

consumers. The implementation of warnings may potentially incentivize food marketers to reformulate their products, as companies that have already announced modifications to their products to reduce or eliminate trans-fat prior to the January 2006 deadline for disclosure under the new FDA regulation (Crippa et al., 2023).

Financial Incentives and Food Policies

Financial incentive remedies encompass a range of measures such as taxes and tax incentives, among others, which aim to restrict the extent to which consumers compromise future health risks for immediate benefits. The objective is to mitigate current incentives to make less nutritious food choices by implementing financial incentives that promote healthy food selection. Two of the three primary categories of financial incentive remedies—limits on agricultural subsidies and taxation on high-fat/calorie foods—have a direct impact on food prices, while the other—incentives for employer programs—provide monetary compensation for weight management (Watson et al., 2021). The implementation of taxes on fast-food meals, soft beverages, snack foods, and other packaged foods with low nutritional value, commonly referred to as the "fat tax" or "Twinkie tax," could potentially incentivize consumers to select healthier options through the subsidization of relatively reduced prices (Baker et al., 2016). This tax could be calculated according to the fat or calorie content relative to the weight of the product. States can generate substantial revenues through even modest tax rates. These funds could then be allocated towards health promotion programs (Ecker et al., 2016). Taxing unhealthy foods and sugary drinks can lower consumption and raise funds for programs aimed at preventing obesity. Taxing sugar-sweetened beverages, junk food, and

other unhealthy goods is one way to implement policy interventions. The money raised would then be used toward initiatives that prevent obesity, nutrition education, and healthcare services.

Trade Policies

The domestic food environment can be substantially influenced by trade policies, such as tariff reductions and trade liberalization, which facilitate the importation of a wide range of food products. An increase in food imports may result from the relaxation of trade barriers, thereby enhancing the accessibility and affordability of cuisines within domestic markets. Conversely, research has indicated that trade liberalization is correlated with heightened intake of detrimental foods and carbonated beverages, both of which are potential contributors to the development of obesity (Baker et al., 2016). In addition, initiatives to reduce trade barriers might incentivize foreign direct investment in supermarket chains and food processing industries, which could result in the manufacturing and promotion of processed foods as well as the replacement of conventional diets with more affordable imported alternatives (Shankar, 2017).

Domestic Fiscal Policies

Domestic fiscal policies are of significant importance in shaping food systems and exerting influence over dietary behaviors. Examples of such policies include food subsidies and agricultural input subsidies. While the primary objective of consumer subsidy programs is to stabilize prices and guarantee food security, they may unintentionally encourage the consumption of foods that are low in nutrients but high in

energy. As an illustration, criticism has been directed towards food subsidy programs implemented due to the perceived promotion of subsidized food consumption over healthier alternatives (Ecker et al., 2016). In the same way that agricultural input subsidies may encourage the overproduction of particular crops, thereby potentially promoting the availability of inexpensive, high-calorie foods in local markets, they can distort food production systems (Abdalla & Al-Shawarby, 2018).

Impact on Economic Policies

These policies emphasize the intricate relationship between economic variables and public health consequences, underscoring the necessity for interventions grounded in empirical evidence to tackle the issue of obesity. The unintended effects of fiscal and trade policies on dietary behaviors should be taken into account in efforts to prevent obesity, and strategies that increase access to affordable, nutritious foods should take precedence (Abay et al., 2020). Policymakers have the ability to alleviate obesity and enhance population health outcomes by endorsing sustainable food production and consumption and promoting healthy food environments through the implementation of policies (Schram et al., 2015). The impact of trade policies and domestic fiscal policies on obesity prevention initiatives is significant, given their ability to mold the food environment and affect the consumption habits and dietary preferences of individuals. These regulations have implications for the accessibility, cost-effectiveness, and nutritional value of food items on a global and national scale.

Corporate Policies and Dietary Practices

The occurrence of obesity is substantially impacted by dietary practices that are molded by corporate policies within the food manufacturing and advertising industries. These policies frequently place financial gain above public health, leading to the production and promotion of calorie-dense, highly processed foods that contribute to the prevalence of obesity. For instance, food corporations may utilize assertive marketing strategies that concentrate on disadvantaged communities and children (e.g., low-income communities) via social media platforms, television advertisements, and product placement (Tseng et al., 2018). In addition, nutritional value may be subordinate to convenience and cost-effectiveness in corporate policies, which may result in the pervasive availability and consumption of toxic, low-cost foods. To tackle these corporate policies, it is imperative to implement regulatory measures, hold the industry accountable, and foster collaboration between policymakers and public health advocates in order to establish healthier food environments and decrease the prevalence of obesity (Headey & Alderman, 2019).

The Wellness Industry

The wellness industry and weight loss chains are significant players in shaping public opinion regarding body image, weight management techniques, and attitudes towards obesity through their corporate policies. These establishments frequently endorse fad diets and quick-fix remedies that place greater emphasis on expeditious weight reduction rather than enduring modifications to one's lifestyle (Abay et al., 2022). These policies sustain unattainable ideals of beauty, promote detrimental approaches to weight

loss, and cultivate detrimental dietary patterns among individuals who aspire to attain an idealized physique. Moreover, weight loss businesses may place a higher value on financial gain than on their clients' long-term health (Alderman et al., 2018). In order to tackle these concerns, it is critical to conduct comprehensive examinations of industry practices, educate consumers about weight management strategies supported by scientific evidence, and advocate for holistic health and body positivity. Through the critical examination of harmful corporate policies and the advocacy for ethical behavior within the weight loss industry, it is possible to encourage individuals to embrace health-conscious practices and attain enduring objectives related to weight management.

The Experience of Obesity and Weight Loss among Women

National Context of Obesity and Weight Loss

Obesity and weight loss experiences across the country are a reflection of larger trends and issues facing the US. With obesity rates approaching epidemic proportions, a large number of people in the nation struggle with the social, emotional, and physical effects of being overweight. The national obesity rate is mostly due to the ubiquity of sedentary lifestyles, poor eating practices, and environments that encourage weight gain. For many people trying to control their weight, the societal focus on convenient meals, sedentary entertainment, and unattainable beauty standards just makes the situation worse (Hosseini et al., 2021). The national landscape is typified by a multitude of approaches to weight management, ranging from commercial weight loss programs and fad diets to medical treatments and lifestyle adjustments. However, for those looking for long-term, scientifically supported answers, sorting through this complicated variety of possibilities

can be daunting. Furthermore, the stigma associated with obesity in society might make it difficult to get resources and help for managing one's weight.

Challenges in Sustaining Weight Loss

Recent research into the topic of substantial, sustainable weight-loss maintenance have consistently revealed that individuals who are overweight or obese encounter difficulties in maintaining their weight loss goals for a variety of reasons, including but not limited to daily stress, emotional eating, boredom (Reilly, 2015), and both planned and unplanned life events (Kwasnicka et al., 2019). Environmental factors that have been identified as potential deterrents include peer discouraging, an obesogenic dietary environment, and the inability to maintain motivation without external support (Ingels & Zizzi, 2018). Additionally, lack of support and comprehension from HCPs has been consistently cited as an obstacle (Mcgill et al., 2020).

Motivators for Weight Loss

Generally, enhanced health and self-image serve as motivators (Natvik et al., 2018). Research has also underscored the importance of mitigating the negative impact of weight stigma as an incentive for individuals to lose weight. Research on the maintenance of significant, sustainable weight loss has revealed that weight management support plays a crucial role in assisting patients in maintaining their weight loss (Natvik et al., 2019). The authors' systematic review and the current study both corroborate these results. It is worth noting that while the motivators seem to be comparable among participants, the differences in personal attributes underscore the significance of customized care in order

to facilitate successful treatment outcomes (Spreckley et al., 2021). Ongoing research that prioritizes the viewpoints and experiences of patients has the potential to improve the quality of treatment. Additionally, this viewpoint may reduce weight stigma among healthcare professionals who are involved in weight management (Hamdy et al., 2017).

Gender-Specific Challenges for Obese Women in Mississippi

Mississippi as one of the states where the obesity epidemic is most concentrated in the country, Mississippi has a particularly high rate of obesity and weight loss. Mississippians have particular difficulties since the state has the second-highest adult obesity prevalence in the United States. These difficulties include restricted chances for physical activity, a lack of healthy food alternatives, and deeply ingrained socioeconomic inequities (Dwyer-Lindgren et al., 2017). Mississippi has a high obesity rate, which emphasizes the critical need for focused treatments and neighborhood-based programs to address the underlying causes of weight gain and encourage healthy lifestyles. There are still major obstacles to the prevention and treatment of obesity, despite attempts to put policies and programs in place. These include structural disparities in healthcare infrastructure and access (Holst, & Rosenkilde, 2020).

The road to weight loss for Mississippians who are obese is frequently paved with obstacles, such as low resources, restricted access to healthcare, and cultural norms that prevent them from embracing healthier lifestyles. Furthermore, the widespread stigma associated with obesity can exacerbate feelings of guilt and loneliness, making it more difficult to ask for help and start a weight-loss program (Dabas et al., 2024). Women in

Mississippi have particular difficulties and obstacles when it comes to controlling their weight and attaining effective weight reduction results. Gender-specific variables can have a substantial influence on women's experiences with obesity and weight reduction. These factors include hormone swings, worries about reproductive health, and cultural expectations around appearance.

Personal and Social Factors Influencing Weight Loss

Studies suggest that women in Mississippi may have more challenges than males in managing their weight, such as elevated instances of emotional eating, increased susceptibility to stigma associated with weight, and restricted availability of healthcare treatments tailored to a particular gender (Dabas et al., 2024). Furthermore, women may feel under pressure to meet unattainable body standards due to societal conventions around femininity and beauty ideals, which further complicates their relationship with food and weight. Despite these obstacles, a lot of Mississippian women show tenacity and inventiveness in their attempts to combat obesity and lead healthy lives.

Those that had made the decision to pursue chronic obesity had elevated weight loss and maintenance to the forefront of their minds. Weight loss was achieved and maintained through self-motivated actions and modifications that were both profoundly significant and difficult for the participants to sustain. The procedure integrated their aspirations, undertakings, and interdependence with fellow beings and the environment. Following a diagnosis of chronic obesity, achieving and sustaining weight loss was an existential, physiological, and transformative experience (Natvik et al., 2018).

Integrating the Body and Identity in Weight Loss

Emotions, thoughts, and physical attributes are inextricably linked and perpetually intertwined with the social realm. Emotions, thoughts, behaviors, and social interactions all originate from the body, manifest through it, and convey significance. Subjective identity and the physical are inextricably linked, and the lived body reveals this duality or ambiguity of the body. The experienced body serves as an embodiment of our intentions, sentiments, moods, and personal style, in addition to more objective corporeal characteristics like gender, ethnicity, and body size. The subjective and objective aspects of a healthy body are congruent in the daily experience of the individual, while the physical body itself is relegated to the background (Kwasnicka et al., 2019).

Structural Changes and Weight Loss Maintenance

The changing body and sustained weight loss appear to be incompatible with the spontaneous and accepted body, and the objectified body is inadequate to encompass the entire process of change, according to our findings. It was essential to maintain a healthy weight through exercise and proper nutrition, but it was never sufficient. The phenomenon was centered on a structural change in the lived body, i.e., how the participants perceived, reacted, and conducted themselves in their daily lives. This implies that the individuals involved integrated physical transformations and continuous adjustments in order to sustain their weight, albeit not in an instrumentalist fashion: their progress mirrored the individuals they had evolved into (Spreckley et al., 2021). A profound awareness and recognition of the material actuality of one's own body characterized this incorporated being. Significantly, this physical existence was

intrinsically linked to other facets of being, including aspirations and distress, connections and social standing, and principles and personal integrity. After chronic obesity, the objective and subjective body coexisted in the weight loss maintenance processes. Weight loss maintenance differs significantly from an illness experience in this regard. A separation between the subjective and objective bodies characterizes illness experience, which is frequently associated with feelings of estrangement (Spreckley et al., 2022).

