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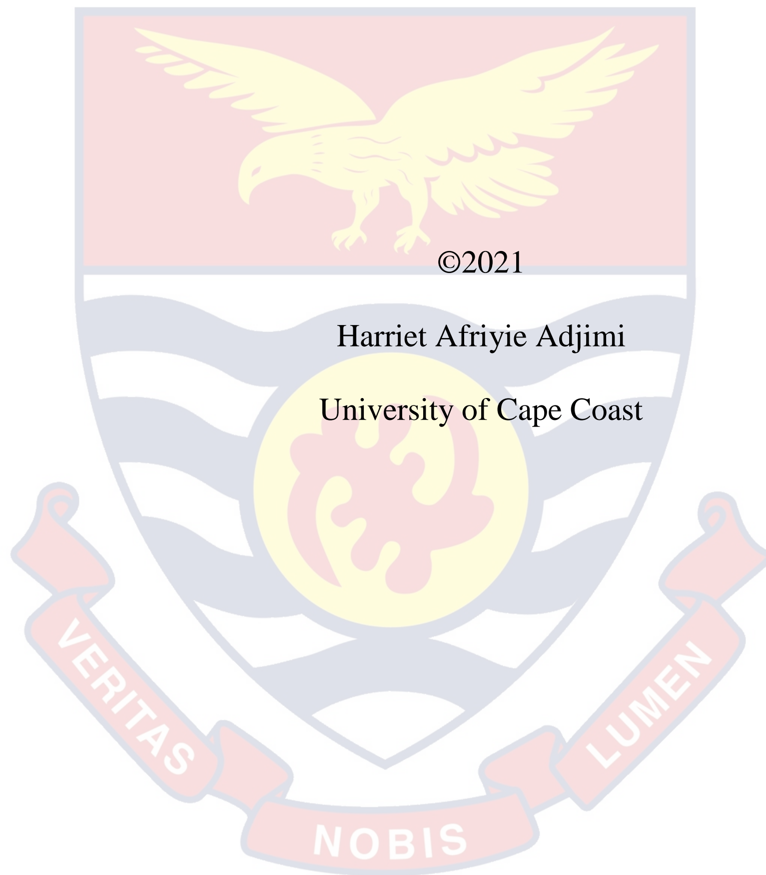

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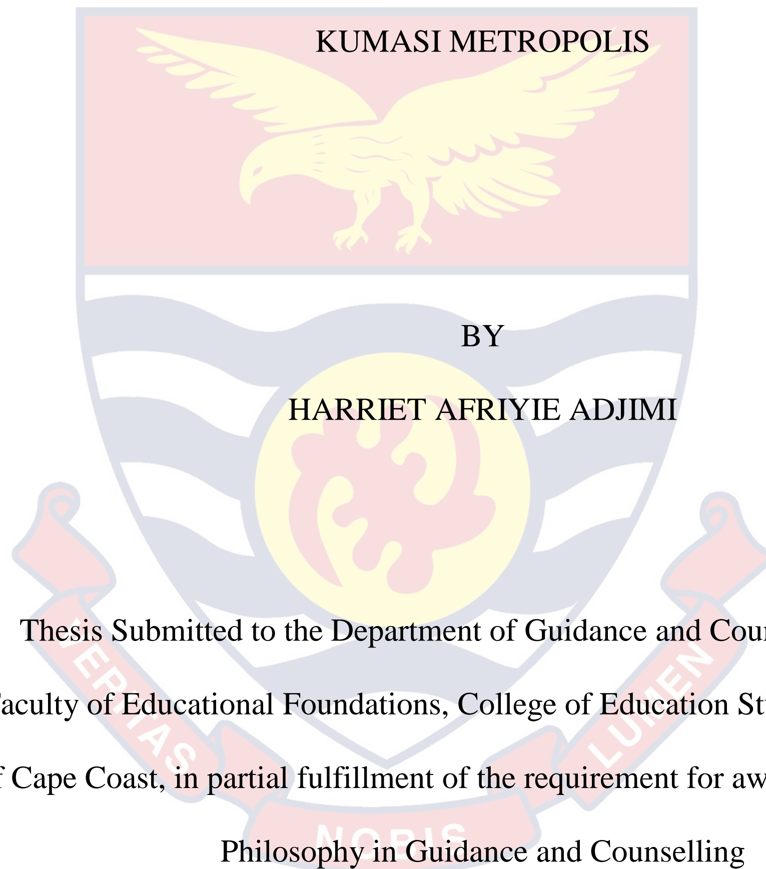
INFLUENCE OF BODY IMAGE AND PERCEIVED STIGMATIZATION ON PSYCHOLOGICAL WELLBEING OF OBESE WOMEN IN THE KUMASI METROPOLIS



BY

HARRIET AFRIYIE ADJIMI

Thesis Submitted to the Department of Guidance and Counselling of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfillment of the requirement for award of Masters of Philosophy in Guidance and Counselling

OCTOBER 2021

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DECLARATION

Candidate's Declaration

I hereby declare that the thesis is the result of my own original research and that no part of it has been presented for another degree in this university or anywhere else.

Candidate's signature……………………… Date………………

Name: ……………………………………

Supervisor's declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidance on supervision of thesis laid down in the University of Cape Coast.

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VERITAS LUMEN NOBIS

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ABSTRACT

Obesity is found to have a significant impact on body image perception and overall well-being. In many western societies, being slim is deemed attractive and very much admired. However, in some developing countries, the opposite seems to be the case. This quantitative study assessed the influence of body image and weight-related stigma on the psychological well-being of obese women in the Kumasi Metropolis. A sample of 384 obese women purposely selected from health shops and some fitness centers. The body shape questionnaire BSQ-34, the inventory of the Stigmatization Situation (SSI) and finally, the psychological well-being tools were used. The statistical tools used for the analysis included frequency distributions, one-sample t-test analysis, Pearson Moment Correlation Coefficient, and simple linear regression analysis. The tests were conducted for significant differences at a significance level of 0.05. From the results, it was found that generally obese women in the Kumasi Metropolis were significantly satisfied with their body image. It was also found that, Perceived weight-related stigma does not significantly influence the psychological well-being of obese women on the Kumasi Metropolis. The study, therefore, concluded that psychological well-being of obese women in the Kumasi Metropolis is not affected by body image satisfaction and weight-related stigma. From the study, it is recommended that counsellors, clinical psychologists and other mental health professionals prioritize and tailor make their therapeutic practices and public lectures to enable concerned obese women to overcome their body image dissatisfaction.

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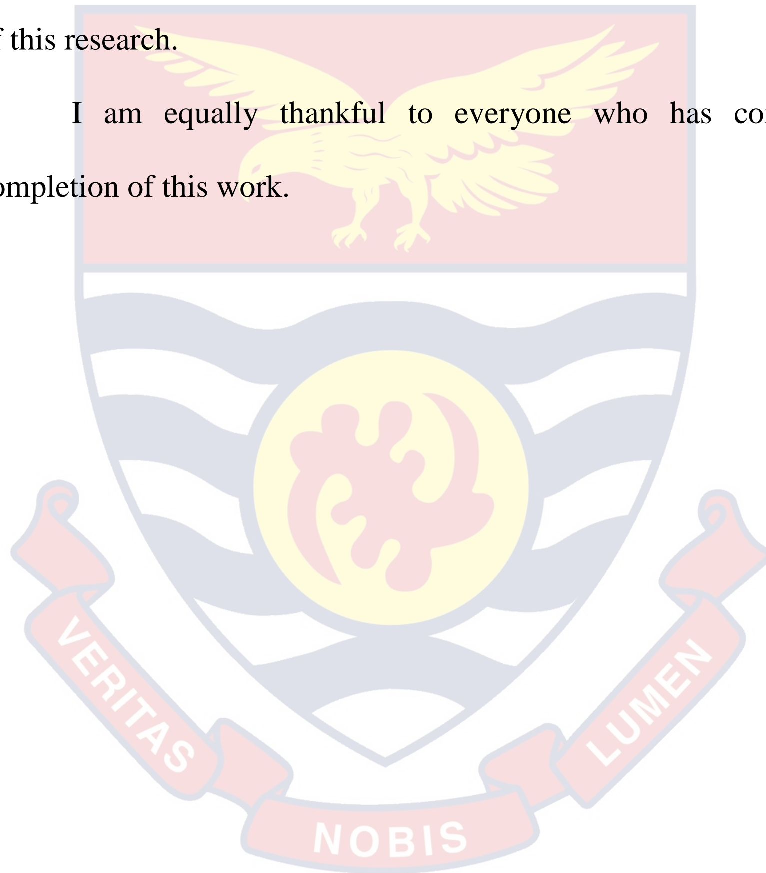
I am equally thankful to everyone who has contributed to the completion of this work.



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DEDICATION

To my husband Eric and our children Amanda, Richard, and David.

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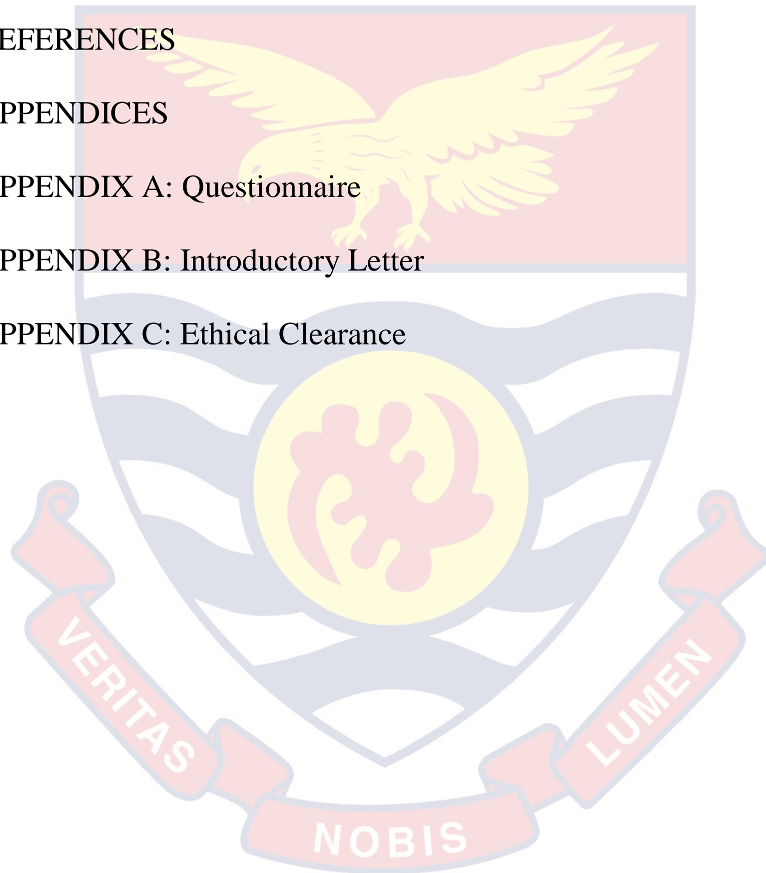

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CHAPTER ONE

INTRODUCTION

Background to the Study

Obesity is described as an unhealthy or excessive buildup of fat that is detrimental to one's health. According to World Health Organisation (WHO) (2020), over 1.9 billion people of 18 years of age and above were overweight. That is, 39 percent (38 percent of men and 40 percent of women) of adults aged 18 years and over were overweight. Of these, were obese (Guin & Bhatia 2020).

In sub-Saharan Africa (SSA) there has been an increase in obesity rates since 1990. Western Africa, for instance, has obesity prevalence increasing from 2.6% to 7% between 1990 and 2015 (Agyemang, Beune, Owusu-Dabo, Mockenhaupt, Addo & Stronks, 2016). Body image varies by gender, and while men usually prefer muscular bodies, women are more comfortable when they are slender. According to Kakeshita and Almeida (2008), males appear to underestimate their body size and are less concerned with weight regulation, while females have a tendency to exaggerate their body size. Sarwer and Polonsky (2016) found that obese women report a higher body image dissatisfaction. The WHO (2016) also has a higher population when it comes to obesity. The fact that women seem to be more worried with their physical appearance and are so willing to improve it sparks my interest to concentrate my research on women rather than men.

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Obesity has gradually risen in Ghana, from 0.9 percent in the 1980s to about 14 percent in 2003, with women having a higher prevalence than men (Amoah, 2003). Ghana ranked 100th out of 142 nations in the world's highest adult obesity prevalence ranking, based on the prevalence of female obesity in 2008 (9.3 percent) (Dake, Tawiah, & Badasu, 2011).

Among Ghanaian women aged 15-49 years, overweight and obesity rates increased from 10% in 1993 to 40% in 2014. The highest rate of 57% was recorded in the Greater Accra Region. In addition, Ofori-Asenso, Agyeman, Laar, and Boateng (2016), in their research on Systematic review on overweight and obesity epidemic in Ghana, reported that nearly 43 percent of Ghanaian adults are either overweight or obese.

A research on the Epidemiology of Obesity in Ghana by app also recorded that obesity was 7.9 percent and 2.8 percent more prevalent in females than in males. Obesity was nearly absent in the Upper East or Upper West, but it was most prevalent in Greater Accra (16.1 percent). The study also found that ethnic obesity was highest amongst Ga Adangbe (14.6 percent), followed by Ewes (6.6 percent) and Akans (6.6 percent). The married were more obese than the single. Obesity-by-age prevalence rose by age up to 60, and respondents with a higher educational level had more people who were obese. Among high-class urban residents, there were more overweight and obese than among low-class residents, and more in urban regions than in rural regions. Ghana Statistical Service (GSS, 2008), records that the overweight/obesity rate rose from 18 percent in 1987-89 to 35.1 percent in 2003, and to 40 percent in 2008.

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The issue of weight stigmatization also remains a challenge with the prevalence of obesity. Arday (2017) reports that some were stigmatized by the use of local names such as ‘okesei’, ‘obolo’, ’maame agbo’ and so on. Others name with social icons and television starts or artiste who are obese. According to their study, participants found these names very insulting for example some were called ‘Ngozie’ and ‘Muchoomudoo’.

The psychological impact of weight stigma in obese Ghanaians are not too different from what pertains in other countries. Duda et al., (2007) indicated that obese Ghanaian women were more dissatisfied with their weight than normal weight women. Many women expressed unhappy sentiments about how being overweight has affected their lives in terms of their health, work life and social life. It has caused many to be anti-social and has affected their productivity at work since they always tired.

The Ghanaian entertainment industry introduced a dance competition programme for obese people nationwide. This dance competition popularly called ‘di asa’ has brought about a lot of positivity in the lives of many obese Ghanaians. The programme has built confidence in a lot of obese individuals and unleashed a lot of potentials hitherto they were not aware of. The added advantage is that, most competitors at the end of the day would have lost significant weight thus improving their quality of life. This new move has contributed positively to the psychological wellbeing of the obese. There are also some fashion schools who have plus size women as models making society know and believe that modelling is not only for the skinny.

In Ghana, the socio-economic, cultural and geographic variations across the country have implications for the variations in obesity prevalence in

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the country (Bruce, 2016). Amoah (2003) as cited in Agyemang (2016) demonstrated that there is a presumed cultural valuation of fatness as a sign of good health, fertility, wealth, and beauty. An increase in body size/weight status after marriage is seen as a sign of good living and happiness as well as the husband's ability to take good care of the wife. Aryeetey (2016), also confirmed that though extreme obesity was considered undesirable by most Ghanaian women, some weight gain was admired as it was perceived as a sign of wealth and good care by a spouse.

The Ghana Demographic and Health Survey (GDHS) findings revealed a high prevalence of overweight/obesity (30.7 percent) among women in the Ashanti region (Ghana Statistical Service [GSS], 2008). The overweight/obesity rate was estimated to be 26% in Kumasi Metropolitan District Health Directorate (KMDHD) in 2008, specifically in Kumasi, the regional capital,

In Ghana consumption and the frequency of traditional meals by most mothers after child birth which are supposedly to cause milk secretion is also seen as a cause of obesity. These meals are typically starchy and in the end results in weight gain (Aryeetey, 2016). For example, the eating of fufu in major homes in Kumasi, which contains a significant amount of starch is seen as a causative agent to obesity. Appiah, Steiner-Asiedu, and Otoo (2014) conducted a study in Kumasi Metropolis, Ghana, to establish a link between dietary intake and health, level of physical activity, preference for body size, and body mass index (BMI) in women. Overweight and obesity were found to be common with Kumasi women in the sample. It also discovered that high

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dietary energy consumption, inactivity, and a desire for a large body size were all strongly linked to female overweight and obesity.

Body image dissatisfaction is predicted to be widespread as the incidence of obesity increases. The body image has also been defined as a subjective acceptance with one's body and is multidimensional, concentrating on how much one weighs, the extent to which people approve their body size and their shape (Medeiros de Morais, Andrade do Nascimento, Vieira, Moreira, Câmara, Campos, Cavalcanti, Maciel, & Almeida 2017). It is a mental image of what a person feels or looks like, which may or may not have a similar relationship to how others see them. Perception of a person's body size can be positive or negative and may be considered as accurate or inaccurate (an overestimation or underestimation of one's body) or a feeling of being pleased or disappointed towards one's body (Gilmartin 2013). A number of people are seeking to improve their bodies, according to the World Health Organization (WHO) (2016). People may call for these changes because they are not happy with how they look, and these could result from all kinds of distortions such as how we feel, exposures, experiences and behaviors of parents and society as a whole (Warren, Castillo, & Gleaves, 2009).

Dotse and Asumen (2015), opined that, the perception of body image has a great influence on psychological well-being. Body image perception is basically subjective and involves one's thoughts, emotions, and imaginations. Yam (2013) argued that cultural factors influence the development of body image, and that when a person perceives, either through people's remarks or self-assessment, when a person's physical appearance differs from that of others, it has an effect on their overall feeling and well-being.

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Obese people tend to feel stigmatized, and this feeling continues to affect their psychological well-being. Weight-based stigma is the societal rejection and devaluation of those who do not conform to the adequate body weight and shape of the prevailing social norms Major, Tomiyama, Carr, Granberg, Robinson, Sutin & Brewis (2018). Weight-based stigma has some negative psychological consequences, such as low body confidence, self-esteem issues, anxiety, and depression (Puhl & Heuer, 2009) and these psychological issues can prevent obese people from living to their full potential (Van, Hunt & Park 2015). Perpetrators of these forms of stigma could be in the homes, workplaces and even in health care centers. There is the likelihood that obese people may be experiencing some psychological issues due to how they perceive themselves and the perceived stigmatization they may experience from their environs.

After a survey of older West African women, Benkeser, Biritwum, and Hill (2012) indicated that almost half of the participants wanted a slimmer body size. In order to prevent stigmatization that comes with a certain weight status, young people seem to want to live up to the standards of beauty set out by the society to which they belong (overweight or underweight). A study among overweight women in the Ga District revealed that most of them are stigmatized and called many names like *obolo*, *oboshie*. This makes them feel uncomfortable stepping out of their homes, as well as going to public places, and thus results in making them anti-social (Aryeetey, 2016).

Statement of the Problem

Lake and Townshend (2006) defined obesogenic environment as the sum of influences that the surroundings, opportunities, or conditions of life

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have on promoting obesity in individuals or populations. In order to assess this characteristic, Bonah, (2016) suggested that individuals and various groups' interaction with their psychosocial environments in terms of physical activity, food intake and psychological wellbeing must be well understood. It was based on this suggestion that this study focused on factors like body image, and stigmatization as well as the psychological wellbeing of obese women.

In the western society, being slim is deemed attractive and very much admired (Bahadur, 2014). In some developing countries however, the opposite seems to be the case. According to Puhl and Heuer (2009), obesity could lead to stigmatization, and stigmatized overweight people who internalize these normative controllability values are more likely to experience psychological distress. These stigmas inhibit their bid to unleash their potentials and actualize themselves as individuals. That aside, they are at risk to various obesity-related diseases. These diseases could affect their productivity, financial status, and eventually their quality of life. This issue thus ceases to be an individual problem but a community and national one and there is the need to explore the phenomenon in the question. However, despite the signs and suggestions that obesity-related stigma could affect the individual's wellbeing and quality of life, studies seem silent on it. Studies have failed to delve more into the psychological implications associated with being obese. This dearth in research and literature paved the way for this study investigate more on the psychological wellbeing of obese women.

Most available studies (Nissen & Holm, 2015; Brown & Sweeney 2009) focused much on individual factors that could cause obesity and their rippling adverse health effect without incorporating how the influence of the

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individual's environment like body size perceptions and how society tend to make fun of and humiliate obese women. Thus, most studies focused on lifestyle and physiological processes (Anto, et al., 2020; Nissen & Holm, 2015). In addition, Nissen and Holm (2015) in their study reported that the bulk of the studies on obesity have been performed outside of Ghana, so little information is available about what is happening in Ghana. They therefore recommended in their study that future studies should cover wider and more differentiated geographical, social and cultural contexts. They again suggested that future research addresses the way perceptions have effect on the individual. This study was therefore conducted to address the situation in the Kumasi Metropolis.

Several studies in Kumasi, discovered that the rate of overweight and obesity among women is approximately three times higher than that of men and thus affecting a wide range of demographics (Anto, et al., 2020; Kumah et al., 2015; Obirikorang et al., 2015; Ofori-Asenso et al., 2016; Obirikorang et al., 2016). For instance Ofori-Asenso et al., (2016) in their study comparing prevalence at the regional level found that the Ashanti region was second to Greater Accra region with the highest number of obesity. Some reasons for the high prevalence in Kumasi included social lifestyle which is typically characterized by funeral celebrations, social gatherings and an abundance of food consumption. Again there is lack of physical activities coupled with sedentary lifestyles from the women most especially the market women who sit at one place all day selling (Anto, et al., 2020). This invariably affects the percentage of obese people found in such an environment, making it an ideal location for such a study. As a result of the studies above, Kumasi is a good

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place to carry out this research. Ofori-Asenso et al., (2016) recommended that the high and rising burden of obesity should be of concern to health and allied workers. It is of concern of concern because not only does it affect the individuals physically but the change in body size and image calls comes with its rippling psychological implications resulting from stigmatization and body shaming.

Researchers such as Benkesesr, Biritwum and Hill (2012) as well as Appiah, Steiner-Asiedu and Otoo (2014) believe that little is known about the psychological effect of body image on the Ghanaian woman. For instance there is the likelihood that a number of Ghanaian women are unhappy in their marriages and relationships because their male counterparts are unhappy with their body sizes. This could probably be due to the perception that being slim is more attractive and better. This stigma is has become imperative to conduct this research to assess the degree to which weight-based stigma affects the psychological well-being of Ghanaian women.

Purpose of the Study

The purpose of the study was to find out the influence of body image and perceived stigmatization on psychological well-being of obese women in the Kumasi Metropolis.

Research Objectives

Specifically, the study sought to:

1. Determine the level of body image dissatisfaction among obese women.
2. Determine the level of perceived stigmatization among obese women.

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3. Determine the state of psychological well-being of obese women.
4. Determine the relationship between body image and perceived stigmatization of obese women.
5. Determine how body image influences psychological well-being of obese women.
6. Determine the influence of weight-based stigma on psychological well-being of obese women.

Research Questions

The following research questions were looked at in order to address the objectives of the study.

1. What is the level of body image dissatisfaction among obese women?
2. What is the level of perceived weight-based stigma among obese women?
3. What is the state of psychological well-being of obese women?

Research Hypothesis

1. Ho: There is no statistically significant relationship between body image and perceived stigmatization of obese women.

H_1: There is a statistically significant relationship between body image and perceived stigmatization of obese women.

2. Ho: There is no statistically significant influence of body image on the psychological well-being of obese women.

H_1: There is a statistically significant influence of body image on the psychological well-being of obese women.

3. Ho: There is no statistically significant influence of weight-based stigma on psychological well-being of obese women.

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H_1: There is a statistically significant influence of weight-based stigma on psychological well-being of obese women.

Significance of the Study

A relatively new phenomenon in Ghana is the idea of obesity, stigmatization and how it affects a person psychologically; hence, counsellors, psychologists, weight loss consultants, teachers, health practitioners such as nurses and doctors, and the general public will all benefit from the results of the report.

This study could enable counsellors and psychologists understand the obese better during therapy and counsel them through any psychological distress they may experience. This study may also contribute to intellectual knowledge on obesity, its perceived stigmatization and the kind of psychological distress the obese go through. It may also facilitate understanding on the subject of body image perception and weight-based stigma through awareness creation and, therefore, make people conscious of these issues, thereby minimizing weight-based stigmatization. Also, the research sought to provide literature that could help the individuals, institutions and firms that render weight loss services, to improve implementation of their services and overall performance. It can also aid health care professionals in their efforts to resolve this crisis and improve the functioning of these programs in the metropolis and country. It may also make the general public aware of and help the obese in this region. The results could also give rise to discussion between students and academics and give rise to interest in more weight control research.

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Limitation

This study was limited in so many ways. Despite the fact that the sample size was determined using an appropriate and approved formula, the surge of the Covid'19 prevented the researcher from accessing certain premises, affecting the sample size. Also, the time for the research was limited considering the nature of the topic and the disperse nature of the study area. Additionally, due to the sensitive nature of the topic, the respondents had to be persuaded before getting them to willingly answer the questionnaire. However, with the use of time schedule, much of the work was done on schedule and the necessary data gathered.

Delimitation

The study centered on obese women in the Kumasi Metropolis. Kumasi in the Ashanti region of Ghana. Culturally, Ghanaians see large body size in a good light and, specifically, women in that group are viewed as attractive. This mentality poses a psychological obstacle that militates against the understanding of overweight/obesity as a health problem and the incentive to regulate weight. A study in Kumasi, Ghana's second-largest city, found that the rate of overweight and obesity is about three times higher among women than men. Social lifestyle in Kumasi encourages binge eating, social gatherings and abundance of food consumption. This invariably affects the percentage of obese individuals, which also made it a good location to carry out such a research.

Operational Definitions of Terms

Weight based stigma: Weight based stigma is any discriminatory behavior targeted at people because of their body weight.

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Psychological well-being: Maintaining a state of calm when confronted by both challenging and enriching experiences.

Body image: The mental picture or perception an individual has with respect to their weight, shape or size of body which could either be positive or negative.

Organisation of the Study

The Introduction, history of the study and the problem statement are addressed in Chapter one; which also covers general and relevant aims, study problems, meaning, nature and limitations of the research. Reviews of related literature is covered in chapter two. The chapter also looks at definition of words used by researcher, related theories, and a description of related work. Chapter three illustrates the study's approach. Areas looked at are the sample, population of the method or techniques of sampling and sampling, questionnaire administration and collection of data. The data analysis is provided in Chapter four. Finally, Chapter five provides an overview, conclusions and recommendations based on the data results.

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CHAPTER TWO

LITERATURE REVIEW

This chapter provides a review of the literature on the subject of the study. Various ideas on the representation of body image and the stigmatization of the obese are discussed. The chapter discusses the numerous research studies on weight-based stigma and its psychological consequences. It offers a number of arguments on the related aspects of the matter. It also looks at body image, the implications of perceived weight-based stigma, and the psychological impact on well-being. Finally, it presents a conceptualization of the study in a framework vis-à-vis the study's variables.

Conceptual Review

WHO Case Definition for Obesity

The World Health Organization's medical conception of obesity makes reference to it as a state of increased body weight, especially with regards to adipose tissue accumulation that results in adverse health implications (Hebebrand, 2020). This is consistent with the definition by the world Health Organization which states that obesity is an abnormal or excessive fat accumulation that may impair health (Kim, 2016). Academic discourse on obesity in the past had been critically been impaired by the absence of an objective, gender-neutral criterion for assessing obesity. The introduction of the body mass index introduces a remarkable consensus in academia and biomedicine by establishing, to a high degree of objectivity with regards to who should be considered as an obese (Wang, 2000).

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The BMI, as a weight classification system leverage on measurements of height and weight (Abrams et al., 2013). The BMI is expressed as the ratio of an individual's weight in Kilograms to their height in meters squared. The standards of the World Health Organization make reference to the fact that a BMI below or equal to 18.5 corresponds to underweight whiles a BMI between 18.5 and 25 is correspondent to a normal weight. Overweight individuals have a BMI of 25 to 29.9. A BMI of above 30 reflects the condition of obesity (Abrams et al., 2013). There is an exception for pregnant women given the fact that pregnancy is a naturally weight inducing condition under biological consideration

Limitations of the BMI

Despite the fact that the body mass index provides a reliable and objective metric of assessing body weight, it is not without limitations (Buss, 2014; Gurunathan & Myles, 2016). For example, it significantly fails to reflect ethnic diversity among populations due to the fact that the cut off points were determined using primarily Anglo-Saxon populations (Boyanov, 2016). It further fails to reflect significantly on the differences in human physique with regards to the different makeup of fat muscle and bone (Cheng et al., 2010). This ultimately suggests that it is possible for an overestimation of body fat in people who are very muscular such as athletes or possibly under estimate body fat and individuals who have significantly lost muscle mass.