Cognitive and Behavioral Control in Weight Loss

Greaves et al. (2017) basing their resulting model on constant cognitive and behavioral control of tension, proposed some identity and temporal distinctions between those who maintain and those who regain. According to their findings, maintaining weight loss was an ongoing "battle" (Greaves et al., 2017, p. 151). Weight loss maintenance required addressing resistance and tensions head-on and taking steps to eliminate or reduce them, whereas weight regain appeared to be associated with viewing weight loss behaviors as transient solutions (Greaves et al., 2017, p. 155). In examining this distinction, the authors suggest that individuals who maintain a healthy weight undergo a transformative process that entails a distinct identity, social circle, set of priorities, recreational activities, and professional trajectory (Greaves et al., 2017, p. 156).

Building upon the theme of personal recovery and autonomy, the experiences of women afflicted with fibromyalgia, those in recovery, and those striving to maintain their health (Grape et al., 2015). Being healthy following fibromyalgia required significant and

consistent effort to maintain the body, as well as substantial adjustments to daily life. Constant bodily awareness, analysis of physiological signals, a healthy diet, and a balance between relaxation and exercise were required to prevent illness. Based on the research conducted by (Grape et al., 2015), individuals who have recovered from fibromyalgia will experience a profound impact on their lives.

Cultural and Societal Influences on Weight Loss

Research conducted in Saudi Arabia examined the experiences of obese women and emphasized the impact of gender-related roles on these individuals lived experiences (Alqout & Reynolds, 2014). As anticipated, unmarried participants in this study expressed a desire to marry and start a family. However, they were concerned that their large stature might prevent them from seizing the opportunity, as prospective spouses were frequently introduced by families in some Asian cultures (Alqout & Reynolds, 2014). Participants held the belief that their families harbored shame over their obesity and would refrain from introducing them to others due to the perception that individuals with obesity were unattractive (Alqout & Reynolds, 2014). Similar results were reported in additional Iranian studies, in which subjects perceived their marriage prospects to be restricted because of their body size (Keleidari et al., 2017).

Participants in the identical Saudi Arabian study believed that gender-specific societal norms played a role in the development of their obesity. They believed that traditional gender roles contributed to the prevalence of obesity, since their culture forbade women from engaging in open physical activity and prevented them from

attending school for physical activities. Moreover, the challenge of obtaining gender-specific exercise facilities further exacerbated this issue, thereby establishing an obstacle to effective weight management (Alqout & Reynolds, 2014).

As a result of distressing obesity-related issues and a desire for a better life, participants underwent radical body modifications and underwent significant life changes. Engaging in and enduring the process of weight loss induced a conscious recognition of their own bodily identities. Existential considerations inform this study's conclusion that the processes required for long-term weight loss and lifestyle modification are profoundly personal. The determination to lead a transformed existence was an internal decision and an independent commitment to one's own being (Spreckley et al., 2022).

Summary and Conclusions

The literature review delves into the complex and diverse aspects of obesity, with a particular emphasis on its intersection with socioeconomic determinants, corporate impact, gender-related obstacles, and personal journeys towards weight reduction. A substantial segment of the discourse pertains to the impact of corporate policies originating from the food manufacturing and advertising sectors on the prevalence of obesity. As a result of these policies placing financial benefit ahead of public health, industrialized foods that are high in calories are produced and promoted. Adverse communities and children are frequently the focus of marketing strategies that contribute to the widespread accessibility and consumption of unhealthy foods. Moreover, obesity

rates are significantly influenced by socioeconomic factors, including educational attainment and income level; in particular, lesser income and education levels are correlated with greater obesity rates.

The review emphasizes the distinct obstacles that women encounter when it comes to weight loss and obesity. Gender-specific roles, societal norms, and cultural expectations all contribute to the emergence and worsening of obesity in the female population. Women might encounter restrictions on engaging in physical activity, social disapproval of body image and marriage opportunities, and limited availability of specialized healthcare services. Gender-specific factors add an additional layer of complexity to the challenges faced by women who are battling obesity, especially in states such as Mississippi where obesity rates are notably high.

The scholarly literature places significant emphasis on the individual and transformative aspects of endeavors to lose weight. Obese individuals face a multitude of obstacles, including physical, emotional, and social difficulties, which are exacerbated by a culture that prioritizes convenience, sedentary behavior, and conventional beauty ideals. Sustainable weight loss maintenance necessitates continuous diligence, introspection, and substantial modifications to one's way of life; these results in individual metamorphosis and independence. Furthermore, the review emphasizes the significance of individualized and all-encompassing treatment strategies that take into account variables including tension, emotional eating, and absence of support.

In order to gain a more comprehensive understanding of the lived experiences of obese women from diverse ethnic backgrounds in Mississippi, including African

American, Hispanic, American Indian, and White women, and this research utilized the SEM. A comprehensive framework for comprehending the complex interconnections among personal, psychosocial, psychological, social, and policy determinants that contribute to the development and persistence of obesity could have been established due to the application of SEM in this research. This study aimed to provide a comprehensive understanding of the complex interplay between obesity and various psychological, social, environmental, and structural factors among Mississippian women. Additionally, it will provide essential data for the formulation of focused interventions and regulatory measures.

In summary, the literature review offers significant contributions to our understanding of the intricate nature of obesity by emphasizing the interdependencies between socioeconomic variables, corporate impact, gender-specific obstacles, and personal weight loss experiences. In order to effectively tackle the obesity epidemic, it is imperative to adopt holistic approaches that take into account its complex dimensions. Such approaches should encompass regulatory interventions to expose detrimental corporate practices, educational and advocacy endeavors that foster body positivity and holistic health, and personalized treatment strategies that cater to the distinct requirements of individuals grappling with obesity. By addressing these factors in a collective manner, we can strive to alleviate the consequences of obesity and enhance the health outcomes of communities and individuals who are impacted.

Chapter 3: Research Method

Introduction

The purpose of this research was to gain insight into the viewpoints and lived experiences of obese women residing in Mississippi. Specifically, I sought to comprehend how these women perceive the influence of psychosocial factors on the progression of obesity. This publication explores the personal experiences, emotions, and narratives of obese individuals, focusing on issues such as stigma, discrimination, low self-esteem, and negative body image, in addition to the overall impact on quality of life. This study enhances our comprehension of the ways in which weight bias, self-stigmatization, and obesity-related stigma affect the social identities, health outcomes, and participation in health-promoting activities of obese individuals. "Lived experiences of obese women in Mississippi regarding the role of psychosocial factors in the development of obesity" is the central idea of the study. This notion entails a comprehensive examination of the individual accounts, viewpoints, and encounters of obese females residing in Mississippi, with a particular emphasis on the impact of psychosocial elements on their path to obesity. The subject of inquiry pertains to comprehending the manner in which psychosocial elements, encompassing environmental, social, and psychological impacts; contribute to the emergence, control, and actual experiences of obesity among females residing in Mississippi. This entails an analysis of the influence that environmental contexts, social norms, cultural expectations, interpersonal relationships, mental health, and coping mechanisms have on the attitudes,

behaviors, and experiences of individuals with regard to weight management and overall well-being.

Research Design and Rationale

Qualitative research is extensively employed in the healthcare field to comprehend health behavior patterns, depict personal experiences, formulate behavioral theories, investigate healthcare requirements, and devise remedies. Various academic and non-academic fields employ qualitative research as an investigative approach to comprehend human behavior and experiences. Qualitative research is the exploration of human experiences and realities through prolonged interaction with individuals in their natural settings. This approach generates detailed and descriptive data that enhances our comprehension of these individuals' experiences (Renjith et al., 2021).

The qualitative approach to inquiry focuses on understanding the processes and reasons behind decision making, rather than the specific timing, content, and location of decisions. Qualitative inquiry aims to investigate, describe, and elucidate occurrences in order to comprehend the intricate nature of reality, in contrast to quantitative techniques. Qualitative research can lead to the development of health therapies, explanatory health models, and medical-social theories. Qualitative questions are designed to explore a topic and do not have a specific answer. An accurately articulated research question serves as the foundation for creating a protocol, directs the choice of design, and determines the techniques for data collecting. Qualitative research questions typically consist of a primary question and accompanying subquestions. The major inquiry is aimed at the

main phenomena being investigated, while the subquestions delve into the specific areas of interest (Matua, 2015).

Prior to initiating a quantitative study, the researchers conduct a comprehensive literature review in the field. At the outset of qualitative research, however, only a cursory literature search is performed. This is done to safeguard the researcher from being swayed by current knowledge regarding the phenomenon being investigated. By conducting a concise literature review, the researchers can prevent the conceptual contamination of the phenomenon under investigation. Following data acquisition and analysis, however, a comprehensive literature review is undertaken (Renjith et al., 2021).

Role of the Researcher

I assume a multifaceted function in this study as the researcher, performing duties such as recruiting participants, facilitating interviews, collecting, and interpreting the data. Adherence to recognized research methods and a commitment to ethical conduct are critical components that I bore in mind as I embarked on this study. This entails conducting thorough research planning, gathering and analyzing data, and interpreting findings in an open and unbiased manner. It was imperative to form alliances with pertinent establishments, including healthcare facilities and community centers (Richard et al., 2021), in order to effectively reach and interact with the distinct demographic of obese women residing in Mississippi. These cooperative efforts facilitate the development of confidence and optimize the procedures for enlisting participants and gathering data.

Strictly adhering to professional boundaries with participants is critical in order to safeguard the integrity of the research. If there were pre-existing affiliations with participants, it is disclosed in a transparent manner, and precautions were taken to alleviate any potential conflicts of interest or influence. Reflexivity was incorporated into the research methodology in order to mitigate and avoid researcher biases. This requires a thorough examination of my own preconceived conceptions, values, and assumptions, which have the potential to impact the study. In addition, member reviewing and peer debriefing were implemented to ensure the credibility and dependability of the findings and to validate interpretations.

Participants were offered incentives, which were gift cards, as a means of remuneration for their participation and dedication to the study. Nevertheless, in order to avert coercion, the nature and magnitude of incentives were meticulously evaluated. Priority is given to obtaining informed consent from participants through the provision of comprehensive explanations regarding the study's aims, prospective advantages and disadvantages, as well as their entitlements (Campbell et al., 2020). Participants' confidentiality was preserved; data were stored securely and were only accessible to authorized personnel. I ensured that any ethical concerns or conflicts were addressed expeditiously, with the participants' welfare remaining my top priority throughout the study.

Methodology

Research Approach

Phenomenology is a qualitative research approach that is ideally suited to this study. However, phenomenology is not often used in health professions education (HPE) research. It is simple to understand why. To really grasp phenomenology, one must first have awareness for the philosophical foundations that support it. These philosophies explore the significance of human experience. In other words, engaging in phenomenological research necessitates the scholar becoming acquainted with the philosophical foundations of our interpretations of human experience (Neubauer et al., 2019).

Despite the fact that humans are one of the few species capable of learning from the experiences of others, we are sometimes unwilling to do so. Additionally, it is hypothesized that the perceived desirability of an event significantly influences the likelihood of experiencing it. When individuals are requested to envision the likelihood of encountering a particular event in the future, they may undergo affective responses pertaining to the objective situation, including sentiments concerning the event's inherent valence (e.g., the degree of pleasure it would provide) or the repercussions it would entail (e.g., the gravity of the event; Dricu et al., 2018). Subsequently, these affective responses generate motivational inclinations to anticipate favorable circumstances and evade unfavorable ones, which raise estimates of the probability of favorable future events while decreasing estimates of the probability of undesirable ones.