In cognizance with these limitations, the BMI is often utilized in conjunction with some other tools and mechanisms for assessment in order to determine health status and a comprehensive body classification (Buss, 2014). For example, measures of weight circumference enable the determination of body

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shape and how excess weight is carried whiles weight to hip ratio is sometimes adopted. Regardless of limitations, the BMI has established credibility since the 1980s following its adoption by the world Health Organization as an international system of weight classification (Madrigal, 2000). The BMI has an inherent advantage with respect to simplicity, convenience and affordability. It continues to be the most widely adopted and frequently used measure for defining and diagnosing obesity. With regards to its functionality be as an ideal mechanism for characterization and knowledge construction on obesity, it serves as the basis and central principle with respect to policy projections on obesity with respect to treatment, control and prevention of obesity (Zhao & Zhang, 2015).

Social Construct of Obesity

Irrespective of the conventional beauty standard in most societies, very thin or plump physique is considered as a deviation from the socially ascribed perspective of beauty (Barbieri, 2015 ; Sobal and Maurer, 1999). Even though there is a cultural shift in perspectives in contemporary societies, there is still a preoccupation with human exteriority as a basis of stereotype. body image forms a significant part of the features that distinguish personalities (Deschamps et al., 2014; Nolan, 2017).

Body image has become a baseline stereotype in predicting identity and personality traits. Previously, obesity had a connotation with wealth and good health as suggested by the thrifty gene theory. In this consideration, it was socially perceived that only the rich had the potential to access abundance of food and avoid energy draining works (Brady, 2016). With shifts in human civilization, obesity is now closely associated with concerns of anxiety and a

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deviation from the standard of beauty. This has resulted in the need for redefinition and social control of obesity. There has been a massive generation of academic models and discourse in an attempt to advance the medical, moral and ideological claims with respect to the causes and solutions (Watt, 2010).

Risk Discourse on Obesity

At the heart of the subject of medicalization of obesity is the issue of risk and surveillance. The risk discourse is intended to reduce, manage and prevent the condition of obesity to the supposed ideal body weight (Watt, 2010). This is significantly reflected in the prevailing circumstances of surveillance, routine measurements within populations and individual-level, even at home through self-diagnosis and self-treatment. There is a significant adoption of skills, self-help, books, diet, books and over-the-counter pharmaceutical products to help in managing obesity (Bhaskar, 2021). This form of biomedicalization of obesity exists outside the medical space. Individuals take voluntary actions without specific collaboration and direction or prompt by health officials in most circumstances (Finlayson, 2017). In this particular regard, the attempts made by individuals to avoid or manage risk are manifested through the consumption of weight-loss goods and services as presented in today's techno-scientific society that ultimately makes available innovative corporeal possibilities.

According to Harjunen (2017), there is an intersection between individual and Society level which leads to commodification of obesity and thus, represents an assimilation of the external world into the internal world or psyche of the individual. This ultimately suggest that the biomedical based obesity discourse has a close association with development in larger neo

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liberal market economy which is significantly influenced by the risk discourse that causes individuals to make considerations about their body image by reinforcing stereotypes and evolving ways of stigmatization for those who do not make these efforts to reduce weight. More importantly, the ascription of a disease status to the condition of obesity is leveraged upon by stakeholders in lobbying for and promoting weight loss product and services. This has generated a wide range of industries specializing in food and equipment, fitness clubs, gyms, weight loss clinics, self-help guide systems, cosmetics and Pharmaceuticals (Hannele Harjunen, 2017). The reinforcement of the biomedical epidemic and risk discourse of obesity is significantly linked to the subject of stigmatization and unhealthy stereotypes against obese individuals (Stephen & Walker, 2017).

Media Complicity in Framing the Obesity Discourse

There has been a significant reinforcement in the media with regards to the fact that obesity is an easily preventable condition which does not only threaten financial viability of national healthcare and individual health systems, but also characterizes obese people as irresponsible social liabilities, thereby imposing close expectations of moral imperatives on them (Marinescu, 2020). The obese, in this regard is given an aspirational duress to act in order to reverse the supposed risk that is a reinforced within the media narratives. In recent times, the mass media has been a haven of significant source of both lay and biomedical knowledge on obesity, thereby forming an active part in the social construction of obesity as a problem (Ward & Moran, 2007). Significant emphasis is placed on the biomedical discourse to selectively sensationalize academic research findings in thought-provoking

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metaphors. This situation has been significantly exacerbated within social media landscape and television reality shows, thereby reinforcing dominant obesity knowledge base with regards to the social understanding of the condition (Atanasova, 2018). There is a media portrayal of obese people as over eating people as depicted in television reality shows and the pop cultural celebration of thinness in fashion, film and other mainstream media (Monaghan et al., 2014). This causes a widespread propagation of risk, fuels in fear of obesity-related problems, thereby causing significant signs of anxiety, stress and tension among obese people (Marinescu, 2020). This reinforced narrative is also leveraged upon in stigmatizing and discriminating against these people within broader facets of society.

Implication of a Disease label on Obesity

Following the declaration by the world Health Organization with reference to obesity as a disease, there is a far-reaching ramification with respect to intractable social dilemma that is created for obese people (Rao, 2018). Not only does the biomedicalization of obesity create discernible experience through scales and weight classification systems but more importantly, it imbues life into and helps to fuel that experience (Hattori & Sturm, 2013). While the disease tag can be beneficial sometimes with reference to social equity, in most significant instances, it is closely associated with varied forms of stigmatization and discrimination. There is the existence of substantial scholarly work across several disciplines that critique the dominant biomedical perspective that obesity is an epidemic (Hilton et al., 2012). Regardless of this, the epidemic perspective is still entrenched within public consciousness and characterization of obesity. Biomedicine has

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fundamentally remained a dominance spectacle through which people actually read and organize their conception of their bodies in specific attempt to improve or enhance on their bodies and lives (Pi-Sunyer, 2012).

Entrenching the narrative that obesity is significantly preventable, curable and probably through very simple common-sense lifestyle changes in diet and physical activity, the biomechanical paradigms signal a varied view that obesity is an issue of individual lifestyle choice and behavior (Pi-Sunyer, 2012). This forms a huge part in the origination of social consciousness and framing of individual perspectives and social narratives on obesity. Whiles the individual is blamed, the medical field, yet, remains firmly in control with respect to what a cure entail. This establishes a framework of preclusion of the multivariate and sophisticated nature of the condition, thereby promoting an individualistic and reductionist approach that heavily places moral and social responsibility for losing weight on the obese (Hilton et al., 2012). A portrait of self-indulgence, lazy, out of control and unattractiveness is reinforced by an individual's inability to lose weight (Herman & Polivy, 2011). This often has a significant close association with psychological health and emotional well-being of the individual who is often marginalized and sometimes socially excluded in a number of instances (Wisman & Capehart, 2010). Studies have also found a close association with depression anxiety, self-blame, isolation and sometimes, suicidal ideation which is often emanated from the sense of failure that characterizes their unrealized weight loss. This ultimately suggests that a disease label on a bay city has an adverse implication on the individual.

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Relationship between Body Image and Perceived Stigmatization

According to Cash and Hicks (1990), whatever weight a person assigned to him/herself had a good relationship with their body image, weight problems, eating/dieting habits, and overall psychosocial well-being. Many who believe that their physical appearance, physical health, and well-being are obese are the ones who are the most dissatisfied. Males and females who tend to be obese show lower psychosocial well-being, including dissatisfaction with life and feelings of isolation, depression, and low social and self-acceptance. Though obese people may subject themselves to such distress, it sometimes turns out that what they believed does not reveal what they are, but is, instead, just a mental picture they have about themselves. An integral part of self-worth and mental well-being is the appearance of the body.

Body image creation is a part of its self-evaluative nature. It is greatly affected by the "goodness of fit" between the body's self-evaluation, the perceptions of one's physical self, and others' assumed judgments. The image of the body is the central element of self-worth and mental health. The development of the image of the body is a function of its self-assessing existence. The "goodness of fit" between the body's self-evaluation, one's physical self-perceptions, and the perceived evaluations of others has a major effect (Rosenblum & Lewis, 1999).

According to Medeiros de Morais et al. (2017), The body image structure focuses on the weight, shape and extent to which people are satisfied with their appearance. However, this varies according to factors such as culture, gender, and status in life. In many cultures, men prefer muscular bodies, whereas women tend to admire slimness (Cash & Hicks, 1990).

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Age also influences desired and real body images, and a person may change their image perception as they age. Negative view of the body image may have complex health and quality of life effects, leading to psychological problems like self-esteem issues, the tendency to be depressed and eating disorders. Rosenblum and Lewis (1999) pointed out that body image perception and perceived stigmatization could start as early as adolescent years. For adolescents, girls' image may worsen while boys' increase in satisfaction.

Culture also plays a role in body image since it clearly shows differing criteria concerning attractiveness. Bouzas, Bibiloni and Tur (2019) observed a different satisfaction level with ethnicity. Several studies have indicated the preference for larger body sizes by Africans, African Americans, and Caribbeans (Rosenblum, & Lewis, 1999). In Ghana for instance some cultures equate weight gain to a sign of prosperity and good living. Amoah (2003); Puoane et al., as cited in Agyemang et al (2016) showed that culturally, there was variation in how fatness is perceived, as a symbol of good health, fertility, wealth, and good appearance. An increase in post-marriage body weight status is perceived as a symbol of a good life and happiness, and willingness of the husband to take good care of the wife. Aryeetey (2016) also confirmed that though extreme obesity was unwelcome by most Ghanaian women, some amount of weight gain was desired and seen as a sign of wealth and good care by a spouse.

The stigma associated with weight stems from various sources in any given society. According to Puhl, Moss-Racusin, Schwartz, and Brownell (2008), close relationships were the most frequent perpetrators of weight-

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based stigma. Unfortunately, not only friends and close relations are perpetrators but also public officials, health care providers, the legislator, and politicians, just to name a few. According to literature, in many fields, including the workplace, social environments, education, and in encounters with health professionals, obese people are stigmatized and discriminated against (Lewis, Thomas, Blood, Castle, Hyde & Komesaroff, 2011).

The internalization of anti-fat prejudice among overweight people through a range of attitudes and stereotypes was researched by Wang, Brownell, and Wadden (2004). According to their study, although many individuals worldwide frown on biases among different groups, the bias towards people who are overweight is accepted and even encouraged. The theory of social identity suggests that members of a different group will receive their own group members more favourably and view members of other groups more negatively (Ellemers, Kortekaas, & Ouwerkerk, 1999). Among obese individuals, however, this is not the case. Overweight individuals tend to experience more unfavorable attitudes from members of the same group.

Mental health practitioners are described as people engaged in the direct provision of counseling and therapy. This indicates a wide variety of occupations and educational backgrounds, such as mental health counsellor, recovery counsellor, substance addiction counsellor, psychiatric social worker, family therapist, counselling psychologist, psychiatric nurse, psychiatric assistant and psychologist. Young and Powell (1985), show that obese clients have been measured more harshly than their counterparts of average weight. Mental health professionals, when working with these clients, may use treatment strategies possibly according to the level of obesity of the client. For

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instance, symptoms like emotional behavior or obsessive-compulsive behavior ascribed to the obese may generally dictate certain therapeutic responses, which may lead to differential treatment (Young & Powell, 1985).

General observation in Ghana revealed that people "not so fat or skinny" are considered desirable and can blend in well with friends and enjoy social interaction. Oduro, as cited by Tuoyire et al. (2018) noted that most women preferred to be busty, have big buttocks, curvy hips and generally a nice body figure. The well-being of the obese is affected by the perception they have about their bodies. Those who hold negative perceptions about their bodies could have a feeling of sadness, shame, and isolation (Oduro as cited by Tuoyire et al., 2018). The environment must offer them the necessary support. On the other hand, obese individuals who can hold on to a positive body image tend to live fulfilling lives (Fenton, Brooks, Spencer & Morgan, 2010). They are pleasant, they get more from others, they are achievers, and most importantly, it is a better choice for their health (Fenton, Brooks, Spencer & Morgan, 2010).

Relationship between Body image and psychological well-being of the obese

The psychological well-being of a person can be affected by their body image. This could be how one sees self or how he/she is perceived by society. The three dimensions of body image are perceptual, emotional, and behavioural (Cash & Green, 1986). The cognitive domain is concerned with the understanding of one's physical appearance, such as weight, height, and body shape (Cash & Green, 1986). The subjective dimension is related to the satisfaction one has about his/her appearance (Cash & Green, 1986). It also

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includes the concern and anxiety the person may have about their appearance. Some obese individuals can be so uncomfortable with their appearance that they tend to isolate themselves and avoid public places. They dread the experience and association with the members of society, be it at work, social gatherings, etc. The aspect where people avoid exposure, become anxious and uncomfortable about themselves can be seen as behavioral (Cash & Green, 1986).

Perceived differences between appearance and ideal body image result in dissatisfaction which may lead to depression, isolation, loss of self-confidence, and obsession with weight loss. This shows that internalization of negative body image has devastating effects and as such obese individuals do need psychological support. (Yazdani et al., 2018).

The “enormous psychological burden” created by obesity may cause psychiatric disorders and poor quality of life, aside from the body image disturbances. According to Jackson, Beeken, and Wardle (2015), the extremely obese proved to have the most devastating psychological effect. According to Young and Powell (1985), the number of obese people seeking mental health care could be higher than the general population's treatment rate.

Overall, obesity affects the satisfaction of life, and evidence suggests that obesity is negatively linked to the satisfaction of life. Obese citizens are less happy with their lives in general. They tend to be unfulfilled in various ways, and though the emotional cost of obesity could be dear for both genders, research has shown that women generally pay a higher emotional cost for being obese than their male counterparts do. (Wadsworth & Pendergast, 2014).

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According to Drewnowski, Kurth, and Krahn (1994), Obesity is likely to have psychological consequences even in teens, which could lead to non-assertion or eating disorders such as anorexia and bulimia. Duda et al., (2007) stated that Ghana's obese women were less pleased with their weight than the ordinary women. Many women expressed unease about the effect of overweight on their health, working life and social life. It has caused many to be anti-social and has affected their productivity at work since they always feel tired.

Relationship between Weight-Based Stigma and Psychological Well-being of the Obese

Stigmatization is a global problem that, based on race, class, capacity, gender, and sexual orientation, is expressed in various ways. In recent years, weight-based discrimination has become much more prominent than discrimination based on race or ethnicity. Weight bias can be explained as any negative attitude and beliefs about obese people which could be prejudice or stereotypes towards them. Though a lot of these stereotypes originate from external sources, sometimes, individuals also do hold certain internalized anti-fat beliefs which also could affect them negatively.

Repeated teasing, bullying, abuse, and hostility, name-calling, marginalization, and social exclusion are all examples of weight-related stigmatization. For instance, an obese individual can be denied access to health care or educational opportunities. Though weight-based stigmatization happens to both sexes, studies reveal that females tend to experience stigmatization more than their male counterparts.

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In all, the media has played an immense role in propagating the stereotypes. Popular narratives by the media and other sources about attitudes of obese people, their inabilities and failures, all hype the negative social pressure they experience. Some of these comments overlook factors like illness, injury, and genetics as causes of obesity and dwell more on the food they consume and their inactivity, thereby making obese people appear lazy in the sight of the masses. In the USA, studies show that 72 percent of media images and 77 percent of videos stigmatize the obese. (Andreyeva, Puhl & Brownell, 2008). In most cases, fat-shaming intends to ignite a positive attitude in the obese to promote weight loss. However, it sometimes ends up being the opposite and rather results in stress which for some people leads to overeating and thus compounds their situation. (http://www.unconrud dcenter.org).

The effects of weight-based stigma cannot be overemphasized. It is the cause of health inequality and affects people more than any issue they may have. Since even health professionals are perpetrators, it can lead to poor health care and increase mortality. The stigma associated with the condition fuels obesity and mental illnesses. Weight-based stigma is associated with severe physiological and psychological effects and leads directly to lack of confidence and satisfaction in one's body as well as low self-esteem, depression, eating disorders, feelings of worthlessness and isolation, thoughts and acts of suicide, depression, anxiety, habits of maladaptive eating, and avoidance of physical activity.

According to Magallares, Morales, and Rubio (2011), Obese people's psychological well-being suffers as a result of prejudice, as factors such as

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self-esteem and life satisfaction are influenced by social exclusion. People need to be educated on the effects of stigmatization on the obese. Such people include family, friends, and health care providers. Eliminating weight stigma would significantly benefit everyone's wellbeing, regardless of gender, age, or race. Obese people have to come to terms with either living with the stigma from people or accepting themselves by dealing with the negative body image expression which comes with it (Macedo, Portela, Palamira & Mussi, 2015).

The psychological impact of weight stigma in obese Ghanaians is not too different from what pertains in other countries. The issue of weight stigmatization also remains a challenge with the prevalence of obesity. According to Arday (2017), some obese women were stigmatized by the use of local names such as '*okesei'*, '*obolo'*, *'maame agbo*', and so on. Some perpetrators also give nicknames to social icons and television stars or artiste who are obese. In their study, participants found names such as '*Ngozie'* and '*Muchoomudoo'* very insulting.

In recent years, the Ghanaian entertainment industry introduced a dance competition program for obese people nationwide. This dance competition, popularly called 'di asa,' has brought about a lot of positivity in the lives of many obese Ghanaians. The program has built confidence in a lot of obese individuals and unleashed a lot of potentials that hitherto they were not aware of. The added advantage is that most competitors at the end of the day would have lost significant weight through dancing, thus improving their quality of life. This new move has contributed positively to the psychological well-being of the obese. Some fashion schools have plus-size women as

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models, thereby making society know and believe that modeling is not only for the skinny.

Prejudice and Anti-fat Beliefs

Anti-fat beliefs can be explained as strong negative thoughts, feelings, and beliefs an individual may have regarding their weight. These feelings could be assumed and not necessarily be true. It has become evident now that a lot of people hold anti-fat beliefs and this increases their struggle when they think about body image. Obese people, according to new studies, will internalize their weight-bearing habits, leading to self-directed shaming and negative self-perceptions. Weight-bearing internalization can also cause poor quality of life and poor health, binge eating, and ill-adapting health habits.

Statistically, most females, and about a fifth of males, tend to feel overweight. Any weight assigned to a person has a clear connection to his/her attitude on image, weight issues, food and eating habits, and overall mental well-being (Cash & Hicks, 1990). People who hold anti-fat beliefs tend to internalize negative stereotypes which affect them greatly. Obese people expressed greater dissatisfaction with their physical appearance, fitness, and health. According to their findings, self-described overweight males and females registered lower psychosocial well-being, including less life satisfaction, isolation, depression, and low social and self-acceptance. An individual may have a different feeling or mental picture of themselves which to them is a discrepancy from the normal acceptable appearance or body image. This self-discrepancy of the person can therefore be said to be a cognitive mechanism that results from a perceived discrepancy between two

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self-states, and this perceived discrepancy then results in and contributes to emotional reactions.

According to Elkan-Barak and Bar-Anan (2018) anti-fat bias attitudes and perceptions were evaluated using three theories, namely the attribution theory, the social identity theory, and sociocultural theory. The social identity theory can be explained as a person's concept of self which comes from a group they identify with or belong to. When a person perceives themselves as part of a group, it becomes an in-group for them. If, however, they do not identify with a group, it becomes an out-group for them. Hence there is the 'us' versus 'them' mentality. A person who perceives himself/herself to be slim will conclude that anyone who is not like them or who doesn't possess their kind of physical characteristic is fat. The belief that one is like people who are fat creates that distinction and differing identity.

Elkan-Barak and Bar-Anan (2018) explained the socio-cultural theory as social interactions and culturally organized activities that play a role in the psychological development of an individual. Tradition is likely to influence preference for big bodies among older women, whereas preference for younger women is due to the media influence of the slim western body size. Even though cultural ideas had an influence, women of the same culture who had high educational status preferred smaller healthier bodies than their uneducated counterparts. (Appiah, Otoo & Steiner-Asiedu, 2018).

Aryeetey (2016) in his study on the Perception and Experience of Overweight Women in The Ga District, points out that some causes of weight gain are inactivity, gluttony, childbirth, and the use of contraceptives. In Ghana, high consumption of food and the frequency of traditional meals by

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most mothers after childbirth, supposedly to cause milk secretion, is also seen as a cause of obesity. These meals are typically starchy and, in the end, results in weight gain.

According to Reichmann, Costanzo, Zelli, Ashmore, and Musante (2005), overweight people are prejudiced against their peers and hate other overweight people almost as much as non-overweight people. Obese people can have stereotypes and anti-fat biases, which may affect their mental health. It has been found that the adverse effects of these interactions are especially detrimental to those who hold strong anti-fat beliefs because they have lower self-esteem than those who support weak anti-fat beliefs.

There is a high level of anti-fat bias even in healthcare providers. Even obese medical students who hold anti-fat beliefs sometimes abuse alcohol and other substances due to internalized weight stigma. This adds to previous studies that the level of anti-fat beliefs an individual may have, could go a long way to affect them psychologically, and even yield unpleasurable results. (Bookwala & Boyar, 2008).

Theoretical Framework

This study looked at the theory of self-discrepancy, Goffman's Stigmatization Theory, and Carol Ryff's Psychological Well-being Model.

Self-Discrepancy Theory

The definition of the self is multifaceted and dynamic and includes different attributes or domains that describe the self. Tory E. Higgins, in his theory of self-discrepancy (SDT), argues that implications that occur when a person equates one self-state to another self-state and sees a discrepancy between the two. (Higgins, 1987). Most people are uncomfortable when they

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realize that they are different from other people, especially if they fall outside a socially approved category. According to the principle of self-discrepancy, there are three domains of self: the 'real' (or existing) self, the 'ideal self,' and the 'ought 'self.' The 'real' self represents the perception of a person of his or her own characteristics or attributes. The 'ideal' self is the attributes or characteristics that the individual or someone else would prefer the individual to be or possess. These may be ambitions, dreams, expectations, and wishes. The 'ought' self reflects the qualities that the person or someone else thinks the individual should possess. It may be a reflection of someone's sense of obligation, duty, or responsibility. According to Higgins (1987), four categories of self are described as real/equal/equivalent, ideal/equal, real/equal, and proprietary/equally equivalent.

The analysis of Hu, Kumar, Huang and Ratnavelu (2017) emphasizes that online users distinguish between the ought self, the ideal self, and the real self. The three self domains have been reported differently and have a direct effect on the level of satisfaction of users. Research has found that a reduction in self-expression, increased self-expression and genuine negative self are related to user satisfaction in the Social Network website. People can choose to regain their virtual identity by using a more ideal self, less self and a more negative real self (Hu, Kumar, Huang & Ratnavelu, 2017), thus reducing the self-discrepancy between their online identity and self-guidance (Hu, Zhao, & Huang, 2015; Hu, Kumar, Huang & Ratnavelu, 2017). This, therefore, provides support for the idea of the ideal-actual discrepancies in the body image of women (Oliver & Flint, 2014). Kowner's research (2004) further describes the definition of multifaceted and complexity of self, which

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reinforced earlier reports of low body satisfaction among young Japanese adults and indicated that a difference between the perceptions of the real body and the ideal self-esteem and predisposition to interpersonal phobia is primarily expected. This demonstrates and confirms the likelihood of a difference between the actual state of the attribute of an individual from its own point of view and ideal expectations.

Argyrides and Sivitanides (2017) further endorsed the theory of disparity by indicating that weight-related anxiety and beauty-satisfactory predictors were important for the actual ideal difference among girls and boys. The real-ideal difference in weight refers to the difference between what is perceived by the individual's weight (actual weight) and what is accomplished by the individual (ideal weight) (Vartanian, 2012). Although there is a substantial difference between actual and ideal body weight, the structures are not identical. The real ideal weight difference is a way to quantify the level of disappointment in a quantitative way. Many surveys have shown that a large number of people are unhappy with their body weight. Furnham, Badmin, and Sneade (2002) reported that the difference between real and ideal body weight is connected to body satisfaction. Therefore, the discussions and the extant literature provide adequate support for the adequacy of the theory of self-discrepancy in explaining the influence of body image perception on the psychological well-being of obese women. This theory is therefore selected to underpin this study.

Goffman’s Theory of Stigmatization

As conceptualized by Goffman (1963), stigma can perhaps best be identified as any socially discrediting characteristic possessed by an

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individual. According to Goffman (1963), stigma stems from an identity conflict. This occurs when a person before us possesses an attribute different from what we expect others in the category to have. Thus, he frames the stigma as being induced by the tension between what the social discourse expects of an individual and the reality of what and who they actually are. This earlier discourse of Goffman (1963) was confirmed by the study of Santuzzi, Metzger and Ruscher (2006) that with greater and higher anticipation for future interaction, especially in the case of a more negative body image, there is an association with less positive relationship expectations. However, when not expecting future interactions, negative body image predicted optimistic relationship expectations. This effect has been reported to be partially mediated by an increased emphasis on self and a partner as a collective unit (Santuzzi, Metzger & Ruscher, 2006).

According to Jones, Farina, Hastorf, Markus, Miller and Scott (1984), the degree of stigma can be classified into six dimensions which are: controllability, disruptiveness, concealability, aesthetic, origin and peril.

Controllability is the degree to which the cause of the stigma can be controlled. In this instance, when an obese person does not make an attempt to lose weight, they are blamed for their illness and kept directly responsible for their situation. The concept of controllable stigmatization is supported by a study by Watson, Levit, and Lavack (2018) that emphasized that bias against obesity is largely focused on the assumption that the disorder is under the control of an individual and is a character defect for which one is responsible. The negative view is the driving force behind weight discrimination in the workplace, from the CEOs to HR practitioners, and involves decision-making,

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recruitment and promotion. The weight loss discrimination in workplaces causes detrimental effects on the obese, the overweight and the community (Watson, Levit & Lavack 2018).

Disruptiveness is the degree to which something interferes with social interactions and relationships. It assesses how much in this instance an obese person's condition may impact relationships or success in society. Magallares, Morales, and Rubio (2011) demonstrated that some obese people are lazy at work and thus prove to be unproductive.

Origin is the responsibility attributed for causing or maintaining the stigma condition. This could be biological or genetic. Fat-cell theory holds that the percentage of body fat an individual carries is determined by the number of fat cells in the body, which in turn is partly determined by inheritance and partly by eating habits (Burniat et al., 2006). As such, if obesity runs in a family, chances are that majority of its members would be obese. Other causes could be as a result of lifestyle or life conditions such as sheer indiscipline with meals, hormonal reactions after childbirth, or inactivity. The discourse on the degree of stigmatization of obesity in the general public and the associated factors were further confirmed by the study of Sikorski et al., (2011) that asserted that the various forms of stigmatization attitudes exhibited by people were due to both external and internal factors. The commonly reported attributions were regulative prevention and childhood prevention.

Concealability is the extent to which a condition is either hidden or apparent to others. Some stigmatizing situations are obvious. For instance, hardly will an extremely obese individual go unnoticed. As a result, this trait

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aids society in distinguishing and stigmatizing people based on their visibility. In support of the concept of stigmatization of concealability, the study by Jeon, Hale, Knackmuhs and Mackert (2018) suggested that more than twice as many remarks were made against overweight individuals verbally than those defended online.

Aesthetics as a dimension of stigma is how society reacts to an existing condition, with dislike or disgust. Discomfort may be created when a person's or a group's assumed actions do not fit anticipated social norms. From literature, obesity is linked to attractiveness and thus, it is easier for society to label or avoid the obese (Young & Powell, 1985). In support of this dimension, Jeon, Hale, Knackmuhs and Mackert (2018), in a report, shed light on the troubling situation of recurring, uninhibited violent messages toward overweight individuals online. Overweight women are blamed for their inabilities (e.g., laziness, maturity), whereas overweight men are attacked for their heterosocial abilities (e.g., rudeness, annoyance).

Peril is whether the condition will physically, socially, or morally contaminate others. Some stigmatizing conditions, like mental illness, have the ability to create fear in the public since a mentally ill person, for instance, has the potential to harm others. In relation to obesity, this attribute may not necessarily affect society unless it is linked to a medical condition that has the potential of contaminating or causing harm.

Social stigma is a belief held by many people in a given society whereby the stigmatized person is seen as less or as part of an inferior group. This creates barriers for such people. This belief system may lead to a gap in access to critical services or promote unequal and unfair treatment. It may

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seem unlikely that social workers and other health professionals would have stigmatized patients, especially those they know are vulnerable to stigma; but research indicates that health workers may often have stigmatized patients (Volmer, Maesalu & Bell 2008). Liggins and Hatcher (2005) show that clients have recorded feeling 'marked' and 'marginalized' by health professionals in their analysis. In further elucidation of the social stigma dimension, Malterud and Ulriksen (2011) reported some forms of stigmatization attitudes of healthcare professionals towards obese persons as perceived by those obese individuals. The research stressed that abnormal bodies could not be integrated into the medical systems and that as a result, the exclusion of obese patients exists. Traditional levels of interpersonal consideration are often legitimately exceeded, and patients with obesity feel disrespected as if they deserved to be.

As asserted by Ahmedani (2011), there are three levels of stigma - the self, the society and the stigma from health professionals. Crocker (1999) points out that stigma may be internalized by the individual with the disease as well as retained by those in society. This feeling can occur as a result of continued stigma from society. Thus, explicit forms of the stigma associated with obesity over time can be internalized in the form of implicit stigma (Burke, 2018). This gives rise to the concept of self-stigma. Even if a person has not been stigmatized directly, understanding that stigma exists in society may have an indirect effect on them. Individuals can internalize stigma in various ways depending on their circumstances, according to Crocker and Major (1989), therefore, depending on an individual's coping mechanism, they may not be affected by the impact of the stigma.