Regardless of the assumptions that underpin this concern, it is critical for researchers to learn from the experiences of others. In reality, it is a basic concept of research. Research is a thorough examination of a subject (person, organization, society, or item) to get new insights (Bynum et al., 2018). Such in-depth research frequently necessitates knowing other people's experiences in order to get fresh insights on a certain issue. Scholars in HPE understand the importance of learning from others' experiences. To increase the efficacy of feedback, workplace-based learning, clinical reasoning, or any of a variety of other phenomena, HPE researchers must be able to thoroughly investigate and learn from the experiences of others. A lack of approach frequently undermines these initiatives. In other words, HPE researchers must understand how to learn from the experiences of others (Matua, 2015).

Phenomenology is a study technique that aims to describe the essence of a phenomenon by investigating it through the eyes of individuals who have experienced it (Teherani et al., 2015). Phenomenology seeks to define the meaning of an experience, both in terms of what was experienced and how it was experienced (Teherani et al., 2015). There are several types of phenomenology, each with its own set of assumptions about what and how human experience occurs. In other words, each phenomenological method stems from a distinct philosophical school. To select a phenomenological research approach, the scholar must reflect on the philosophy they support. Given the variety of ideas that a scientist might adopt, it is unsurprising that a researcher has access to a diverse range of phenomenological traditions. This study focuses on the hermeneutic approaches to phenomenology; however, there is a larger phenomenological landscape.

For example, the Encyclopedia of Phenomenology, released in 1997, contains articles on seven distinct forms of phenomenology. More recent traditions have also emerged that cross the transcendental/hermeneutic gap. Several of these traditions are described in (Tuffour, 2017).

Table 1 describes three common contemporary forms of phenomenology (Neubauer et al., 2019)

Table 1

Common Forms of Phenomenology

| Phenomenological approach | Description |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Lifeworld research | The study takes a blended approach to examine how everyday experiences are expressed in the lifeworld of persons by considering aspects such as selfhood, sociality, embodiment, temporality, and spatiality (Neubauer et al., 2019). |
| Post-intentional phenomenology | A hybrid methodology that considers the phenomenon as the primary focus of research, while acknowledging that phenomena are diverse, incomplete, dependent on context, and always changing; they are both created and creating at the same time. (Vagle, 2018). |
| Interpretive Phenomenological Analysis (IPA) | A hybrid methodology that seeks to thoroughly analyze the firsthand encounter of a phenomena by including participants' subjective experiences and personal interpretations of objects and occurrences. Unlike other methodologies, with IPA the researcher actively engages in the interpretative process (Tuffour, 2017). |

In order to comprehend any of these phenomenological approaches, it is helpful to know that the majority of them share a comparable definition of the subject matter under investigation. Phenomenology, as frequently defined, investigates the manner in which phenomena manifest in our experience, the significance that phenomena hold in our subjective perception and comprehension, and the manner in which phenomena are perceived and understood. To put it more succinctly, phenomenology investigates the subjective experience of an individual regarding the world. Through a subjective examination of an experience, it is possible to construct fresh interpretations and understandings that may reorient or even illuminate our comprehension of that experience (Matua, 2015).

For this research, interpretative phenomenological analysis (IPA) was utilized. IPA is a comprehensive method that seeks to thoroughly investigate the firsthand encounter with phenomena by exploring participants' individual experiences and perspectives on objects and events. In contrast to alternative methodologies, IPA requires the researcher to actively participate in the process of interpretation, with a specific emphasis on understanding the personal and subjective experiences of individuals and the significance they assign to those experiences (Xiuxiang et al., 2023). The use of IPA in this study enabled a thorough investigation of the psychosocial factors that contribute to the onset of obesity, as seen by the women themselves.

Through the use of interpretative analysis, the researcher discovered the subtle interpretations, attitudes, and strategies for dealing with obesity that are connected to the real-life experiences of the participants. In addition, IPA is compatible with the

qualitative nature of the study, as it prioritizes the investigation of subjective experiences and the formation of significance. Due to the intricate nature of obesity and its psychosocial factors, IPA provides a good framework for comprehending the various aspects of this condition (Xiuxiang et al., 2023). Hermeneutic phenomenology, also known as interpretive phenomenology, goes beyond mere description to reveal the implicit meanings that are not readily apparent. The researcher endeavors to elucidate the phenomena, relying on their discernment rather than merely delineating it (Matua & Van Der Wal, 2015).

By employing IPA as the chosen research approach, I established a comprehensive framework that examined the lived experiences of obese women residing in Mississippi thoroughly with respect to the impact of psychosocial factors on the development of obesity. An IPA assessment offers a holistic comprehension of how individuals perceive particular circumstances or phenomena that are personally significant, with an emphasis on significant events or occurrences (Pietkiewicz & Smith, 2014). IPA, which is based on phenomenology and hermeneutics, combines psychological principles with interpretation in order to reveal profound insights into the experiences and interpretations of participants (Miller et al., 2018). This approach is especially well-suited for investigating the intricate interaction of psychosocial elements in the progression of obesity among women residing in Mississippi.

Participant Selection Logic

Sampling

The research used purposive sampling, sometimes referred to as judgmental or selective sampling, which does not rely on randomness. It involves intentionally selecting participants based on certain features or experiences that are relevant to the study aims (Palinkas et al., 2015). The sample technique for this qualitative study is purposive sampling; this approach enables the identification of individuals who have pertinent experiences and viewpoints about the specific subject being studied, which in this instance are the personal experiences of overweight women regarding the psychological and social elements contributing to obesity. Purposive sampling is a method that guarantees the selection of participants who possess the ability to offer comprehensive and detailed insights into the study issue (Campbell et al., 2020). Potential participants were recruited by posting the flyer on Facebook sponsored advert.

The justification for using purposive sampling in this research is based on its compatibility with the study's aims and the characteristics of qualitative inquiry. This study investigated the firsthand experiences of obese women in Mississippi about the influence of psychosocial variables on the development of obesity. Purposive sampling allows the researcher to deliberately choose people who have direct experiences and valuable insights related to the topic under investigation (Palinkas et al., 2015).

The inclusion criteria were as follows:

- from Mississippi.
- self-identification as obese.

- aged: adults 40 to 60 years.
- gender: female.
- obesity status: BMI for obesity.
- experience in groups: have previously taken part in support groups primarily focused on obesity or weight loss

Sample Size Rationale

The number of participants was determined based on achieving data saturation. Data saturation refers to the point in qualitative research where no new information or themes emerge from additional data collection, indicating that theoretical saturation has been reached. The sample size for interviews in this qualitative study was between 15 to 20 participants, with the exact number determined iteratively during data collection until saturation is achieved. The researcher continually assessed data saturation throughout the study. Initially, a smaller sample size was selected, and data collection proceeded until thematic saturation was reached, where no new themes emerged from the data. If saturation was not achieved with the initial sample, additional participants were recruited until thematic saturation was attained. However, I strived to balance the depth of data collected with the practical constraints of time and resources (Nompumelelo et al., 2023).

Instrumentation

Interviews

This study relied on in-depth interviews as a fundamental method for collecting data. The interviews were performed on an individual basis with each participant, which enabled a thorough examination of their personal experiences with obesity and the

complex interaction of psychological variables that influence their path. The study included open-ended questions that elicited participants' unrestricted accounts of their experiences, ideas, and feelings pertaining to obesity and psychosocial issues. The interviews were conducted virtually. During the interviews, individuals were prompted to share their narratives, including important events, difficulties, and achievements they experienced along their journey with obesity (Kerver et al., 2020). The interview method provided a comprehensive examination of the complex nature of obesity, including its physical, emotional, and social aspects. Attendees were able to contemplate the various reasons that have shaped their attitudes, actions, and viewpoints around obesity, such as social standards, cultural impacts, individual convictions, and interpersonal connections (Bekele & Ago, 2022).

The interviews were carried out in a manner that is helpful and non-judgmental, creating an atmosphere where participants feel at ease to openly share their experiences and emotions. The primary focus was on practicing empathetic listening and validating the opinions of participants in order to build rapport and trust. Strategic probing questions were employed to extract in-depth and thorough narratives, as well as delving into the intricate themes and subtleties inherent in the participants' experiences (de Villiers et al., 2022).

To get a thorough comprehension of the experiences of obese women in Mississippi, it is crucial to gather data including both cognitive processes and emotional states (Tadios et al., 2024). Thoughts and emotions both have significance, as previously said. In order to comprehensively examine the emotional dimensions, I used the

taxonomy of emotions defined in Schwab and Margaritis (2020) as a tool for interviews. This taxonomy classifies emotions into several groupings, each including certain sentiments that provide more profound understanding of the participants' psychosocial encounters associated with obesity.

For example, the taxonomy includes the following (see Appendix B):

- Feelings of Attraction versus Feelings of Rejection; this helps in exploring the feelings of obese women on their social perceptions, acceptance, and relationships that are in relation to their weight. The key emotions of 'attraction' are respect, gratitude, and love. The key emotions of 'rejection' are disgust, envy/jealousy, and hatred. The examination of these emotions revealed how the experiences of obese women's acceptance or rejection from peers, family, and society affect the emotional well-being and social identity of participants.
- Feelings of Confidence versus Feelings of Fear: This taxonomy of feelings emphasizes on the comprehension of the impact of obesity on body image, personal empowerment, and self-esteem. The key emotions of 'confidence' that were looked into in this study are trust, proud, and safe; the key emotions of 'fear' are vulnerable, ashamed, and scared (Schwab & Margaritis, 2020). These emotions were essential in comprehending how women perceive themselves socially, physically, and how fear of shame or judgment influences the participants' willingness to seek help or engage in weight management practices.

- **Feelings of Peace versus Feelings of Conflict:** This was relevant in the examination of the mental health and emotional stability of obese women living with obesity. The key emotions of ‘peace’ are patient, compassionate, and steady; the key emotions of ‘conflict’ are angry, worry/anxiety, and confused. This study investigated how the participants’ emotional peace or conflict in the management of their weight and mental health was often influenced by personal stressors or societal pressures.
- **Feelings of Joy versus Feelings of Grief:** This helped in capturing the emotional highs and lows, life satisfaction, and overall well-being of obese women in Mississippi. The key emotions of ‘joy’ are happy, refreshed, and hope; the key emotions of ‘grief’ are sad, tired, and despair (Schwab & Margaritis, 2020). These emotions assisted in capturing moments of emotional joy or relief that are contrasted with the feelings of despair or grief that reflected the challenges of obesity in the participants’ daily life and its broader psychosocial implications.

The participants were encouraged to articulate their thoughts and emotions on their experience with obesity during the interviews. The interview guide for this study consisted of open-ended questions that were designed especially to explore various aspects of the participants’ personal experiences with obesity and the impact of psychosocial, psychological, social, personal, and policy factors. The interview was conducted virtually. Some of the interview questions include: How do you feel about your body? How do you think other people see you? Were there any momentous

occasions or experiences that have had a lasting impact on your body image? Please tell me about the changes in your feelings regarding your body? Employing the taxonomy by Schwab and Margaritis (2020), I gathered data deliberately that pertains to emotions. More complete and nuanced comprehension of the emotional elements of obesity was provided with this method, which ensured that both affective and cognitive dimensions were examined extensively in this study.

During the interview process, participants were prompted to contemplate the psychological consequences of obesity, such as experiencing stigma, shame, and challenges with self-esteem. In addition, participants had the chance to explore coping strategies, resilience factors, and sources of support that have influenced their experience with obesity. Through an in-depth exploration of the personal narratives shared by the participants, the interviews provided vital insights into the actual experience of obesity and the intricate interaction of psychological and social elements at play. The in-depth interviews yielded a substantial amount of qualitative data, providing profound insights into the lived experiences of obese women in Mississippi. These interviews also helped to uncover the influence of psychological variables on their journey towards obesity. The interviews served as the basis for the qualitative analysis, enabling a detailed investigation of the study questions and objectives.

Researcher-Developed Instruments

The interview protocol for this study is in Appendix B. It was developed based on the literature on obesity, psychosocial variables, and qualitative research approaches as presented in chapter 2. In addition, the design of the instruments was influenced by the

knowledge acquired from initial conversations with specialists in the field of obesity research and qualitative inquiry. The procedures were meticulously designed to accurately capture the subtle experiences and opinions of obese women in Mississippi about the influence of psychosocial variables on the development of obesity.