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When coping with a stigmatized identity, some individuals choose to resist or reject the stigma in various ways. For instance, black journalists reported that while their stigmatized identities did place them at a disadvantage in terms of their professional identities, it, however, worked to turn their cultural identity into a positive, advantageous characteristic (Slay & Smith, 2011). Ogden and Clementi (2010) did a study focused on the experience of being obese. Most people used descriptions such as hideous, freak, hate, blob, and disgust, which represented the overwhelmingly negative effect of their weight. According to this research, participants highlighted a complex and conflicting relationship with food, and indicated that eating is usually the result of emotional control. Whenever they were depressed or not accepted socially, they resorted to food and they admitted that their binge eating was rarely triggered by hunger. They, thus, associated eating behaviors and food addiction with stigmatization and social influence.

Weight bias, however, is a common form of prejudice, perhaps as common as racial bias, according to Goffman's stigmatization theory (Shkolnikova, 2008; Hand, Robinson & Creel, 2013). In a wide range of settings, weight bias can have adverse effects on social interactions, schooling, work, and health care (Durso & Latner, 2008). Thus, in their study on the effect of perceived stigmatization on the psychological well-being of obese women, the emphasis is made on the self, society, and the stigma from professional caregivers.

The Goffman's Theory is fundamental to the objectives of this study. The fundamentals of controllability, disruptiveness, concealability, aesthetics, origin and peril allows for the explanation of the degree of stigmatization

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experienced by obese people. The theory also draws insight on the social considerations of stigmatization for which the context of obese individuals can be properly understood.

The Psychological Well-Being Model of Carol Ryff

Carol Ryff developed a hypothesis of the six-factor psychological health model. It describes six factors which contribute to the psychological well-being, happiness and satisfaction of a person (Seifert, 2005). Personal mastery, a sense of intent and meaning in life, autonomy, as well as personal development and growth, are all aspects of psychology (Ryff, 1989). Maintaining a state of calm, which is influenced by both challenging and enriching experiences in life, is the key to psychological well-being. (Dodge, Daly, Huyton & Sanders, 2012).

The self-acceptance factor considered to affect the individual's psychological well-being is when a person has a positive attitude towards self so that he/she recognizes and acknowledges several aspects of self, including both good and bad qualities. An individual with high self-acceptance will feel optimistic about past life and the qualities of self-reliance. On the contrary, where self-acceptance is low, one feels unhappy with self, frustrated with a past life, and disturbed by those personal attributes that they may possess. The inverse relationship between self-acceptance and psychological well-being is supported by a study by Bookwala and Boyar (2008), which indicated that women have lower psychological well-being due to low self-acceptance levels. Clinical seekers are also considered to have poor self-acceptance. Clinical sample studies, therefore, usually show treatment-seekers' psychological well-being are lower relative to normal-weight controls (Wardle

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& Cooke 2005). It is therefore evident that previous studies support the view that being overweight is associated with psychological distress in women with lower self-acceptance (e.g., Gray & Leyland, 2008).

Positive relations as a predictor of psychological well-being describe the positive state of mind of an individual (Seifert, 2005). An individual with positive relationships is warm and satisfying; such a person trusts relationships with others and is concerned about the well-being of others. When this positive relationship trait is strong, the individual shows a strong sense of sympathy, affection, and intimacy that is expressed in their relationship (Sagone & De Caroli 2014). An individual with poor positive relationships has few close, trusting relationships with others. They will usually find it hard to be warm or open to people. Such a person is not so concerned about others and is more isolated and frustrated in interpersonal relationships. The idea of a positive relationship is supported by the study of Ghasempour, Jodat, Soleimani, and Shabanlo (2013) that reported a positive relationship between the happiness of individuals and psychological well-being. This result implies that the increasing happiness of obese individuals is highly dependent on their level of a positive relationship with others. Obese individuals with negative relations with others, however, experience a higher level of depression (Ghasempour, Jodat Soleimani & Shabanlo 2013).

Autonomy as a predictor of the psychological well-being of individuals defines the degree to which one shows freedom or independence. People may display high or low autonomy through the way they behave. A person with a high level of autonomy is self-determined and autonomous and is able to resist social pressures to think and act in a certain way. Such a person can monitor

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actions from within and judge himself on a personal basis. A low self-employed individual is concerned about the perceptions and assessments of others, relies on the judgments of others to make crucial decisions, and conforms to social pressures to think and behave in a particular way. Such people are likely to have issues with low self-esteem and inferiority complex. An obese person who is highly autonomous can withstand social pressure and may not be affected by weight-based stigma. Such people are comfortably able to relate and do well in their environment. They can take decisions irrespective of how society sees them, and some even become motivators to others by the way they display confidence and carry themselves with independence.

In support of autonomy as a predictor of psychological well-being, Vieira et al., (2011) reported that autonomous self-regulation positively predicts health-related quality of life (HRQOL) and psychological well-being. The study of Lubans et al., (2016) also asserted that obese individuals with a higher level of autonomy have positive psychological well-being, whereas those with a lower level of autonomy experience negative psychological well-being. So, this implies that overweight and obesity are linked to poor levels of subjective health, particularly in physical well-being (Doll, Petersen & Stewart-Brown, 2000), and is also dependent on the level of autonomy wielded by the individual.

Environmental mastery as a predictor of psychological well-being defines the degree to which a person is in control over his/her environment (Grant et al., 2017). An individual with a high degree of environmental mastery has a sense of mastery and competence in environmental management; such a person can monitor a complex array of external activities

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and make effective use of surrounding opportunities (Yazdani et al., 2018). Individuals with environmental mastery are better able to select or construct contexts that are relevant to their personal needs and values. In a situation where environmental mastery is low, it can be difficult for a person to handle daily affairs. Many surrounding opportunities may elude such people because they may be unaware of such opportunities and thus be unable to change or improve upon their lives (Gray & Leyland 2008). Such persons simply lack a sense of control over the external world. The idea of environmental mastery is confirmed by the study of Cash and Hicks (1990) that reported that stigma has the potency to promote positive consequences and encourage behavioral change. The study, therefore, asserts that stigma, though uncomfortable, resulted in some beneficial consequences. The judgments and stereotypes have the tendency to motivate obese individuals to change their behavior, thereby promoting weight loss.

Purpose in life as a measure of psychological well-being implies that a person with a clear purpose in life has a goal and a sense of direction and believes that there is a value to present and past life. People with a strong purpose in life have values that offer life purpose and are often life-oriented. Anyone who has a poor purpose in life, on the other hand, shows no sense of meaning in life, has few ambitions or priorities, and lacks a sense of direction. Such people are typically time-wasters who do not see the point of past life and have no outlook or conviction that brings meaning to life. Thus, obese persons with a strong purpose in life are not limited by their physical appearance, but are largely motivated by their personal achievements, which explain their high levels of happiness. This assertion is supported by the study

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of Ghasempour, Jodat, Soleimani and Shabanlo (2013) that reported a positive relationship between the happiness of individuals and psychological well-being. This result implies that the increasing happiness of obese individuals is highly dependent on the strength of their purpose in life. An obese person with stronger or positive life purpose is reported to be happier and exhibit positive psychological well-being, unlike obese individuals with negative purpose in life who experience greater depression (Sagone & De Caroli 2014).

A sense of personal growth as a measure of the psychological well-being of individuals has got to do with the self-developments and progress an individual may experience in their lifetime. An individual with good personal growth has a feeling of continuing progress, sees himself increasing and evolving, and is open to new experiences. This individual has a sense of future realization and sees a change in self and actions over time. On the other hand, a person with a weak personal development experiences personal stagnation; he or she has no sense of improvement, feels dull about life and cannot establish new attitudes or behaviours. A person's sense of growth can define any form of happiness or depression associated with obesity. Thus, the reported positive relationship between happiness and well-being (personal growth) implies that obese individuals with a greater sense of purpose are less likely to experience depression than their counterparts with a low sense of purpose in life (Ghasempour, Jodat, Soleimani & Shabanlo 2013). The study of Sagone and De Caroli (2014) asserted that when one shows resilience that is high, there is an increase in personal growth.

This study relies on six components of Carol Ryff's psychological well-being model: self-acceptance, environmental mastery, good ties with

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others, life goals, personal development and freedom in the measurement of the psychological well-being of obese Ghanaian women.

Empirical Review

Body Image Dissatisfaction Among Obese Women

Several experiments were conducted to assess whether obese women had an image satisfaction. According to Alhussaini, Alsuwedan, Alnefe, Almubrek, Aldaweesh, Anitha & Qassem (2018) women are typically influenced by many social and cultural factors. Cross-sectional research has been conducted at Princess Nurah University in Riyadh, Saudi Arabia, on their own body image, bodily mass index (BMI) and the relationship between the two. It employed the use of both qualitative and quantitative approaches. 336 people were recruited aged 18-50 years, the majority of whom were 18-29 years old and single. The mean BMI was 26.1±9.41 kg/m2, and over half of the participants were overweight (55.7 percent) in the 55-80 kg weight range. Cohen's Kappa K value of 0.635.68.6 percent of respondents gave positive opinion of body image; 83.9 percent believed the appearance was very significant in body image perception; 47.1 percent welcomed abdominal enhancement while 52.8 percent chose to lose weight to improve their appearance. It was concluded that an underestimation of body weight in terms of BMI was observed amongst the participants. However, perceived stigma and psychological effects were not taken into account in their study.

Erkaya, Karabulutlu, and Çalik (2018) took a survey to develop the relationship between maternal obesity, self-esteem, and body image. In addition, 300 non-selected pregnant women from the delivery unit of Turkey were recruited to be part of the study. Data collection tools were used between

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April and May 2016 for Body Image Scale (BAS) and Coopersmith Self-Esteem Scale (GIS). The BMI variables of 12.3%, 57.0% and 30.7% of pregnant women, respectively, showed moderate, overweight and obese and gained an average of 12.11 ± 3.03 kg during pregnancy. The results showed that the majority of pregnant women involved were obese and overweight. Although the study surveyed pregnant women had a high-corporate reputation (158.84 ± 21.34), their average self-esteem (64.01 ± 15.88) was moderate. According to BMI, 56.8% of women with average weights were seen to be normal, 48.0% of women with overweight were seen to be normal and 53.3% of women with overweight were seen as obese. The body image of the participants and their BMI was substantially positive ($r = 0.119$ $p<0.05$). Pregnant women were more likely to feel content with a typical BMI. The majority of pregnant women was overweight and obese by BMI, respectively high and low in their overall body image and self-esteem. This research considered pregnant women too which isn't popular with other researchers. Nonetheless, it looked at their self-esteem which is a psychological factor.

Frempong (2017) studied the factors that affect weight management choices in the estimation of body size. The approach was both quantitative and qualitative. A total of 395 individuals aged 18-70 years were included in the survey. Logistic regression modeling analyzed the study. In total, 8 focus group conversations and 14 in-depth interviews took place. A thematic network analysis was used for the study of qualitative data with the assistance of Atlas ti. About 57 percent were overweight or obese and 5 percent were underweight in the overall sample, the results showed. Nonetheless, 66.5 percent of them viewed themselves as obese or overweight and 3 percent

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viewed themselves as underweight. There were, therefore, differences in perceived and real body size: 55.7 percent of respondents estimated their body size accurately, while 44.3 percent estimated their body size inaccurately. Also, 58.5%, 29.6%, and 11.9% respectively decided to retain their body size, lose or gain weight. Variables such as age, marital status, length of stay in the group, household wealth status, community behavior, and locality, have significantly predicted weight control behaviors. It was concluded that the calculation of body size has no important effect on weight management behavior. However, societal representations of fatness and thinness affected people's preference for bigger body size, and this affected the weight control behavior option. The study used both quantitative and qualitative methods.

Appiah, Otoo, and Steiner-Asiedu (2016) also tried to explore the effect of sociocultural factors on the issue of rising obesity/overweight in the Kumasi Metropolis in Ghana. The study involved women from 6 randomly selected churches in the Metropolis of Kumasi. A total of 394 women aged 20 years and above undertook a cross-cutting survey of calculating their favorite sizes. The photographers had to pick their chosen body size from six random mounted BMI female images (20, 24, 28, 30, 33 and 38kg/m2). The photography silhouettes were used. Independent t-test samples and variance analysis were used to examine variations in preferred body size between BMI groups and socio-demographic characteristics. It was found that obesity/surface weight prevalence among women is 68.4%. A large (overweight) body size was favoured by the respondents. The wide silhouette (overweight) was the combined result of good food, good income and high social value. This study demonstrates that for the chosen body size of women,

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sociocultural ideals for body size outweigh health reasons. A systemic interdisciplinary approach should include nutrition, fitness, social and behavioral scenarios to establish culturally responsive strategies against the emerging obesity epidemic.

The study of Weinberger, Kersting, Riedel-Heller and Luck-Sikorski (2016) aimed to investigate the degree of body dissatisfaction in people with obesity relative to normal-weight people. A systemic literature search was performed. Both objective studies reported results of body differences between people with average weight and obese people. The obese person has demonstrated greater discomfort than the average person (questionnaires: $d = 0.89$, 95% CI = 0.63-1,16, $p<0.001$; silhouette scales: $d = 1.41$, 95% CI = 0.57-2.25, $p < 0.001$). Scales of body silhouette: Meta-regression revealed a significant association between female sex and higher body unhappiness ($b = 0.60$, $p = 0.007$). In conclusion, the findings show that people with obesity and particularly women have a great deal of body dissatisfaction.

A research was conducted by Benkeser, Biritwum and Hill (2012) with a selection of 2,814 Ghanaian women aged 18 and over, in the metropolitan area of Accra. The Standard Stunkard figure rating scale was used to identify silhouettes of different corporeal sizes that closely resemble a woman's current corporeal image (CBI), a body image which she considers to be the best for Ghanaian women (IBI) and a body image that she sees as the healthiest, in addition to registered socio-demographic function, medicine history, and dietary history (HBI). The validity of the use of the standard Stunkard FRS to determine the body image of Ghanaian women has been tested using the study of the Receivers' Operating Curve (ROC). The relationship between different

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socio-demographic features was evaluated using logistic and linear regression. Using the WHO BMI criterion, the researchers found that 3.6 percent (95) of women were underweight, 31.5 percent (828) were normal weight, 27.8 percent (730) were overweight and 37.1 percent (973) were obese. In general, among the women sampled, 64.9 percent were either overweight or obese. Overweight and obese women were marginally more likely to want weight loss than females of average weight. Ghanaian women should not see the urban areas as an inhibitor of good weight control, as promoting obesity as the acceptable image of the body. Strategies should be designed to help females achieve their optimum and healthier weights. The sample size of this work was relatively high. This work considered obesity and the socio-cultural factors whilst neglecting perceived stigma and psychological well-being.

Level of Perceived Stigmatization Among Obese Women

The level of perceived stigma among obese women has been researched by some authors. Arday (2017) sought to establish attitudes and stigmatization in the Ghanaian environment among women of reproductive age in relation to overweight and obesity. A descriptive cross-sectional sample design and a mixed approach to methods were used in the study. The exact test for categorical variables by Pearson Chi-square was conducted to test the correlation between the perceived definition of body weight (outcome variable) and socio-demographic characteristics. The findings showed that the majority (56.4 percent) were obese out of the 276 survey respondents. These respondents reported their body misperceptions; 56.5 percent of obese individuals were overweight, while 28.6 percent and 14.3 percent of respondents who felt they were overweight and obese were in fact overweight

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and obese, respectively. The researcher concluded that people who are obese and overweight feel stigmatized because their weight status is attributed to them. Overweight and obese people ought to be shielded from others' stigmatizing and racist attitudes.

In a related research, Tucci, Boyland, Halford, and Harrold (2013) examined whether negative judgments are gender-specific and modulated by the BMI of the evaluators themselves. 202 young adults (106 men and 96 women), along with one of two claims about their former weight (overweight (OW) or always average weight (NW), looked at a picture from a young attractive female (target) then categorized them using the Fat Phobia Scale (FPS). In the OW comment, women evaluators classified the goal more negatively than the tar-get with the NW remark. On the other hand, men under the OW word categorized the goal as less emotional/psychological and less stupid/uncreative. The investigator concluded that peer review had an effect on the findings of the weight sense. These impacts are gender and BMI based. knowing that a young woman was overweight caused negative assessment, but this did not seem to influence male judgement.

In their research, Ogden and Clementi (2010) sought to examine how individuals view their obesity and to analyze the effect of this on their weight loss motives. Interviewees were asked about their personal experiences. Participants used words like "ugly," "freak," "hate," "blob," and "disgust" to characterize the impact of obesity on various aspects of their self-identity, expressing the negative effects of their body size. They illustrated a dynamic and sometimes contradictory relationship with food and explained how such unpleasant experiences were created by the connection between their obesity

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and a stigmatizing social climate. Some, however, proposed that by facilitating and supporting behavior improvement, such stigma may also have positive implications. As a result of living within a social framework that stigmatizes their condition, many obese people, thus, perceive their weight in deeply negative ways.

Similarly, Sikorski, Spahlholz, Hartley and Riedel-Heller (2016) demonstrate weight-based stigma attitudes across countries. Their study proves that obese children experience about a 63 percent chance of being bullied, and while about 54 percent of adults are stigmatized by co-workers, 69 percent are stigmatized by health care professionals. The emphasis was on adolescents; children, on the other hand, present a different dimension concerning how this subject is viewed.

Psychological well-being of obese women

Bookwala and Boyar (2008), studied gender differences in relation to body mass index (BMI) and psychological well-being. Regression studies of 3,251 adults have shown that the relationship between BMI and psychological well-being is moderated by gender. Studies have shown that increased BMIs predict that females have poorer psychological well-being. Women demonstrated poorer mental well-being than men in the overweight and obese categories when participants were split into 5 BMI groups. In the highly obese or normal weight groups, gender disparities have not been observed.

Gray and Leyland (2008) aimed to examine correlations in the sex, in the social, lifestyle and contextual variables between adolescents with psychical distress and those who are overweight. The association of variation in overweight status in area-level was investigated in adolescents and adults.

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635 men and 618 women and male and female teenagers (13 to 15 years), from two cross-section surveys on population health, in Scotland in 1998-99/2003-04, were available for psychological distress, physical activities and alcohol use. Multilevel logistic regression analysis was used. The significance of the adolescent-adult area-level variance association was calculated using adult data. There was a slightly higher risk of overweight in children, this did not affect the relationship between adolescents and adults. For girls in multivariate tests the findings were still relevant (OR = 2.44, CI 95-4.50: 1,35-4.50, 95%) but for boys not meaningful (OR = 1.31, CI 95-4%: 0.56-3.05). Findings indicate that overweight is connected to psychological distress in teenage girls but not boys. Effects are not mediated in psychological, lifestyle and contextual variables.

Body Image and Perceived Stigmatization of Obese Women

Aryeetey (2016) conducted a research to evaluate women living in the Accra suburb of Ghana with overweight values, attitudinal experiences, and behaviours. Four focus groups were set up for discussions and 10 in-depth interviews conducted for 42 women over the age of 18, in preventive child health services, at Dome, Accra. Many women considered it unacceptable to be overweight. They have also got nasty names such as freight, *obolo* etc., although these women and their families and friends have been respected and wanted to gain some weight. It was believed that weight gain that occurred naturally was good, while medically-induced weight gains are perceived to be unhealthy and not beneficial. Overweight is believed to be synonymous with inheritance, gluttony, and contraception. Bad self-image, declining social lifestyles, and elevated health risks were included in overweight negative

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experiences. It was concluded that women are celebrated for weight gain, but they are stigmatized when it comes to unhealthy and unnecessary weight.

The incidence of institutional and interpersonal discrimination and psychological associations identified by underweight, medium weight, overweight, obese I, and obese II/III among Americans was reported in Carr, and Friedman (2005).

For this research, over 3,000 people aged 25-74 from the United States Midlife Development were used as a national sample in 1995. Obese II/III persons are more likely than average persons to report institutional and interpersonal discrimination on a regular basis (BMI 35 or greater). Obese II/III_professionals are more likely to report Workplace prejudice and behavioural mistreatment than non-professionals. Obese II/III persons are less self-accepting than persons of average weight, but this relationship fully mediates the belief that one is discriminated against by physical or body weight. Their results show further proof that obesity is a constant stigma and a detrimental impact on life chances of stigmatised identities.

Bouzas, Bibiloni, and Tur (2019), in related research, assessed the relationship between body image and body weight control in overweight adults who were over 55 years old. It was realized that as age increases, people conform to their body shapes and their expectations concerning body weight decreases. The author noticed that more men were pleased with the image of their body than women. Aging, as indicated by the writer, is associated with weight loss and also reduces perception of overweight, particularly among women.

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From their research, it can be said that overweight people could be perpetrators of their weight stigmatization due to the lack of in-group preference. This research used explicit self-report measures whereby obese individuals stated their responses based on their experiences. The validity of this method could, however, be compromised for reasons such as inability to verbalize or accurately report the beliefs. It is reported that weight loss was explicitly positioned by the then Secretary of Health and Human Services in the United States, Tommy G. Thompson, as a civic duty rather than just a matter of individual health. As a patriotic gesture, he instructed Americans to lose 10 pounds. He called obesity a threat to America that is every bit as real as weapons of mass destruction. It was perceived that obesity was equal to the war on terrorism. A politician said that obesity threatened the defense capabilities of the nation directly in the sense that "Overweight troops can hinder not only their performance but that of their units as well as the success of their military assignments." (Bouzas, Bibiloni, & Tur, 2019, p.22). The use of cross-sectional self-report on experience data was a limitation of the study, giving participants the freedom to write about their own expertise.

Magallares, Morales, and Rubio (2011) focused on weight-based discrimination in the workplace and noted that it affects millions of people in industrialized societies. Stereotype threat is a disruptive concern that exists within a group and it has been shown that this threat undermines the performance of people's work output. The obese could be influenced by the stereotype that they are worse at jobs and this affects them psychologically, making them live a self-fulfilling prophecy and hence tend to see themselves as less skilled. The fact that there is a negative stereotype that gives the

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impression that obese people are less competent than slim people makes obese persons in the workplace, tend to exhibit high anxiety during work, which can result in bad performance.

A study by Young and Powell (1985) also confirmed weight-based stigma by teachers who have rated academic performances based partially upon student attractiveness; and the same applies to some mental health workers and their clients by mental health professionals. Empirical studies reviewed here used mostly interviews for data collection. It also looked at the influence of stigma and body image on the quality of life and performance of the obese. Relating to my research, questionnaires were used. The impact on the pathological well-being of an obese body image and stigma were also taken into account.

Weight-Based Stigma and Psychological Well-being of Obese Women

In their research, Puhl, Moss-Racusin, Schwartz and Brownell (2008) employed qualitative methods to classify and explain their subjective perceptions of weight bias with a group of overweight and obese adults. The study participants consisted of 274 women and 44 men. They answered questions about their worst weight stigmatization experiences, their perceptions of common weight-based stereotypes, their weight experiences and suggestions for reducing weight stigma in our culture. In a variety of ways and involving a variety of interpersonal outlets, participants reported experiencing weight stigma.

Near relationship partners were the most common cause of their stigmatizing experiences (such as friends, parents, and spouses). They challenged traditional weight-based assumptions and shared the willingness of

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the public to gain a deeper understanding of weight loss problems, the causes of obesity and the emotional consequences of stigmatization. The most promising path for potential attempts to eliminate stigma has been identified as education. For males versus females or overweight versus obese people, the experiences and views expressed were not considerably different.

A minority of respondents expressed opinions suggesting the internalization of self-reported and weight-based biases. Although obese people are at risk of weight damage in different fields, more attempts to minimize stigma could be directed at stigmatizing interactions in close relations, including parents, spouses, and friends of obesity.

Jackson, Beeken, and Wardle (2015) Obesity's negative effect on psychological well-being was studied to see whether weight discrimination was to blame. Included in the research sample were 5056 elderly men and women residing in England who participated in the English Longitudinal Study. The participants noted everyday experience with discrimination in weight and completed assessing quality of life (scala CASP-19, life satisfaction, and depressive symptoms (Life Scale Satisfaction) (eight-item CES-D scale). Obesity was defined as 30 kg/m2 BMI, and height and weight were measured objectively. By mediation analysis the role of perceived weight discrimination was evaluated in the connection between obesity and every psychological factor. Results: Both were closely interconnected to obesity, unequal weight and mental well-being. Models of mediation have been shown to have major indirect effects on quality of life by perceived weight discrimination (b 5 20.072, SE 5 0.008), overall life content (b 5 20.038, SE 5 0.008), and depressive symptoms (b 5 0.057, SE 5 0.008), with perceived

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discrimination by weight of around 40% of the overall relationship between obesity and psychology (range: 39.5-44.1 percent). It was found that a major proportion of the connection between obesity and psychological well-being is explained in perceived mass discrimination in older English adults. By attempts to reduce the weight stigma in society, the psychical burden of obesity could be minimized. Magallares, Morales, and Rubio (2011) in their study, focused on weight-based discrimination in the workplace and noted that it affects millions of people in industrialized societies. They observed that discrimination generates a decline in the psychological well-being of obese people since aspects such as self-esteem and life satisfaction are affected by social exclusion. People need to be educated on the effects of stigmatization on the obese. These include family, friends, and health care providers. Eliminating stigma associated with weight gain will greatly improve the health of all individuals. Obese people have to come to terms with either living with the stigma from people or accepting themselves by dealing with the negative body image expression which comes with it (Macedo, Portela, Palamira & Mussi 2015).

Influences of Body image on psychological well-being of obese women

Sabik (2012) in his research focused on the problem of the appearance of young women. For older women, concerns with the image of the body may focus on changes of appearance and function due to age. He theorized predictors and outcomes of older women's body perceptions using aging and body theorizing theories throughout this research. Data from two community-based surveys of females aged 65 and older are used in three experiments to test this model (African American and European American). The first study

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looked at how women rated their satisfaction with different body features and how much they valued them.

Body function and appearance preferences were characterized by two subscales, and cosmetic appearance and factor analytics revealed that the factor structure between the two ethnic groups did not differ significantly. Study 2 showed that the association between social comparison and European American women's perceptions of body satisfaction and attractiveness is not related to African American women's physical perceptions, but rather moderates them. For European American women, more positive body esteem was associated with social comparison participation, while for African American women the opposite pattern occurred.

Study 3 showed that depression was negatively associated with body function and appearance for both ethnic groups. Depression was, however, irrelevant to standards of cosmetic appearance. For European American women, social interaction mediated the connection between perceptions of bodily function and appearance and depression. The results show that older women are particularly concerned about the position of the body, and that the effect of social comparisons on body perception varies greatly across ethnic groups.

There is a need for more research to explore the impacts on perceptions among diverse older women of functional disabilities and changes in age. The principles of the body affect health, psychological health, and the quality of life and more study is needed in order for these aspects to be better understood.

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Dotse and Asumeng (2015) carried out experiments to see if there was a correlation between the body's picture as a BMI and mental variables. The current study looked into the impact of body image satisfaction on people's psychological wellbeing in African cultural contexts. Face voice, appendage presence, physical appearance and complexion, and index of body mass are four other components that have been redefined and expanded to include the body image dimension.

The sample was taken in Ghana, but from 9 Africa countries' nationals. The Pearson product-moment correlation, variance and multiple hierarchical regression have been tested for information analysis. Results showed that the correlation was moderated as predicted by an important positive connection between the satisfaction of body image and psychological well-being with African values. Males with their body image, too, were happier than females. However, there was no substantial impact on the satisfaction of a person's body image, contrary to the predicted level of education.

Cognitive-behavioral therapy was randomly assigned to college women who were very unhappy with their body image. These women considered themselves to be physically unattractive before the treatment; they had low self-esteem, social anxieties, and inhibitions, sexual issues, and were prone to depression. They could change their mindset about a negative body image after going through the cognitive-behavioral procedures. The findings demonstrated the therapeutic effectiveness of cognitive-behavioral procedures for modifying a negative body image's dysfunctional affective and cognitive aspects. Therefore, if supported, people who have negative body image

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dissatisfaction can have a more optimistic outlook and orientation about how they feel (Cash, & Brown, 1987).

Young and Powell (1985) According to Rand, Vallis, Aston, Price, Piccinini, Rehman, and Kirk (2017), the percentage of obese people seeking mental health help may be higher than the general population's care rate, despite the fact that obesity management services have insufficient resources for mental health. According to the writer, obesity as a status characteristic of a client negatively affects counselors' and therapists' clinical judgments. From the study, there was an association made between obesity and attractiveness, and it is said that sociologists and psychologists have begun to categorize beauty as a "status characteristic" or "status cue" comparable with that of race and sex.

Conceptual Framework

This study largely encompasses three main concepts which are body image, weight-based stigmatization, and the psychological well-being of individuals. Body image is a growing psychological and medical problem that requires enormous research attention. According to Self-Discrepancy theory, the adverse effect on the psychological well-being of women increases when a comparison is often made between their self-state and another self-state and they find that a discrepancy exists between the two. Most obese women worldwide are uncomfortable when they realize that they are different from other people, especially if they fall outside a socially approved category. The self-discrepancy theory emphasizes that there are three domains of self - The 'actual' (or current) self, the 'ideal' self, and the 'ought' self. The psychological well-being of obese women often deteriorates when they

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perceive differences between their actual self and the 'ideal' self or the 'ought' self. The deterioration in the psychological well-being of obese women often emanates from the stigmatization experienced in a society or community. The societal stigmatization experienced by obese women is well-explained by Goffman's Theory of Stigmatization that emphasizes that individuals encounter the issue of stigmatization when they possess attributes different from others in the category of which they are part. Thus, this is a serious challenge confronted by obese women who often perceive differences between their actual self and the ideal self or the 'Ought' self. This eventually adversely affects the psychological well-being of the women. The discussed phenomenon is presented in Figure 2.1.