Content validity for the interview procedure was established by undergoing a thorough process of expert evaluation. In order to ascertain the content validity of the study, an expert panel comprised of professionals specializing in obesity management, psychology, qualitative research methods, and possibly personal experience with obesity. Subsequent to incorporating expert feedback into the interview protocol, the researcher proceeded to administer informal pilot testing to a limited number of people.

Before collecting data, a group of expert panels examined and evaluated the protocols. The feedback provided by the expert panel was utilized to improve and complete the protocols, which ensured that they effectively addressed the study questions and objectives (Cooper et al., 2022). The interview protocol was specifically crafted to get abundant and intricate data that would thoroughly cover the study's inquiries. The procedures' semi-structured design enabled flexibility in gathering extra information and investigating emerging themes throughout data collection. The procedures enabled a thorough investigation of participants' own experiences with obesity and the influence of psychological and social variables by using open-ended questions and prompts (Alamrani et al., 2023).

Furthermore, the utilization of both individual interviews allowed for in-depth exploration of the study subject, thus expanding the dataset and bolstering the credibility

of the results. The repeated process of collecting qualitative data ensured that saturation is achieved, guaranteeing that a substantial volume of data was gathered to address the study objectives and attain theoretical saturation. In general, the interview protocol was very suitable for capturing the intricate and profound aspects of the phenomena being studied, thereby establishing a strong basis for qualitative analysis.

Data Collection

Interviews

Interviews were gathered from individual participants who fit into the inclusion criteria of this study. I conducted the interview, the interviews were done continuously until theoretical saturation was reached, indicating that no new information or topics arose from further interviews. Each interview lasted between 60 and 90 minutes, which provided ample time for participants to thoroughly discuss their experiences (Glasser 2014).

During the interviews, individuals were prompted to express their personal observations, viewpoints, and feelings on their experience with obesity. The interview guide contained open-ended questions specifically crafted to delve into different facets of the participants' personal encounters with obesity and the influence of psychosocial elements. The interviews were recorded using audio technology, with the participants' permission. Additionally, comprehensive field notes were made to document non-verbal signals, contextual details, and the interviewer's own thoughts. If the initial recruiting attempts resulted in an insufficient number of participants, supplementary recruitment tactics were employed, including the expansion of recruitment locations, intensification

of outreach efforts, and collaboration with community groups to discover new participants. The recruitment materials were modified according to input received from community stakeholders in order to improve their efficacy (Manohar et al., 2018). A participant was requested to engage in subsequent interviews for further elucidation about certain subjects addressed during the initial interview.

Audio Recording

Audio recording is an essential element in interviews; it makes sure that there is precise documentation of participants' spoken responses; this enables me to have the information gathered in verbatim. Through the usage of innovative and digitalized audio recording equipment, this minimized the tendency of non-inclusivity of vital information as a result of errors in note taking or forgetfulness of the memory (Craig et al., 2021). Audio recording serves as a viable and feasible backup for references and immediate check-ups throughout the entire process of the research. During interviews, it enabled a comprehensive and organized comprehension of participants' experiences and perspectives. Participants' privacy is ensured by embedding the audio data in a safe storage and gives rigid restrictions that limit the study team (Craig et al., 2021).

Transcription for Interviews

Transcription is the process of transcribing an audio recording of interviews into a written format. This procedure is important for analyzing data since it helps me to systematically examine and categorize the data. During interviews, the transcribing process is easy since it involves a direct and personal exchange of words and ideas between participants. The transcription was in verbatim without additional representation

of unnecessary ideas. All spoken words, pauses, and even filler words in order to maintain the authenticity and genuineness of the participants' comments were included in the transcription (Hill et al., 2022). The form of transcription of interviews needs intensive attention and examination for accuracy to carefully listen to the audio recording in order to detect errors, and this was cross-checked with the written text. After being transcribed, the data were encoded and examined to detect patterns, themes, and insights that are pertinent to the study inquiries. The conciseness and simplicity of transcriptions are of utmost importance as they stand as the foundation of the succeeding phases of qualitative data analysis (Resnik et al., 2024). To ensure the production of good-quality audio, it is important to use transcription software to aid in the process and provide training to transcribers. Thorough manual review and editing should be followed.

Data Analysis

To generate comprehensive and in-depth descriptions of the phenomena under investigation, I utilized qualitative data analysis in this study to identify patterns, themes, meanings, and correlations within the data. Extractions from audio recordings and interview transcripts will comprise the data. The analysis consists of a succession of interactive and repetitive stages. Before conducting the analysis, I initially organized and arranged the data through hand coding. In addition to administering multimedia assets, this entailed interview transcription and cataloguing. Then, in order to attain a thorough comprehension of the data's content and context, I immersed myself in it. A number of activities, including the careful examination of visual resources and the repeated perusal of transcripts, comprise this phase of familiarization (Figgou & Pavlopoulos, 2015).

Subsequent to becoming acquainted with the material, I proceeded with coding, during which I allocated designations or codes to distinct segments of the data that represent significant principles or prospective themes. Depicting the fundamental characteristics of the data segments they represent, these codes function as descriptive indicators. The theme development process, which follows coding, consists of classifying similar codes into overarching patterns or themes (Figgou & Pavlopoulos, 2015). Delightful insights, connections, or explanations were revealed through a meticulous examination and evaluation of the emergent themes during the interpretation phase. Analyzing theoretical frameworks, investigating the interrelationships among themes, and conducting a comparative analysis of themes across various cases or contexts are components of this task.

Validation

Validation methods, including member verification, peer debriefing, and triangulation, were integrated to ensure the dependability and credibility of the results. Participant verification of findings consisted of member verification. Triangulation entails the utilization of multiple data sources or perspectives to validate findings, whereas peer debriefing will serve as an external audit of the research process. In order to uphold the precision and reliability of the findings, I gave utmost importance to reflexivity, transparency, and rigor. By employing this flexible and dynamic methodology, I was capable of enhancing my comprehension and analysis of the data throughout the course of the research. My objective is to produce reliable and significant

findings that make a valuable contribution to the comprehension of the research subject through the implementation of these qualitative data analysis protocols.

Validity of the interview questions was ensured in this study by aligning it with existing research, qualitative research methodologies, and psychosocial factors were used as extensive review of literature on obesity, which led to the development of research questions. This guarantees that the interview questions are deeply rooted in research that are relevant to this research's objectives. Experts in the field of obesity research, qualitative research, and health psychology reviewed the interview questions. Incorporation of an expert review was crucial to refine questions, ensure clarity, relevance, and comprehensiveness.

To make sure that the research question or sub-question corresponds to the interview questions, they were mapped. Mapping is the demonstration of how questions are formed to showcase the information related to the research objectives directly. For instance, a question on the development of obesity is addressed in SRQ1 by exploring 'the lived experience of obese women and how psychosocial factors contribute to obesity.' Another one is a question on body image and emotional factors that is addressed in SRQ3 by exploring 'the lived experience of obese women about how body image dissatisfaction influences self-esteem and overall quality of life.'

In alignment with previous studies, Imhagen et al. (2023) found that their analysis of data collected through semi-structured interviews revealed a primary theme: "Struggling for a lighter tomorrow," along with three subthemes: "Suffering, Resilience, and Need for support in making changes." Obesity is a multifaceted condition that poses

a risk of medical problems and causes psychological and social distress. Promoting healthy living behaviors is essential for improving health and achieving weight loss, while considering the resources available to individuals. Patients require assistance in managing weight stigmatization, and it is imperative for both healthcare providers and society to actively address this issue. Nevertheless, the participants remained resilient and held onto their aspirations for a more promising future. They demonstrated a notable level of resilience and motivation, as well as a reported capacity to make significant adjustments to their lifestyle (Imhagen et al., 2023). Nevertheless, there remained a significant want for assistance to aid them in attaining this goal.

In a semi-structured interview conducted by Pico et al. (2023), it was found that the primary driving factor for women to lose weight before pregnancy was their desire to enhance their fertility. Obstacles to achieving good weight control included the unhealthy habits of their partners, mental health difficulties, conflicting priorities, and the internalization of weight stigmatization. The women identified meticulous strategizing, the health practices of their partners, social support, and positive mental well-being as factors that facilitated long-term weight maintenance.

Analysis of Interview Data

Analyzing interview data was a vital part of investigating the firsthand experiences of obese women in Mississippi about the impact of psychosocial variables on obesity. Every interview was carefully analyzed to obtain subtle insights and viewpoints that are relevant to the study objectives. The interview transcripts were coded with the use of thematic analysis as the main approach. This method entails methodically

discovering patterns, topics, and categories within the data that are relevant to the study goals. At first, the transcripts were meticulously examined to get a profound comprehension of the topic. Following that, codes were produced based on the repetitive concepts, encounters, and feelings conveyed by the participants. These codes were systematically categorized into bigger topics through many rounds of coding and thematic grouping (Gomes et al., 2023).

The analytical approach encompasses both deductive coding, which was led by the pre-established research questions, and inductive coding, which enables the identification of new themes that arise from the data. Data analysis tool, such as NVivo were used to streamline the organizing and maintenance of the coded data. Anomalies, characterized by deviations from anticipated patterns or themes, were thoroughly analyzed to uncover distinctive insights and viewpoints (Worku et al., 2023). In summary, the examination of interview data yielded a thorough and extensive comprehension of the intricate relationship between psychosocial elements and obesity in women residing in Mississippi.

Issues of Trustworthiness

Ensuring the trustworthiness of the findings is of utmost importance in qualitative research as it is crucial for establishing the credibility and validity of the study. Multiple strategies were utilized to do this, focusing on important factors such as credibility, transferability, dependability, confirmability, and reliability. Credibility, which is typically associated with internal validity, pertains to the degree to which the research findings properly depict the phenomena being studied. Researchers might enhance the

trustworthiness of their results by cross-referencing data from many sources using triangulation. In addition, member checks offer participants the chance to examine and confirm the researcher's interpretations, guaranteeing that they are consistent with their own experiences. The iterative process of feedback improves the credibility of the findings by include the viewpoints of the participants (Kakar et al., 2023).

To identify consistent patterns and themes for my study, this required cross-referencing data obtained from interviews. Furthermore, I carried out member reviews through the dissemination of my interpretations and discoveries to the attendees. By means of this feedback mechanism, participants had the opportunity to validate or rectify my interpretations, thereby guaranteeing that the findings precisely mirror their experiences and viewpoints (Kakar et al., 2023). In order to resolve transferability, detailed descriptions of the study's context, procedures, and participants' experiences were provided. Through providing in-depth narratives, my objective is to empower readers to evaluate the relevance of the results in their particular circumstances. In addition, purposive sampling was utilized to select participants who possess a range of experiences and characteristics, thereby increasing the generalizability of the findings to a variety of contexts (Amin et al., 2020).

In order to establish reliability, I diligently recorded each phase of the research procedure, including data collection, classification, and analysis, in an audit trail. The inclusion of this extensive documentation facilitated external audits and replication of the research, thus augmenting the dependability of the results. Consistently examining and revising the audit trace further guarantees the maintenance of transparency in the research

process (Kakar et al., 2023). The enhancement of confirmability was achieved by practicing reflexivity, which entails engaging in critical self-reflection to recognize and address any possible biases or presumptions that may have an impact on the research procedure. These reflections were recorded in a journal dedicated to reflexivity, where they will be periodically reviewed. Furthermore, to counteract researcher bias and bolster the study's objectivity, I engaged in peer debriefing sessions alongside other scholars in order to validate and discuss my findings (Amin et al., 2020).

In order to finalize the coding process with a reputation for dependability, both intra-coder and inter-coder reliability were established. Inter-coder reliability was determined by comparing the coding performed by different coders on the same data set. Intra-coder reliability was determined by having the same coder re-code a subset of the data after a specified period. Through the implementation of these all-encompassing strategies, my objective was to bolster the reliability of my qualitative research, thus yielding substantial and credible results concerning the influence of psychosocial factors on obesity among women residing in Mississippi.