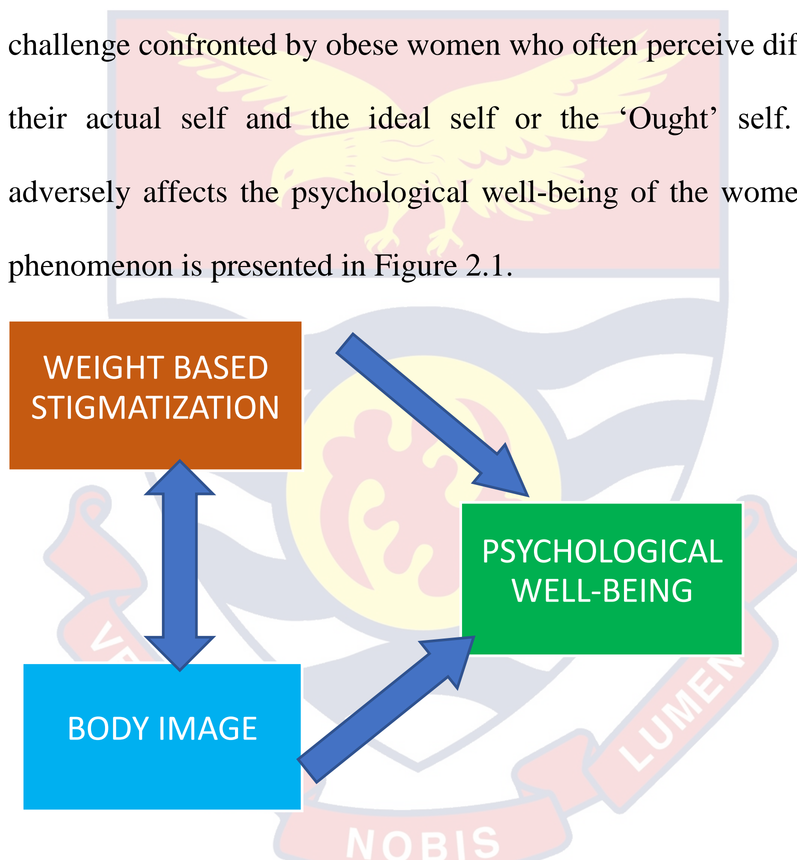

Figure 1.1: *Conceptual framework of the study*

Source: Author's construct (2019)

The above diagram shows that there is a correlation between body image and weight-based stigmatization; individuals with a negative body image appear to experience social stigma, whereas those with a positive body image may not perceive stigma. However, both the depiction of the body and the stigma centered on weight may affect the individual's psychological well-

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being. A negative body image may negatively impact the psychological well-being of individuals and vice versa, even as a person facing weight-based stigma is likely to be psychologically adversely affected.

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CHAPTER THREE

RESEARCH METHODS

This chapter defines the approach used to assess the influence of body image and perceived stigmatization on the psychological well-being of obese women in the Kumasi Metropolis. The chapter discusses the research design, the population, technique of sampling, sampling instrumentation, data analysis procedure and ethical considerations.

Research Design

The study was a descriptive survey. The descriptive design decides and reports on problems the way they are, according to Amedahe (2002). The primary concern of the descriptive design is the collection of data to test theories or address research questions relating to the current status of the topic of the analysis. Amedahe (2002) also stated that the descriptive research design is concerned with current situations or relationships, such as the existence of prevailing circumstances, behaviors, attitudes, and opinions held by individuals about problems or phenomena that are occurring and patterns that are being created. In view of this, the current study was done to collect the opinions, views or perceptions obese women have concerning their body image and the extent at which stigmatization do impact their psychological well-being.

The quantitative approach was used for the study. The most commonly used method of data collection in this approach is the use of questionnaires for primary data collection. Some researchers also do include interviews,

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observations, and documentary analyzes. The quantitative approach adopted for this study was required in order to allow for a clear testing of hypotheses in relation to the research questions so as to describe the findings in greater depth. The mathematical data obtained through the use of quantitative approach allowed the researcher to effectively analyze it statistically as posited by Castellan (2010). The approach further maximized the level of objectivity, reliability, replicability and generalizability of the findings due to the rigorous statistical analyses.

Study Area

The metropolis of Kumasi is between the latitude of 6.350N and 6.400S and the longitude of 1.300W and 1.350E and between 250 t0 and 300 meters above sea level. Its area is approximately 214.3 kilometers square. The metropolis is one of the thirty (30) administrative districts of the Ashanti region and borders the districts of Kwabre East to the north, the districts of Afigya Kwabre to the west, the districts of Asokore Mampong, Atwima Kwanwoma and Atwima Nwabiagya to the east, and Ejisu-Juaben to the west, and the districts of Bosomtwe to the south (Ghana Statistical Service, 2014). Asokwa, Suame, Bantama, Kwadaso, Manhyia, Oforikrom, Subin, Asawase, Tafo, and Nhyiasoo are ten (10) Sub-Metropolitan District Councils (Ghana Statistical Service, 2014). Kumasi Metropolis has numerous infrastructure and health-boosting facilities, and has a population of about 1,730,249.

Population

Mugenda and Mugenda (2003) define population as an entire group of individuals, events and objects with some observable characteristics. The study's target population was obese women in the Metropolis of Kumasi. The

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accessible population consisted of obese women who visited the areas chosen for the study. The researcher concentrated on health shops and the gym or fitness centers in Kumasi.

The fitness centers were chosen because majority of its customers, who are obese, visited the place looking to lose weight through exercise. With respect to the health shops, a number of their customers also visited because of obesity-related conditions, typically, people with hypertension, diabetes, protruding bellies etc. They hoped to get supplements and other organic foods to cure their diseases or boost their health. On the whole, these categories of people were selected because the majority of people who visit these places were a perfect fit for the target population.

Inclusion criteria

1. Obese women who visited the selected premises within the week, month, and year.
2. Health personnel who took the anthropometric data, such as the height and weight.
3. Officials (Health personnel) of the said premises for assistance and support during the research.

Exclusion criteria

1. Obese men and children were excluded from this research.
2. People with physical deformities, because of the difficulties in getting accurate anthropometric measurements.
3. Those with mental impairment with inability to understand and answer questions.

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Sample and sample size

The population of obese individuals in the Kumasi Metropolis who visit the selected premise for the study was undefined or unknown. This was because there were either no or inadequate records of client visits. Considering that the study population was unknown, the study relied on the Cochran formula for calculating sample size.

This formula allowed the optimal sample size to be determined based on the desired accuracy level, the confidence level, and the approximate proportion of the population with the target attribute. In this circumstance with large population, Cochran's formula was considered suitable.

The formula for Cochran:

$$n_0 = \frac{Z^2 pq}{e^2} = \frac{(1.96)^2 \text{X}(0.5)(0.5)}{(0.05)^2} = \frac{3.8416\text{X}0.25}{0.0025} = \frac{0.9604}{0.0025} = 384 \text{ Obese Individuals}$$

1. N_0 is desired sample size for a large population,
2. e is the desired level of precision (i.e. the margin of error),
3. p is the (estimated) proportion of the population which has the attribute in question,
4. q is 1 – p.

Sampling procedure

From the 384 calculated sample size, 192 participants were sampled from the two main selected centers. The sample size was disproportionately shared among the two groups. This meant 192 participants from the health shops and 192 from the fitness centers. This equal distribution was necessary due to the difficulty in justifying any form of proportionate distribution as the population of obese individuals from the health shops and

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fitness centers (Gyms) are unknown. The study employed multi sampling. Multi sampling techniques were used because the researcher needed to employ various sampling techniques. In the sampling units, obese individuals were selected from the two basic centers; the health shops and the fitness centers (Gyms) in Kumasi. Obese women using these centers were purposively chosen because the researcher subjectively focused only on obese women and these centers were places they were more likely to be found. These two centers especially, in Kumasi are often visited by obese individuals seeking professional advice and solutions on their weight. Sharma (2017) wrote that purposive sampling was appropriate when the researcher relied on his or her own judgments in selecting the units (people, case/organisations, events, pieces of data). One advantage of purposive sampling is that they can provide researchers with the justification to make generalisations from the sample that is being studied (Sharma, 2017). Using the snowballing technique, the fitness centers and the health shops were located beginning with identifiable points. The researcher identified obese individuals who visited these places for assistance and they in turn directed to other places where there was the likelihood of finding similar characteristics the researcher was interested in. Finding units to include in your sample can be sometimes be very difficult, perhaps because there is no obvious list of the population of interest. For example, especially when there are no lists that is representative of the population (Sharma, 2017). The individual participants were further selected from the identified centers through the convenience sampling method. With the convenience sampling, the researcher contacted the participants as and when they visited the gym and the health shops. Saunders, Lewis, and

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Thornhill (2014) defined convenience sampling as a method that relies on data collection from population members who are conveniently available to participate in study. It is a sampling method that involves getting participants wherever you can find them and typically wherever is convenient. In convenience sampling no inclusion criteria identified prior to the selection of subjects. All subjects are invited to participate. Convenience sampling was appropriate because it could be applied in order to gain initial primary data regarding specific issues such as perception of body image, stigmas and their psychological wellbeing.

Data Collection Instrument

For this analysis, a standardized questionnaire was used. There were four parts of the questionnaire: anthropometric results, the body shape questionnaire, the inventory of the stigmatization situation, and finally, the psychological well-being. The instruments used for the analysis were all adopted.

To assess the individual's B.M.I. status, anthropometric data was taken. This determined the obesity status of the person. With a stadiometer, the individual's height was taken to the nearest 0.1 cm. The weight was also taken to the nearest 0.1 kg on a weighing scale. The body mass index was measured and rated according to W.H.O. standards by dividing the weight in kg by the square of the height in meters. In an underweight person, there is (B.M.I. <18.5), normal weight (BMI 18.5-24.9), overweight (B.M.I. 25-29.9), and obese (B.M.I.>30). (1998-W.H.O.).

The Body Shape Questionnaire BSQ-34 is a 34-item questionnaire that discusses body image and body shape issues, especially the 'feeling fat'

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phenomenon, which measures the urge to lose weight, body dissatisfaction, feeling fat after eating, public self-consciousness, distressing thoughts about weight, and low self-worth concerning weight (Cooper, Taylor, Cooper & Fairbun, 1987).

On a six-point rating scale, items are answered: 1-never, 2-rarely, 3-sometimes, 4-often, 5-very often, 6-always. The individual answers have to be summed up. Between 34 and 204 is the possible score. The scores are grouped into 4 classes: satisfied (not nervous) <81, mildly anxious (81-110), moderately anxious (111-140), and highly anxious (>140). The variables can then be divided broadly into satisfied (34-80) and dissatisfied for scores above 80. This scale not only measures body shape dissatisfaction but is also used to assess bodily concerns and feelings among women and young girls. Nevertheless, one downside is that it was made for women and not men, although the test has sometimes been used for men and boys (Flores-Cornejo, Kamego-Tome, Zapata-Pachas & Alvarado, 2017). Studies investigating sex differences between BSQ respondents (Amaral & Ferreira, 2017; Di Pietro & da Silveira, 2009) usually find that men and boys earn substantially lower BSQ scores than women and children. The Cronbach's Alpha for reliability for BSQ is 0.928.

The Stigmatizing Conditions Inventory (SSI) by Myers and Rosen, (1999) is used to assess weight stigmatization over time. Each item describes a stigma encounter and asks the respondent to rate the intensity of the experience on a 10-point Likert scale ranging from 0 (never) to 9 (frequent) (daily). Hearing children's remarks, being screamed at, and overcoming physical challenges are all examples of item types. The sum of all things is

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used by researchers to assess the average incidence of stigma experiences. A higher level of stigma attitudes has been linked to higher levels of depression and anxiety, lower self-esteem and quality of life, greater body dissatisfaction, and higher binge eating in several studies using the SSI. This inventory showed excellent internal consistency and good validity (Cronbach's alpha = 0.95) (Myers & Rosen, 1999). One drawback of the SSI, however, is that it is a relatively long measure (50 items) and may, therefore, be impractical for certain researchers with limited time interested in studying weight stigma.

The 18-item psychological well-being scale will be used. It is a 7-point Liket with responses ranging from 1- strongly agree, 2- moderately agree, 3- a little agree, 4- neither agree nor disagree, 5- a little disagree, 6- somewhat disagree, to 7-strongly disagreement. The subscales assess the control of the world, autonomy, personal development, positive relationships, intent in life, and acceptance of oneself. Answers are reverse coded to some of the issues. Higher scores indicate levels of greater psychological well-being. For the six scales, internal accuracy varies from 0.86 - 093 (Henn, Hill & Jorgense 2016). Several studies examining the structure of PWB structures (Ryff & Keyes, 1995; Van Dierendonck et al., 2007) have had some methodological limitations. Although 120 items were included in the original model (Ryff, 1989b), and 84, 54, 42, and 18 items were included in shorter versions, there are problems with the validity of these results since the items comprising the shorter versions of the PWB scales lack consistency.

Confirmatory factor analysis

This section contains the results on the validation of the body shape questionnaire, psychological wellbeing and stigmatizing situation inventory.