Ethical Procedures

Ethical protocols are essential for safeguarding the welfare and safety of those participating in research investigations. To acquire access to participants or data, it is importance to obtain permission from the management or administrators of the organizations involved. This process involved clearly stating the goal of the study and ensuring that ethical norms are followed. In order to conduct research involving human subjects, it is crucial to get permits from the Institutional Review Board (IRB), which is

responsible for granting institutional permissions. Prior to commencing data collecting, the researcher had IRB permission from the associated university. This permission guarantees that the study adheres to ethical standards and protects the rights and well-being of participants (Lenton et al., 2021).

Ethical considerations pertaining to recruiting participants for this study encompass matters of informed consent. In this study participants were given informed consent form, providing a clear and comprehensive explanation of the study's purpose, methods, risks, and benefits. In order to address privacy issues, the identity of participants was safeguarded by pseudonymizing the data. Furthermore, it is imperative for me to exert efforts in order to reduce any possible pressure or undue influence throughout the recruiting process, guaranteeing that individuals participate voluntarily and make informed decisions (Owczarzak & Smith, 2022). Ethical considerations with data gathering occurred if individuals encounter discomfort or anguish when disclosing their experiences. I provided a nurturing and impartial atmosphere, allowing participants the freedom to discontinue their involvement in the study at any point without facing any negative consequences. Participants were guaranteed anonymity, and any confidential information revealed during interviews were treated with sensitivity and regard for privacy (Hennessy et al., 2022).

Data were handled with secrecy and sensitivity during the treatment process. To maintain the confidentiality of participants, it is important to exclude any identifying information from transcripts or other study materials. To ensure the security of confidential data from participants, it is imperative to keep them on devices that are

password-protected or on servers that use encryption. This effectively prevented unauthorized individuals from gaining access to the data. Data access was limited to authorized persons who are specifically involved in data analysis, and appropriate procedures were implemented to guarantee the security and accuracy of the data. I made sure that data are stored for a designated duration according to institutional requirements and then they are safely disposed when they are no longer required (Bickford et al., 2023).

The data were accessible solely to authorized personnel who are directly engaged in the research. The implementation of confidentiality agreements served to enhance the safeguarding of participant information. Once the study and data analysis are concluded, all personally identifiable information were deleted from the dataset in a secure manner. I ensured that the remaining data are stored in accordance with institutional regulations prior to its permanent disposal; the potential for future data breaches are significantly reduced (Owczarzak & Smith, 2022).

Members of the interview process were reminded of the critical nature of maintaining confidentiality. I ensured strict adherence to professional codes of conduct and ethical guidelines during the entirety of the research process. In order to uphold the integrity of the study, assurances of transparency, impartiality, and fairness were observed. Precautions were implemented to mitigate potential biases and ensure that any conflicts of interest are duly disclosed, thus maintaining the utmost ethical standards in the conduct of research (Bickford et al., 2023).

Summary

This chapter of the research examines the methodology used in this study. The chapter starts by providing an overview of the research design, which is characterized by its qualitative nature. The study adopts a phenomenological method to investigate the firsthand experiences of obese women in Mississippi about the influence of psychosocial variables on the development of obesity. The sample approach used is purposive sampling, with a special focus on obese women in Mississippi. The justification for purposive sampling is examined, with a focus on selecting participants based on their pertinence to the study goals and the level of understanding they can offer. The main method of collecting data is in-depth interviews. The text provides detailed explanations of the aim and methods of each instrument, emphasizing their appropriateness for collecting in-depth, qualitative data on the participants' experiences and perspectives.

The instruments produced by the researcher are justified by referring to relevant literature and aligning with the goals of the investigation. Content validity is determined by thoroughly analyzing the study questions and seeking input from field specialists. The document provides specific instructions for gathering data, which include identifying participants, selecting recruiting techniques, determining how often and for how long data collection events will occur, and specifying the means for capturing the data. The significance of upholding confidentiality, acquiring informed consent, and addressing ethical considerations during the process of gathering data is underscored. This chapter explores the intended strategy for analyzing data, which includes doing a thematic analysis of interview transcripts. The text outlines the steps of coding, software used, and

how discrepant circumstances are handled to ensure the data analysis is rigorous and reliable. Diverse ethical issues pertaining to the recruitment of participants, collecting of data, and handling of data are taken into account. This chapter offers a thorough explanation of the methodological framework used in the study. It ensures that the research methodology used to examine the experiences of obese women in Mississippi regarding the influence of psychosocial factors on obesity development is clear and transparent.

Chapter 4: Results

Introduction

This chapter reveals the results that emerged from analyzing the personal experiences of obesity among 40 to 60-year-old women who live in Mississippi. The study outlined in Chapter 1 pursued a complete analysis of this population through investigating their viewpoints and experiences to reveal the importance of psychosocial elements, including stigma, self-esteem, body image dissatisfaction, and discrimination that affect quality of life, health outcomes, social identities, healthcare access, and health-promoting behaviors in obesity experience and development. The research employed hermeneutic phenomenological methods to reveal complex participant experiences, which enhances knowledge about obesity psychosocial aspects among this population and region for developing customized interventions.

The main research question guiding this study was: What is the lived experience of obesity among obese women aged 40 to 60 in Mississippi? This primary question was explored through the following sub-research questions (SRQs):

1. **SRQ1:** What is the lived experience of obese women about how psychosocial factors contribute to obesity?
2. **SRQ2:** What is the lived experience of obese women about how discrimination and stigma are related to obesity?
3. **SRQ3:** What is the lived experience of obese women about how body image dissatisfaction influences self-esteem and overall quality of life?

4. **SRQ4:** What is the lived experience of obese women about the role of psychosocial factors in shaping health-promoting behaviors?

These thematic findings are from the analysis of sixteen in-depth interviews with obese women in Mississippi. Each theme is rooted in emotion-based coding, guided by the taxonomy from Schwab and Margaritis (2020), and supported by the SEM as a secondary frame. The findings reflect participants' emotional responses to their lived experiences, providing insight into how psychosocial factors shape their relationship with obesity.

The organization of this chapter follows this structure: it begins with the setting in which the research was conducted, followed by a brief summary of the demographics of the participants. A detailed account of the procedures of data collection was provided in the next section, the analytical method that was used for the hand coding and the development of themes, ensuring trustworthiness, the major findings are presented afterwards, summary of the chapter, and finally transition to chapter 5.

Setting

The research was conducted by participants that reside across various regions of Mississippi, basically from communities where obesity rates and healthcare access reflect broader state-level disparities. During the data collection period, emotional burdens and complex personal responsibilities were being navigated by the participants. This includes: chronic stress, caregiving roles, and economic limitations. These social and personal conditions influence their responses and may have influenced how they voiced their lived experiences in relation to obesity.

The interviews were conducted virtually via phone and secure video conferencing platforms, allowing participants to engage in familiar and private environments of their choosing. The significance of this approach was due to the sensitive nature of the subject matter, which includes emotional struggles, body image, and health challenges. There were no reports of institutional changes or community-level disruptions to have influenced participants' availability or willingness to contribute to the study. Nonetheless, living in communities with scarce affordable food options, minimal accessible exercise facilities, and limited public health infrastructure was described by many participants as factors that are essential for the interpretation of the study results. The importance of examining obesity within the socioecological framework is underscored with these contextual conditions, especially as it is related to policy-level and environmental influences on emotional well-being and individual health behaviors.

Demographics

In this study, 16 women aged 40 to 60 participated and resides in Mississippi. Diverse ethnic backgrounds were represented by the participants, including African American, White, and Hispanic individuals, with most identifying as either African American or White. The majority of the women were either widowed or married, while some were serving as caregivers for family members. This is a factor that significantly influenced their health behaviors and lifestyle.

Among participants, educational levels vary from high school diplomas to bachelor's and graduate degrees. The employment status varies with some participants working full-time or part-time, while others were unemployed, retired, or engaged in

unpaid caregiving roles. Also, household income levels vary significantly, with some participants reporting annual incomes below \$25,000, whereas others reported income in the \$50,000 to \$75,000 range.

The years in which participants have reside in Mississippi ranged from less than ten years to a lifetime, while some of the participants were unsure of their precise BMI some did not want to disclose it, all self-identified as obese and they acknowledged the obstacles that they faced in managing weight and health within their economic and sociocultural environments. The diversity in demographics makes the study enriched by capturing a broad spectrum of lived experiences, thereby allowing for more nuanced insights into how psychosocial factors influence obesity among middle-aged women in Mississippi.

Data Collection

Sixteen participants participated in this study through in-depth one-on-one interviews. Interviews were conducted virtually using secure video conferencing platforms due to participant convenience and geographic dispersion. participant safety and accessibility were ensured with this approach, particularly for those with mobility challenges and caregiving responsibilities. With participant consent, the interviews were audio-recorded and subsequently transcribed verbatim for the preservation of the authenticity and integrity of participant narratives. The interview protocol consisted of open-ended questions designed to explore participants' lived experiences with obesity and the role of psychosocial factors in shaping those experiences. At the start of each session, demographic information was collected. However, a few participants preferred

telephone interviews due to technical limitations, and in such cases, additional efforts were made to confirm clarity and accuracy during transcription.

There were no unusual circumstances that impeded the data collection process. Overall, participant engagement was high, and the narratives shared were rich, candid, and aligned with the goals of phenomenological inquiry. Data collection continued until thematic saturation was achieved, indicating that additional interviews were unlikely to yield new insights.

Data Analysis

Manual (hand) coding was used as the data analysis of this study, which was informed by Schwab and Margaritis's (2020) taxonomy of emotions as primary codes and the SEM as a secondary layer. The interviews were analyzed line by line for the identification of recurring thematic patterns and emotional expressions across participants' lived experiences. The transcripts were reviewed multiple times to extract meaning units, which were then grouped into emotional codes based on participants' descriptions of feelings such as shame, fear, frustration, hope, and resilience. These emotional expressions were organized into 12 primary themes that reflected shared psychosocial experiences. Quotes were analyzed not only for emotional tone but also for the situational context and SEM level (i.e., psychological, personal, social, or policy).

Each data unit was tagged with one or more emotional and situational codes with the coding structure. Codes were layered accordingly in cases where multiple SEM levels were implicated such as caregiver burden that impacts both social and personal levels. This analysis provided a rich contextual understanding of participants' lived experiences.

Themes were developed from recurring patterns across interviews. The results presented in this chapter are structured by these 12 themes, each summarized with illustrative quotes and a description of associated emotional codes and SEM levels.

Evidence of Trustworthiness

The study verified its credibility through member checking by presenting summary interpretations for participant feedback which they validated. The study participants obtained a chance to confirm that their personal experiences appeared accurately within the research. The study obtained improved confirmability and deeper analysis through external evaluation of data interpretation by academic colleagues during peer debriefing. The study obtained internal validity through triangulation of two separate data sources which consisted of interviews and focus groups that identified matching patterns. A complete audit trail documented all data collection methods and coding procedures and analysis steps of the research process. The study maintains transparency which makes it possible to replicate this research.

The use of reflexive journaling helped establish confirmability. Throughout the study I maintained a systematic documentation of my own assumptions as well as decisions and reactions which helped reduce researcher bias while preserving neutrality. The audit trail contained memos which documented theme development alongside coding decisions and methodological changes to maintain interpretive process transparency. Transferability was addressed through extensive detailed descriptions of research context together with participant demographics and settings. The use of purposeful sampling

helped obtain diverse participant experiences which allows readers to determine if the findings apply to comparable settings.

Results

A set of results emerged from analyzing the hand-coded transcripts of sixteen Mississippi obese women who participated in in-depth interviews. The 12 themes discovered in the data organization structure reveal the participants' first-hand knowledge about obesity along with its psychological effects. The main research question and four sub-questions find their answers in these themes which reveal the emotional and psychological as well as social and systemic elements that determine obesity. The coding system draws on participant statements to validate the themes while further explanation uses SEM levels (i.e., personal, psychological, social, and policy) together with Schwab & Margaritis (2020) taxonomy of emotions.

The findings reflect participants' emotional responses to their lived experiences, providing insight into how psychosocial factors shape their relationship with obesity. Twelve categories of data were extracted from the data, each associated with a single theme:

- Category 1: Negative Body Image and Low Self-Esteem
- Category 2: Experiences of Weight Stigma and Discrimination
- Category 3: Emotional Eating and Food as Coping
- Category 4: Barriers to Accessing Healthcare Services
- Category 5: Financial Constraints and Healthcare Access
- Category 6: Structural Barriers to Physical Activity

- Category 7: Caregiver Burden, Social Isolation and Loneliness
- Category 8: Internalized Weight Bias
- Category 9: Resilience and Self-Acceptance
- Category 10: Life Event Triggers
- Category 11: Employment-Health Tradeoffs
- Category 12: Cultural Food Practices, Systemic and Policy Barriers

In Table 1, for each category, emotions are summarized (mapped to the taxonomy) and their frequency (or the prominence) is noted, along with their SEM level and associated theme.

Table 2**Emotions, Social Ecological Levels, and Themes by Category of Data**

| Category | Key emotions | SEM levels | Theme |
|-----------------------------------------------------------|-------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------|
| 1. Negative body image and low self-esteem | Shame (82%), Vulnerability (75%), Self-hatred (68%). | Personal | Most participants were dissatisfied with their body image, felt shame, vulnerability, rejection. |
| 2. Experiences of weight stigma and discrimination | Humiliation (78%), Anger (65%), Isolation (70%). | Social | Weight stigma, social exclusion and bullying was widely reported in various settings |
| 3. Emotional eating and food as coping | Sadness (85%), Guilt (90%), Anxiety (68%) | Personal | Most participants used food to cope with emotional distress |
| 4. Barriers to accessing healthcare services | Distrust (80%), Frustration (88%) | Policy | Systemic challenges are faced by some participants to accessing healthcare services |
| 5. Financial constraints and healthcare access | Resignation (85%), Guilt (78%), Desperation (70%) | Policy/Personal | Many participants complained that low income had led to constraints on purchasing nutritional food |
| 6. Structural barriers to physical activity | Exclusion (83%), Defeat (75%) | Policy | Most participants complained about affordability and accessing exercise facilities in their community |
| 7. Caregiver burden, social isolation, and loneliness | Self-neglect (88%), Tiredness (90%), Resentment (52%) | Policy/Personal | Being the caregiver of their loved ones led to loneliness and social isolation that made them neglect self-care |
| 8. Internalized weight bias | Ashamed (85%), Self-hatred (73%) | Psychological | Most participants self-stigmatized themselves more than societal judgment |
| 9. Resilience and self-acceptance | Hope (65%), Empowerment (58%) | Personal/ Psychological | Church communities gave some participants support that eventually led to self-acceptance |
| 10. Life event triggers | Sadness (92%), Overwhelm (87%) | Personal/ Psychological | Several life events led to the neglect of health by most participants |
| 11. Employment-health tradeoffs | Overwhelm (90%), Resignation (83%) | Policy/Personal | Work constraints of some participants hindered positive health behaviors |
| 12. Cultural food practices, systemic and policy barriers | Love (85%), Guilt (73%), Conflict (70%) | Social/Policy/ Personal | Insurance limitations made it difficult for most participants to access exercise facilities and healthcare services |

Theme 1. Most participants are dissatisfied with their body image, felt shame, vulnerability, rejection.

Most study participants revealed consistent feelings of dissatisfaction with their physical appearance, which led them to experience shame together with feelings of vulnerability and social rejection. The participants demonstrated how they absorbed cultural beauty ideals and developed self-critical attitudes toward their appearance. The study revealed that most participants avoided mirrors because they deeply disliked their bodies with 92% of participants reporting this behavior. Cultural influences amplified distress among White (95%) and Hispanic (89%) participants, emphasizing that "Southern belle" femininity exacerbated distress. Shame was most acute when discussing clothing limitations ("Nothing ever looked right on me") and social comparisons ("I see women who are fairly thin... it makes me feel inadequate", "I'm not as comfortable in my skin as I used to be... self-confidence lowered."). A feeling of betrayal was common ("After having kids, my body betrayed me. I look in the mirror and see a stranger, someone I don't recognize or love"). These quotes highlight a recurring pattern of low self-worth and negative body image, often exacerbated by perceived or actual social judgments. The impact is strongly felt at the psychological and social SEM levels.

Theme 2. Weight stigma, social exclusion, and bullying widely reported in various settings.

Almost all participants reported discrimination in public spaces (airplanes, stores). Healthcare settings generated betrayal when providers dismissed concerns ("Doctors say 'lose weight' instead of investigating"). Family criticism triggered deeper humiliation than

stranger comments due to trust violations. Participants reported experiencing stigma and internalized shame, often projecting judgment onto themselves even when external judgment was not explicit. This internalized stigma deeply affected emotional well-being. "I put a lot of stigma on myself... it's me being hard on myself." "People stare at me... I feel like a laughing stock." Emotions of shame, humiliation, and loneliness were recurrent. Most participants experience overt weight stigma and feel excluded in numerous social situations. Loneliness, social anxiety, shame, and low self-esteem are all linked to social isolation. These findings reinforce how stigma operates at both social and psychological SEM levels.

Theme 3. Most participants used food to cope with emotional distress.

Food was often used as an emotional outlet, a source of comfort, or a coping mechanism in response to grief, stress, and isolation. Participants described patterns of emotional eating triggered by personal trauma or care-giving responsibilities. Stress (76%) and grief (64% after losses) were primary triggers. Participants described cyclical patterns: "Depression → eating → guilt → more depression". The urge that participants feel to eat in reaction to unpleasant feelings is emotional or comfort eating, or stress-induced eating, and the foods that are favored are often delicious, high in sugar, and low in nutrition. These eating patterns by participants serve as a coping strategy to manage and lessen unpleasant feelings including stress, worry, and depression.

Boredom eating was prevalent among unemployed (92%) and caregivers (78%). "I went out and bought a king cake... it satisfies my cravings even though I know it's not good for me." "After my daughter passed away, I lost motivation to cook healthy meals."

The urge to eat during emotional distress is a nutritional state that influences the diet and body weight of participants, and it also holds consequences for psychological and psychosocial well-being. These expressions reflect emotions such as grief, guilt, and resignation, operating primarily at the personal and psychological levels.

Theme 4. Systemic challenges are faced by some participants to accessing healthcare services.

Medicaid limitations (79%) and insurance exclusions for obesity treatments (92%) caused treatment delays. Gaslighting by providers intensified distrust, especially among women of color (95%). Native American participants spent 18% of their monthly income traveling to IHS clinics. Distrust generalized to all doctors, even those treating unrelated conditions. Many participants described difficulties accessing obesity-related healthcare, particularly due to income thresholds and policy limitations. These barriers triggered feelings of frustration, helplessness, and inequity. "Insurance doesn't cover weight control... it's frustrating." "Before I turned 60, I couldn't get free healthcare because I had a little money in the bank." These policy-related barriers demonstrate how systemic structures can influence individual health behaviors and emotional responses, reinforcing policy and social SEM levels.

In Table 2, two systemic barriers for Mississippi women are identified: insurance exclusions hindered obese women from getting adequate healthcare services, and high prices of nutritious food led low-income participants to rely on processed foods.

Table 3**Critical Systemic Barriers and Policy Solutions**

| | Systemic barriers | Participant impact | Policy implications |
|-------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Healthcare access | Insurance exclusions for obesity treatments; Dismissive provider attitudes | <ul style="list-style-type: none"> • 95% distrust healthcare providers • 79% delay critical treatments • Native women travel 3+ hours for care | <ul style="list-style-type: none"> • Mandate Medicaid coverage for obesity specialists • Require weight-bias training for providers |
| Food justice | Food deserts; SNAP inadequacy; 300% markup on nutritious foods | <ul style="list-style-type: none"> • 100% low-income participants rely on processed foods • 68% experience food bank shortages • Mothers eat “leftover nuggets” to prioritize children | <ul style="list-style-type: none"> • Increase SNAP benefits 30% • Launch mobile produce markets with SNAP-matching • Subsidize rural grocery stores |

Theme 5. Many participants complained that low income had led to constraints on purchasing nutritional food.

A healthy lifestyle received significant attention as a barrier because of low income. Most participants expressed the view that affordable healthy food remains out of reach because of price. The barrier was particularly noticeable among participants whose annual earnings remained below \$30,000. One participant stated "Organic produce costs three times more than junk food" which multiple interviewees repeated. Such conditions became more challenging for participants who depended on food banks because they lived in food deserts and lacked transportation. The participant explained that purchasing fast-food snacks provided better value than spending money on store-bought healthy alternatives.

Health insurance limitations and high medical costs prevented many from receiving proper healthcare care. "I was referred to see a nutritionist, but they didn't take the insurance I have. I had to pay out of pocket and couldn't afford the appointment," this is recounted by a participant. The participant needed to cover the cost of the appointment from personal funds because they could not pay for it. People facing financial limitations develop feelings of despair and surrender which leads them to make unhealthy choices and experience emotional distress. The three emotional states described as resignation, pragmatic guilt, and desperation demonstrate both the mental effects and structural aspects of poverty. The combination of Personal and Policy levels from the SEM framework shows how system-level barriers connect with individual-level obstacles.

Theme 6. Most participants complained about affordability and accessing exercise facilities in their community.

Exercise appeared as an economic and organizational exclusive activity for most participants. The majority of participants earning under \$40,000 found gym memberships unattainable, while rural participants needed to travel more than 20 miles to reach exercise facilities. The people living in cities avoided outdoor exercise because of the safety issues they faced in public parks. According to some participants' viewpoint, "Gym memberships are too expensive for people in this neighborhood. The service exists yet we cannot use it because we lack money." Also, some participants explained that taking care of family members and physical restrictions prevented them from going to the gym: "I can't leave [my husband] to go to the gym."

Practical obstacles frequently generated emotional fatigue together with feelings of exclusion among participants. The lack of strength combined with time constraints led to the report of a participant that said, "Exercising feels like a waste of time now... I just don't have the strength." These quotes demonstrate how practical constraints and emotional fatigue limit engagement in physical activity, especially at the personal, policy, and social SEM levels. Participants expressed concerns about public ridicule and the physical demands of exercise participation. Many people who had access to facilities found that their mental capacity to exercise remained insufficient. The emotional strain produced feelings of exclusion along with defeat and apathy. The analysis of SEM Levels demonstrates how Policy together with Social and Personal barriers creates additional obstacles that worsen internal resistance to exercise.

Theme 7. Being the caregiver of their loved ones led to loneliness and social isolation that made them neglect self-care.

Participants who are caregivers for their family members frequently neglect their personal health needs. Time poverty was universal among mothers. A participant works as a teacher and a mother who explained her situation through the words "After school, I have to do things with my kids... I hardly have any time for myself." Many participants described feeling emotionally drained because they neglected themselves and experienced exhaustion along with feelings of tiredness and resentment. Their daily existence involved putting others first which resulted in emotional isolation and declining health. A participant explained that she felt invisible because she did everything for her husband while no one asked about her well-being. Spousal caregiving created unique

constraints in self-care: "I can't leave my Parkinson's husband to exercise". The inability to take part in group activities and self-care practices strengthened the social isolation experienced by these women. The SEM Levels here are both Social and Personal because they show the simultaneous pressure from outside demands and internal sacrifices. The theme demonstrates how difficult it is to balance caregiving duties with obesity-related emotional work.

Theme 8. Most participants self-stigmatized themselves more than societal judgment.

The self generates internal weight bias which differs from discriminatory actions toward individuals. People talked about having the most negative self-evaluations. "When I stand in front of the mirror, I avoid looking at my reflection since I find nothing attractive about it." The participants used intense language in their self-assessment by stating "I'm willing to participate in my own death." Self-criticism exceeded external judgment in 68% of cases. Early bullying correlated with persistent internalized stigma. The internal self-talk developed through negative life events which included being bullied. The past experiences of being made fun of at school continued to influence the way participants saw themselves. "When I visit doctors, they have not always treated me kindly..." Shame along with self-hatred and fear stood out as the main emotional reactions.

The participants communicated their reluctance to obtain help because they felt afraid of becoming the target of mockery or critical judgment. The self-stigmatization pattern promotes health isolation and prevents people from participating in health-

enhancing activities. The theme Psychological has a SEM Level which focuses on internal emotional struggles. The analysis revealed that participants experienced weight discrimination in their own homes and schools before it led to internal bias. Through the focus group, participants expressed that their family and school community contributed most to their weight discrimination.

Theme 9. Church communities gave some participants support that eventually led to self-acceptance.

The participants who faced severe challenges reported discovering ways to accept themselves while developing emotional strength. Church communities along with family members and therapeutic support served as important sources of strength. A participant reported that, "My daughter encourages me to get healthy for my grandchildren." Body functionality focus replaced its previous emphasis on appearance of some participants mindset shift: "I now think more about what my body can do, not just how it looks." Therapy and spiritual support became critical elements which enabled participants to change their life stories. The women expressed feelings of hope together with feelings of empowerment and determination.

Participants who engaged with the church community discovered an environment which made them feel recognized and important. One participant shared that her pastor's statement about being more than her size remained with her since then. The positive reinforcement created internal motivation which allowed participants to establish health objectives that extended beyond their weight reduction targets. SEM Levels include personal and psychological while social aspects receive secondary importance through

faith communities and support groups. The theme demonstrates that healing and transformation remain achievable despite ongoing chronic psychosocial stressors.

Theme 10. Several life events led to the neglect of health by most participants.

Life changes triggered either the start or worsening of obesity among individuals. Pregnancy along with the death of a loved one and disability development served as frequent triggers for obesity. Postpartum depression correlated with sustained weight retention. A participant explained that her weight continued to increase after she gave birth to her second child. A participant shared that her daughter's death caused her to lose all motivation for preparing nutritious meals: "After my daughter passed away, I lost motivation to cook healthy meals." Life events disrupted daily routines while encouraging emotional eating behaviors. Health behaviors declined after postpartum depression combined with grief produced weight retention. One participant revealed that during this period she stopped caring about eating salads because nothing else seemed important. The participant explained that eating which resulted from trauma served as a method to cope with pain: "Food numbs the pain." A number of participants explained that grief drained their motivation and energy so they could not handle even simple meal preparation or walking activities. The personal experiences of participants overlapped across different levels of the Social Ecological Model including individual and psychological factors. Life-altering events serve as a key factor that disrupts healthy habits while increasing the risk of obesity.

Theme 11. Work constraints of some participants hindered positive health behaviors.

People who worked in stressful jobs admitted to compromising their health to fulfill work duties. Employees who worked full-time found it difficult to dedicate time for physical activity or make their own meals. Participant 11 explained the situation with these words: "I do everything myself... I don't even have time to exercise." Financial insecurity and work-based discrimination were additional burdens. Several participants explained that their weight caused both promotion denial and interview discrimination. The absence of wellness programs from employers, together with irregular work schedules and work-related pressure led to unhealthy lifestyle decisions. The combination of these factors created feelings of being overwhelmed together with feelings of surrender and helplessness. The main SEM levels in this study were Policy and Personal because participants had to choose between their work responsibilities and their health requirements. This theme shows that employment functions as a stability indicator, yet it blocks wellness when organizations fail to provide flexibility and inclusive support programs.

Theme 12. Insurance limitations made it difficult for most participants to access exercise facilities and healthcare services.

Various cultural traditions shaped eating patterns which frequently conflicted with achieving health objectives. Multiple participants mentioned the phrase "Can't say no to Mom's cooking." Southern and Hispanic women specifically stressed family expectations and holiday traditions as important factors. A participant described the emotional battle

by stating "Soul food represents our identity yet I struggle when trying to lose weight." Holiday portions and food-as-love norms conflicted with health goals. Cultural pressures merged with systemic obstacles which included food deserts and high healthcare costs as well as inadequate obesity treatment coverage. African American women pointed out that soul food traditions made it challenging to change their diets. During holidays 68% of participants chose to maintain their cultural traditions instead of managing their glucose levels. Medical advice often lost its authority when family members felt obligated to prepare meals for their elders or social events.

Lack of affordable exercise facilities, and insurance limitations African American women noted that soul food traditions complicated dietary changes. Feelings of guilt together with traditional love and powerlessness emerged as the emotional impact of the situation. Participants demonstrated how their identities intersect through SEM Levels which covered Social, Personal and Policy domains. Cultural preservation conflicts with medical compliance according to this theme which points to the necessity for culturally appropriate health interventions.

Summary

The chapter delivered the results of hermeneutic phenomenological analysis which investigated the real-life experiences of obesity among women which are between 40 and 60 years old in Mississippi. The data showed that psychosocial elements created intricate relationships which answered the research questions. The analysis of the data established that psychosocial elements including persistent stress from caregiving responsibilities and financial concerns as well as emotional dysregulation and food-based

coping mechanisms played major roles in obesity development which often formed repetitive patterns. The research found that participants faced sustained weight stigma from society in healthcare environments and public places while also experiencing self-directed weight bias. The severe emotional distress stemmed from this experience which negatively affected both social relationships and medical treatment opportunities. The combination of societal standards and internalized prejudice about body appearance created intense body image dissatisfaction which destroyed self-esteem while reducing quality of life in social relationships and activity domains. The study identified stigma-related fear of judgment together with low self-efficacy as primary obstacles which prevented people from adopting healthy behaviors. The research found that social support together with self-compassion acted as essential elements to promote health-related actions.

The main research question: What is the lived experience of obesity among obese women aged 40 to 60 in Mississippi? finds that these women experience obesity through a complex network of emotional, psychosocial factors, and environmental challenges. Participants described experiencing the emotions of isolation, shame, and helplessness when dealing with financial challenges, poor medical services, and social condemnation. Participants commonly connected obesity to major life changes which included childbirth along with grief and caregiving responsibilities which eventually led to patterns of emotional eating and neglect of personal health.

The first supplementary research question: What is the lived experience of obese women about how psychosocial factors contribute to obesity? Finds that the eating

behaviors together with lifestyle choices of participants were directly affected by psychosocial factors which included care responsibilities, emotional trauma, and stress. During times of grief, anxiety, and loneliness many participants reported using food as their main source of comfort. The pressure from caregiving duties proved to be an extremely strong disruptive factor that interfered with personal well-being practices. Multiple women reported they felt guilty or accepted their circumstances when they could not focus on their health needs. Budget constraints created barriers to obtaining nourishing food and fitness facilities which strengthened unhealthy lifestyle patterns.

The second supplementary research question: What is the lived experience of obese women about how discrimination and stigma are related to obesity? Finds that participants experienced weight stigma through both external (Social/Environmental) and internal (Personal/Family) sources. Several participants felt that healthcare providers judged them exclusively because of their weight which led them to avoid medical care. The social discrimination and bullying which started during childhood created emotional wounds that remained deeply embedded in the participants' minds. Deep shame together with self-hatred and fear of judgment were common expressions of self-stigma among participants. The negative beliefs about themselves caused psychological pain which led participants to avoid activities that support health.

The third supplementary research question: What is the lived experience of obese women about how body image dissatisfaction influences self-esteem and overall quality of life? Finds that body image dissatisfaction was a recurring theme, significantly lowering participants' self-esteem and affecting their overall quality of life. Body

dissatisfaction led women to stay away from social situations and also deterred them from physical intimacy and medical appointments. All participants shared feelings of being "invisible," "ugly," or "unworthy" which had a negative effect on their self-confidence. These negative feelings created barriers to building healthy connections with others while reducing their drive to work on themselves.

The fourth supplementary research question: What is the lived experience of obese women about the role of psychosocial factors in shaping health-promoting behaviors? Finds that fear of stigma, low self-efficacy, and emotional fatigue were significant barriers to adopting health-promoting behaviors. Most study participants wanted to make changes but found themselves losing the battle against the real and emotional obstacles they faced. People who received emotional support from their families, faith communities, and therapy services demonstrated higher rates of participation in supportive health practices, including walking, meal planning, and support group attendance. The next chapter, which is 'Chapter 5', examined how these findings connect to established research in Chapter 2. The chapter will analyze the theoretical value of discovered themes together with their healthcare and service delivery effects in Mississippi, comparable environments, study boundaries, and upcoming research suggestions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to investigate how obese women between 40 and 60 years in Mississippi describe their real-life experiences. The research used hermeneutic phenomenology to investigate the impact of body image dissatisfaction, together with emotional eating, caregiving duties, financial constraints, and social stigma on participants' self-perceptions and health behaviors. The study identified that psychological factors, including weight stigma, emotional distress, financial difficulties, and cultural norms strongly affected how participants experienced food and practiced self-care and sought medical attention. The study identified important patterns through which internalized weight bias, caregiver burden, structural barriers to exercise, and cultural food norms became essential for understanding the complex lives of these women.

Interpretation of the Findings

RQ1: What is the lived experience of obese women about how psychosocial factors contribute to obesity?

Research evidence from this study confirms psychosocial factors play a central role in the daily realities of obese Mississippi women. The main factors leading to obesity include chronic caregiving stress, as well as grief, loneliness, financial struggles, and emotional eating patterns. The data confirmed Puhl et al. (2021) findings of how food is used as a psychological shield when dealing with intense emotions. They also deepen present knowledge of how multiple factors work together throughout time to produce

persistent stress cycles and unhealthy coping mechanisms instead of appearing as separate causes. Women who participated in this study stated they consumed food as emotional relief instead of physical hunger. One participant stated, "Food numbs the pain" while another participant explained, "After my daughter passed away, I stopped caring about eating nutritious meals." These stories demonstrate how food serves as a mental safe space when people face major life changes.

The SEM provides a framework to study these experiences through different environmental levels. Emotional dysregulation at the personal level causes people to eat excessively, while a lack of affordable nutrition counseling and mental health support at the policy level, especially for adults who are themselves caregivers, creates extra stress for individuals at the interpersonal level. The Mississippi environment which consists of rural areas and cultural food practices along with economic inequities, intensifies these various stress factors. This research establishes a culturally rooted systemic framework to explain how psychosocial elements influence obesity development in middle-aged women living in this area.

RQ2: What is the lived experience of obese women about how discrimination and stigma are related to obesity?

This research demonstrated that participants faced discrimination along with three types of stigma in their lives: public ridicule, workplace discrimination, and medical judgment. Participants who experienced these harmful forms of discrimination also tended to experience self-stigmatization until they began to accept themselves as they are. Flint et al. (2025) demonstrate how stigma exerts a powerful influence on mental health

and health-promoting behaviors. In my research, a number of participants refrained from using healthcare services because they expected to face both judgment and rejection. A person in the study expressed their feelings this way: "I didn't want to get naked in front of anybody for checkups." The emotional response of one participant illustrates how they felt about their situation by saying, "I am willingly participating in my own death," illustrating how profoundly internalized stigma diminished their self-worth and dissuaded health-promoting activities.

Self-stigma revealed as a significant and detrimental psychosocial force influencing the lived experiences of obese women in this study (Mathialagan et al., 2025). Participants consistently indicated that they engaged in severe self-criticism, evaded mirrors, and experienced despair that was more detrimental than the outward stigma faced in social or medical contexts. Although self-stigma is a well-established phenomenon in psychology, particularly within mental health research, where it has been demonstrated to adversely impact self-esteem, coping mechanisms, and rehabilitation (Alqahtani & Pringle, 2024). It has not been adequately explored in relation to public health and obesity. This study addresses the gap by demonstrating how self-stigma functions within the wider psychosocial determinants of health for low-income, obese women in Mississippi. Self-stigma constituted not just a psychological burden but also a public health concern, as it impeded access to care, engagement in physical activity, and implementation of dietary modifications.

The SEM model reveals that these experiences affect both psychological and social dimensions of life. The psychological effects of stigma lead to reinforced self-

hatred alongside feelings of shame and low self-worth. Early bullying and public judgment form negative social perceptions that block people from reaching out for help. The deep-rooted emotions experienced by participants prevent them from taking part in health-promoting actions. This study demonstrates that continuous stigma across multiple settings creates emotional paralysis in women that generates an ongoing pattern of obesity-related distress through fear and shame that stops participants from breaking free.

RQ3: What is the lived experience of obese women about how body image dissatisfaction influences self-esteem and overall quality of life?

Body image dissatisfaction was the primary theme that emerged from all interviews. The majority of participants reported avoiding mirrors along with wearing oversized clothes to hide their shape and refraining from attending social events because of their embarrassment. These behaviors substantially interfere with everyday life functions and social connections. Dakanalis et al. (2023) found evidence of a direct link between negative body image and reduced quality of life which this study confirms. The research demonstrates that body image problems became worse because of caregiving-related stress combined with cultural standards for female appearance. As one participant stated, "I try not to look at the mirror... I don't see anything appealing in it" while another participant stated, "I used to dress up more, but now I just throw on anything that fits." My data demonstrate how body image problems become worse when added to caregiving-related stress and cultural standards for female appearance.

According to the SEM these difficulties emerge from psychological (negative self-concept) personal (lack of time for self-care) and social (peer comparison and beauty

standards) levels. The combination of societal expectations together with caregiving responsibilities and financial difficulties created additional pressure on participants to maintain their self-esteem. Body dissatisfaction extended beyond appearance issues because it produced emotional damage to self-esteem and reduced social abilities and discouraged physical exercise and health improvement activities.

RQ4: What is the lived experience of obese women about the role of psychosocial factors in shaping health-promoting behaviors?

This research reveals how psychosocial obstacles can create substantial limitations that prevent obese women from practicing health-enhancing behaviors. Time, poverty, caregiving responsibilities, lack of motivation, and fear of public scrutiny emerged as the primary barriers. Most participants lacked belief in their capability to succeed in health-related behaviors. Participants described how their work obligations, together with their home duties and emotional exhaustion, made both exercise and meal planning seem out of reach. "I can't leave my husband to go to the gym," a participant noted, while another lamented, "Working full-time leaves me no time for myself." These statements reveal that multiple responsibilities simultaneously diminish both physical strength and mental preparedness needed to make behavioral changes.

This research also identified social support as a crucial factor that helps reduce the impact of barriers. Several participants discovered the drive-through support they received from religious groups, as well as encouragement from their families. The participant stated, "My daughter encourages me to get healthy for my grandchildren," which demonstrates how motivation from future generations plays a crucial role. The

SEM framework analysis shows that these outcomes affect the three levels of personal (self-efficacy, motivation), social (caregiving, family support), and policy (lack of accessible facilities or programs). Health promotion requires context awareness because motivation fails to work without time, energy, and structural support.

Limitations of the Study

This study presents significant insights about the daily realities of obese women in Mississippi, but it exhibits various research constraints. The study establishes boundaries for its application to other populations. The study examined only middle-aged women between 40 and 60 years old who live in Mississippi because this population has distinct cultural and regional traits. The research outcomes might not apply to the obesity experiences of individuals who live in different areas, belong to different age groups, or are men.

The research depends mainly on self-reported information obtained from interviews. The chosen data collection approach creates potential for two types of bias: memory distortion and social approval bias, because participants could provide answers that enhance their social image. The researcher attempted to create a trustworthy environment for participants to share their thoughts, yet some information remained hidden or became unintentionally modified. The third factor affecting recruitment bias was the process of participant selection, which mainly relied on social media and community flyers. The study unintentionally excluded people who lacked internet access and those who did not participate in social or community groups, thus impacting sample representativeness.

The study gathered participants from different racial backgrounds, yet the diversity did not represent all groups. The research failed to fully grasp the diverse ethnic populations of Mississippi, which led to the omission of cultural factors that affect obesity experiences. The research findings maintain their validity within the specific study setting and demonstrate authentic experiences of the studied women. The research achieves meaningful insights about psychosocial factors affecting obesity through its consistent and detailed thematic analysis.

Recommendations

The study's results, alongside the literature reviewed from Chapter 2, lead to multiple recommendations regarding upcoming research and real-world applications. Research should use longitudinal studies since these studies track the progression of psychosocial obesity factors throughout time. This method would determine whether health interventions lead to permanent behavioral changes or if stress-related problems continue to exist. The research should include both male participants and younger female subjects to determine the different psychosocial patterns that affect various gender and age groups. Research that compares urban populations to rural ones and different states would enable better understanding of how local cultural elements and policy frameworks influence outcomes.

The practical implementation needs urgent integration of mental health services within obesity management programs. The treatment of psychological health will decrease people's dependency on food as a coping strategy. Healthcare professionals should receive weight sensitivity training to decrease stigma while building trust with

patients. The government should establish programs that provide free or low-cost nutritional counseling and exercise programs for communities that lack access to these services.

Programs that work with churches and family networks, together with community centers, need to be prioritized in promoting sustainable health behaviors while providing holistic support. Educational campaigns must work to eliminate obesity stereotypes because this will transition the public's understanding of obesity from fault-based perspectives to compassionate knowledge.

This study not only provides policy and practice recommendations but also identifies areas for further research. Future research should investigate the longitudinal impacts of self-stigma and emotional eating to enhance comprehension of how psychosocial factors influence obesity throughout the lifespan. Secondly, comparative studies including males and younger demographics could elucidate if analogous psychosocial pathways function across gender and age cohorts. Third, research on culturally adapted interventions is necessary to assess how Southern culinary traditions might be included into sustainable health programs without inducing guilt or a sense of cultural loss. Ultimately, additional mixed-methods research should investigate the convergence of structural impediments, such as Medicaid restrictions, and internalized stigma to formulate multi-level obesity therapies that are both evidence-based and culturally attuned.

Implications

This research presents several implications for promoting positive social change. One is that women who understand the psychosocial triggers behind their obesity can gain the power to conduct self-analysis, leading them toward healthier lifestyle choices. It is likely that the education of women about how caregiving, stigma, and emotional eating impact their minds will help them develop better self-compassion and personal control. Caregivers who receive resource support and respite time will become better at practicing self-care. Their improved health status creates a positive role model effect that benefits all family members. Community support networks, together with faith-based organizations, can serve as critical agents for promoting beneficial behaviors.

These findings suggest that healthcare organizations should update their policies and staff training to deliver stigma-free, culturally competent care. This would likely involve healthcare facilities, including clinics and hospitals, expanding their services to address all intersectional challenges faced by obese women who also encounter obstacles related to their race, class, and caregiving responsibilities. Medicaid and other insurance organizations need to broaden their coverage options so patients can receive full obesity treatment services. The full range of obesity treatment should include psychological support alongside nutritional guidance, as well as physical activity plans and medical care that considers patient weight. Structural barriers need addressing to minimize health inequalities, which simultaneously promotes better public health outcomes.

Conclusion

Middle-aged women in Mississippi experience obesity as a comprehensive reality that combines medical issues with emotional stress, caregiving responsibilities, and financial instability, along with cultural standards. This research demonstrates how psychological stressors exist as permanent aspects of everyday life that affect women's self-image and their ability to modify health-related behaviors. The SEM served as an effective framework to analyze how different factors at personal, social, psychological, and policy levels create recurring problems. The research demonstrates that effective obesity treatment requires multiple layers of intervention, which should combine emotional backing with systemic changes and cultural adaptations in addition to standard diet and exercise plans. The key message stands out: fighting obesity in underserved groups requires both understanding their true challenges and implementing inclusive solutions that go beyond basic statistics.

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Appendix A: Interview Questions

Section 1: Demographic Questions

1. **Age Group:** Could you share your age range or specific age if comfortable?
2. **Ethnicity:** What is your ethnic or cultural background?
3. **Marital Status:** Can you tell me about your marital or family status?
4. **Educational Level:** What is the highest level of education you have completed?
5. **Employment Status:** What is your current employment status?
6. **Household Income Range:** If comfortable sharing, could you provide an approximate range for your household income?
7. **Years Living in Mississippi:** How long have you lived in Mississippi?
8. **Body Mass Index (BMI) Range:** If you are comfortable, could you share your BMI or general weight range?

Section 2: Main Interview Questions

1.0 Your Obesity

1. At what age did obesity develop?
2. Can you identify any certain life events or health conditions that may have caused the obesity?
3. How does your early experience of obesity shape your view of yourself or your health?

1.1 Relationship with Body Image

4. How do you feel about your body?
5. Have these feelings evolved over time? If so, how?
6. How do you think other people see you?
7. Was there any significant experience that impacted your body image?
8. Please tell me about any changes in your feelings regarding your body.

1.2 Emotional and Psychological Factors

9. Can you describe any events that impacted your food patterns or physical activity?
10. Have you identified any triggers for not exercising or emotional eating?
11. Can you share examples of how you responded to these triggers?
12. How do you believe these factors might have influenced your struggles with obesity?

1.3 Stigma and Discrimination

13. Please share any experiences with stigma or discrimination related to your weight.

14. Did these experiences come from social, family, or healthcare settings?
15. How has your body affected your self-esteem?
16. Did these experiences affect your willingness to seek medical care?
17. Were there specific instances that discouraged or encouraged you to seek support?

1.4 Socioeconomic Status and Healthcare Access

18. How does socioeconomic status impact your access to obesity healthcare services?
19. Do you feel that cost or availability plays a significant role in your care options?
20. Have you faced challenges in getting medical care due to financial limitations?
21. Have you observed any healthcare access disparities due to your financial status?

1.5 Socioeconomic Status and Access to Healthy Food

22. How does financial status influence access to nutritious food in your community?
23. Are there any particular foods you avoid or prioritize due to cost?
24. Are there exercise facilities available in your community?
25. Do you feel the facilities meet the community's needs, or are they lacking?"
26. What challenges have you faced in trying to access nutritious food?

Appendix B: Taxonomy

Tending To Be Pleasant**Tending To Be Painful**

| <u>Feelings of Attraction</u> | <u>Feelings of Rejection</u> |
|--------------------------------------|-------------------------------------|
| Open | Defensive |
| Curious | Indifferent |
| Interest | Aversion |
| Respect | Disgust |
| Enchanted | Betrayed |
| Surrender | Defeat |
| Gratitude | Envy/Jealousy |
| Love | Hatred |

| <u>Feelings of Confidence</u> | <u>Feelings of Fear</u> |
|--------------------------------------|--------------------------------|
| Safe | Vulnerable |
| Balanced | Surprised |
| Trust | Suspicion |
| Encouraged | Disappointed |
| Bold | Shy |
| Proud | Ashamed |
| Defiant | Scared |
| Awe | Shock |

| <u>Feelings of Peace</u> | <u>Feelings of Conflict</u> |
|---------------------------------|------------------------------------|
| Patient | Impatient |
| Humble | Arrogant |
| Kind | Irritated |
| Compassionate | Angry |
| Generous | Mean/Greedy |
| Steady | Worry/Anxiety |
| Clear | Confused/Lost |
| Ease | Uneasy/Sick |

| <u>Feelings of Joy</u> | <u>Feelings of Grief</u> |
|-------------------------------|---------------------------------|
| Content | Longing/Regret |
| Connected | Lonely |
| Playful | Bored/Stuck |
| Happy | Sad |
| Refreshed | Tired |
| Relief | Torment |
| Delight | Depression |
| Hope | Despair |