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Data were collected from 100 obese women in the Kumasi metropolis. Confirmatory factor analysis (CFA) was performed using Smart-PLS. The details of the results are presented in the table below

Table 1: Factor loadings, AVE and Reliability for body shape questionnaire, psychological wellbeing and stigmatizing situation inventory

Constructs		Items	Loadings	rho_A	CR	AVE
Stigmatising Situation Inventory						
1.	Comments from children			.772	.840	.518
		C1	.601			
		C6	.786			
		C7	.805			
		C19	.799			
		C32	.572			
2.	Comments from doctors			.802	.871	.629
		C2	.857			
		C16	.763			
		C22	.686			
		C23	.855			
3.	Comments from family			.774	.839	.511
		C3	.624			
		C4	.772			
		C5	.757			
		C24	.692			
		C44	.720			
4.	Comments from others			.759	.835	.563
		C10	.835			
		C30	.687			
		C33	.623			
		C43	.832			
5.	Negative assumptions			.752	.854	.663
		C28	.788			
		C29	.883			
		C42	.767			
6.	Physical barriers			.834	.859	.443
		C8	.680			
		C15	.702			
		C35	.706			
		C36	.377			
		C37	.607			
		C38	.767			
		C39	.827			
		C40	.555			
7.	Avoided, excluded, ignored			.789	.668	.603
		C13	.710			
		C18	.898			
		C45	.785			

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8.	Being stared			.971	.969	.397
		C14	.809			
		C47	.763			
		C49	.820			
		C50	.719			
9.	Loved ones			.781	.858	.670
		C25	.868			
		C26	.852			
		C27	.729			
10.	Job discrimination			.684	.791	.575
		C11	.881			
		C34	.448			
		C41	.865			
11.	Physically attacked			.868	.875	.480
		C9	.407			
		C12	.786			
		C17	.634			
		C20	.849			
		C21	.881			
		C31	.710			
		C46	.629			
		C48	.503			
Psychological Well being						
1.	Autonomy			.789	.668	.603
		D15	.305			
		D17	.936			
		D18	.917			
2.	Environmental mastery			.714	.629	.512
		D4	.160*			
		D8	.839			
		D9	.897			
3.	Personal growth			.730	.593	.580
		D11	.909			
		D12	.861			
		D14	.414			
4.	Positive relations			.189	.036	.377
		D6	.451			
		D13	.767			
		D16	.583			
5.	Purpose in life			.570	.003	.428
		D3	.898			
		D7	.466			
		D10	.508			
6.	Self-Acceptance			.654	.533	.566
		D1	.833			
		D2	.874			
		D5	.489			
Body Shape Questionnaire				.960	.956	.401
		E1	.647			
		E2	.778			

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E3	.577
E4	.622
E5	.644
E6	.528
E7	.579
E8	.550
E9	.207*
E10	.722
E11	.708
E12	.710
E13	.626
E14	.716
E15	.734
E16	.607
E17	.529
E18	.528
E19	.685
E20	.825
E21	.757
E22	.377
E23	.491
E24	.768
E25	.595
E26	.578
E27	.607
E28	.492
E29	.680
E30	.334
E31	.773
E32	.656
E33	.808
E34	.607

*Items deleted

As indicated in the table above, two items (D4 and E9) had factor loadings below .30 and therefore were discarded. In all 90 items were deem valid for the data collection. The AVEs for all the dimensions were resonable, hence convergent validity was achieved. The results of the discriminant validity are presented in the table below.

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Table 2: Discriminant Validity for psychological wellbeing

Construct	1	2	3	4	5
Autonomy					
Environment	.279				
Personal	.330	.219			
Positive relations	.862	.816	.649		
Purpose in life	.500	.772	.728	.885	
Self-acceptance	.788	.877	.548	.660	.718

Table 3 :Discriminant Validity for stigmatising situation inventory

	1	2	3	4	5	6	7	8	9	10
Child										
Doc	.431									
Fam	.646	.733								
Other	.333	.892	.646							
Neg	.894	.875	.857	.828						
Bar	.550	.768	.633	.716	.758					
Avoid	.352	.816	.847	.675	.459	.887				
Stared	.790	.881	.833	.538	.545	.843	.697			
Loved	.695	.502	.805	.767	.840	.594	.874	.662		
Job	.545	.765	.795	.653	.890	.716	.246	.772	.328	
Phys	.623	.845	.804	.743	.853	.845	.675	.828	.707	.743

According to Ringle et al. (2015), to achieve discriminant validity, the HTMT values must be below .90. For the discriminant validity, all the HTMT values for the dimensions of stigmatising situational inventory, body shape questionnaire and psychological wellbeing were below .90, hence discriminant validiy was achieved. Further the internal reliability was estimated using the rho_A and most of the coeffiecients were above .70. In all 90 items were used for the data collection. Figure 1 presents the measurement model of the

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stigmatising situational inventory, body shape questionnaire and psychological wellbeing.

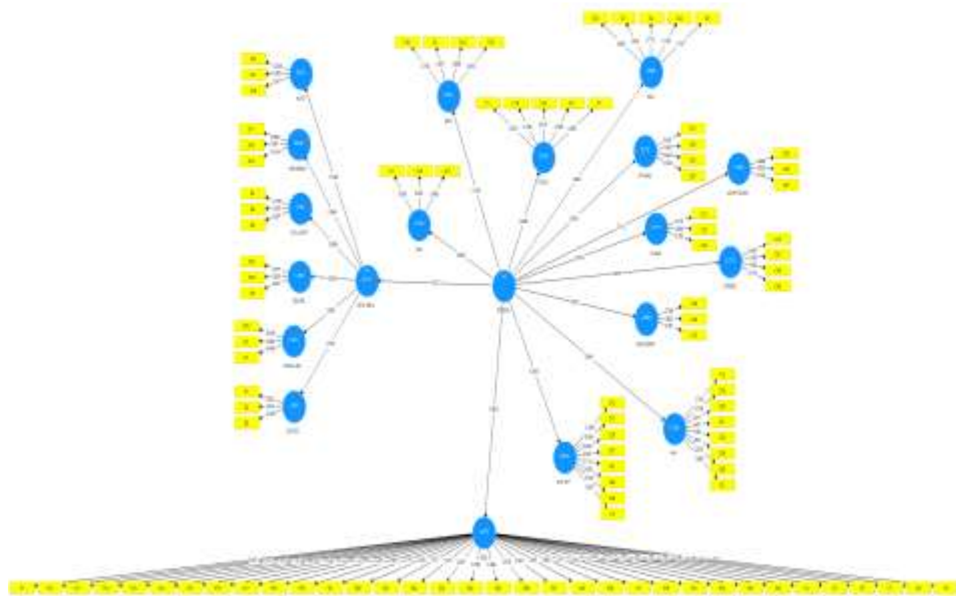

Figure 2.1: - Measurement model for stigmatising situational inventory, body shape questionnaire and psychological wellbeing.

Validity and Reliability of Data Collection Instrument

Validity establishes the extent to which the data collection instrument can be able to collect the data it is supposed to collect. In the development of a research design, the researcher needs to be sure that empirical findings that reflect the reality of situations are collected (Mcburney & White, 2013). Pretesting is fundamentally important in determining the strengths and weaknesses of the instrument before the actual data collection and corrected. It also allows for rectification on invasive or intrusive questions (Aylmer, 2017). Consistent with this view, the researcher pretested the instrument with 50 respondents in the study area in order to examine the understanding of the respondents and the possibility of gathering the required information with the instrument. The outcome of this activity enabled the researcher to review and restructure the instrument to reflect this goal. The questionnaire was also

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reviewed by expert colleagues and their inputs were gathered and factored in the restructuring to obtain both content and face validity of the instrument.

Ethical consideration

Ethical clearance was sought from the Institutional Review Board of the University of Cape Coast after all the requirements had been fulfilled. The right to privacy, voluntary participation, no harm to participants, anonymity, and confidentiality were the ethical concerns considered in the report. Permission was sought from the respective management of the various selected premises for the study to be carried out. One graduate student and one health personnel who undertook the study were educated to hold in high esteem the values mentioned above. The respondents were to participate voluntarily. Their rights for involvement would be respected. Clients and staff of the selected premises were also informed about how this exercise could disrupt normal activities at the various premises. Besides, the issue of plagiarism was considered in every facet of the study. This was done by avoiding copyright issues and rather acknowledging the right sources of information.

Data Collection Procedure

There are several ways data can be collected. Some researchers use tests, interviews, observations, etc. For the purpose of this study, however, questionnaires were used. According to Amedahe (2002), questionnaires consist of questions or statements that relate to the research question or hypothesis. Respondents are supposed to answer appropriately to enable the researcher to compile and make valid conclusions. There are broadly close-ended and open-ended forms of the questionnaire. Close-ended questionnaires

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require responses to short checkmarks to the various questions. The open-ended questionnaires require that a respondent freely expresses self as they answer the questions (Sarantakos, 1998).

Data collection was undertaken by some university graduates who were engaged to do so. Reliability was achieved through prior training on all data collection tools to ensure consistency. One health worker was also employed to undertake the anthropometric data. With the various locations where data was collected, permission was sought from the management of the various premises so access could be gotten to the various participants. Participation was voluntary through informed consent from the participants. The researcher clarified the purpose of the study to the participants and assured them of confidentiality and anonymity. Questionnaires were then administered to the participants at the various selected locations. The estimated time for collecting the data was one week at each premise, from Monday to Friday, during the institutions' working hours. Due to the coronavirus (COVID-19), all safety and health protocols were observed in the data collection process. This included the frequent washing of hands and wearing of nose masks at all times, as well as keeping a distance of six feet from other people.

Data processing and Analysis

The data obtained through the quantitative method were edited, coded, and fed into to the Statistical Software Program for Social Sciences. The six objectives of the study with corresponding three research questions and three hypotheses were analyzed as indicated.

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Research question one, which sought to find the level of body shape dissatisfaction, was analyzed using the mean and standard deviation.

Research question two sought to find the level of perceived weight-based stigma and was also analyzed using the mean and standard deviation.

Research question three which sought to find the level of psychological wellbeing of obese women in the metropolis was also analyzed using the mean and standard deviation.

Hypothesis one which stated that, there is statistically significant relationship between body image and perceived stigmatization was analyzed using Pearson Moment Coefficient Correlation.

Simple linear regression was used to analyze hypothesis two which stated that there is statistically significant influence of body image on the psychological wellbeing of the obese.

Hypothesis three stated that there is statistically significant influence of weight-based stigma on psychological wellbeing of obese women. This was also analyzed using simple linear regression. The measurement items were validated through exploratory factor analysis and reliability checked through Cronbach Alpha analysis.

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CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

The study examined the influence of body image and perceived stigmatization on the psychological well-being of obese women in the Kumasi Metropolis. Specifically, the study investigated the following objectives:

1. Determine the level of body image dissatisfaction among obese women.
2. Determine the level of perceived stigmatization among obese women.
3. Estimate the state of psychological well-being of obese women.
4. Examine the relationship between body image and perceived stigmatization of obese women.
5. Explore how body image influences the psychological well-being of obese women.
6. Investigate the influence of weight-based stigma on the psychological well-being of obese women.

This chapter presents the findings and discussion based on the analysis of data collected from participants. Data from participants were gathered quantitatively using questionnaires. The statistical tools used for the analysis included frequency distributions, one-sample t-test analysis, Pearson Moment Correlation Coefficient, and Simple Linear Regression Analysis. The tests were conducted for significant differences at a significance level of 0.05.

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Demographic Characteristics of the Respondents

The demographic characteristics of the respondents are presented in this segment. The age, educational level, anthropometric measures, body mass index, and marital status of the respondents are among the demographics addressed. This was carried out to generalize the characteristics of the sampled respondents and how it influences the results of the study such as the correlational and regression analysis. The results are represented in Table 4.

Table 4: Demographic Characteristics of the Respondents

		Frequency		Percentage
Educational Qualification				
None		5		2.2
JHS/**JSS**		4		1.7
SHS/VOC./TECH.		93		40.3
Tertiary		129		55.8
Total		231		100
Marital Status				
Single		120		51.9
Married		111		48.1
Total		231		100
Descriptive statistics	**Mean**	**SD**	**Minimum**	**Maximum**
Age	40.35	9.35	23.00	67.00
Height	158.47	6.96	146.00	180.00
Weight	107.89	12.20	83.00	135.00
Waist circumference	43.15	3.66	38.00	54.00
Hip circumference	50.34	4.40	40.00	65.00
Body mass index	42.94	3.73	35.92	56.89

Source: Field survey, 2020

Results from Table 1 are discussed under the following sub-headings: Educational level, Marital Status, Age, Anthropometric Measurement, and Body Mass Index.

Educational Level of Respondents

The results in Table 1 reveal that majority of the respondents have been educated up to the tertiary level and this represents (129) 55.8% of the total respondents. Only 4 of the respondents are educated up to JHS level

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representing 1.7% and these were in the minority among the sampled obese women. The distribution implies that a higher percentage of respondents with experience in education will understand the questionnaire and respond.

Marital Status

From Table 1, the results reveal that (120) 51.9 % of the respondents were unmarried whiles married respondents were (111) 48.1% of the respondents. The results implies that majority of participants were unmarried women.

Age of Respondents

The results in Table 1 show that the average age of the respondents is 40.35 years. The minimum age of participants was 23 years whiles the oldest participants was 67 years old. The average age implies that the majority of participants were between middle and late adulthood.

Anthropometric Measurement

The results show that the average height of the respondents among obese women is 158.47 cm with a standard deviation of 6.96 cm. The standard deviation shows that there were less variations in the heights of the sampled obese women. The average weight of the respondents among obese women is 107.90 kg with a standard deviation of 12.20 kg. Standard deviation is low suggesting that the average weight is representative. Again, the standard shows less variation in the weight of the sampled obese women. The average hip circumference of the respondents among obese women is 43.15 cm with a standard deviation of 3.66 cm. Standard deviation is low suggesting that the average waist is representative. Again, the standard shows that there were less variations in the waists of the sampled obese women. The average waist

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circumference of the respondents among the obese women is 50.34 cm with a standard deviation of 4.40 cm. Standard deviation is low suggesting that the average waist circumference is representative. Again, the standard shows less variation in the average waist circumference of the sampled obese women.

Body Mass Index

Finally, the average body mass index (BMI) of the sampled women is 42.94 kg/m with a standard deviation of 3.73kg/m. Since the minimum BMI and average BMI are all above 30kg/m, it implies that women sampled for the study are obese (W.H.O 1998). Standard deviation is low suggesting that the average BMI is representative. Again, the standard shows that there is less variation in the BMI of the sampled obese women.

Analysis of Main Data

Research Question 1: What is the level of body image dissatisfaction among obese women?

The purpose of this research question was to determine the perception of obese women regarding their body image in terms of being satisfactory or unsatisfactory. To answer this research question, a 34-item scale which measured respondents' overall thoughts about their body shape and desire to lose weight was_applied. Responses of participants were measured on a 6 point Likert scale type. One sample t-test was conducted to test the statistical significance of the means at 0.05 level of significance.

A test value of 3.5 was determined as the cut-off mean score for each item. An item mean score below the test value indicate that participants disagree with the statement whiles a score above the test value indicates that respondents support the statement. An overall cut-off mean score was

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calculated for overall Body Shape scores. This was done by multiplying the number of items (34) by the item cut–off mean (3.5) which gave a criterion mean of 119. This hypothesized mean (119) was compared with the obtained mean score for the level of perceived body image. An overall obtained mean score above the hypothesized or criterion mean connotes that participants are dissatisfied with their body image, while a lower score would mean that participants are not dissatisfied with their body image and shape. Table 5 and 6 present the level of Body Image Dissatisfaction.

Table 5: Item analysis of Means and Standard deviation of Level of Body Image Dissatisfaction among Obese women

Items	M	SD
1. I have ever been bored and thought about my body shape.	2.04	1.29
2. I have been so anxious with my appearance that i've been compelled to diet.	3.05	1.44
3. I have ever felt like my legs, hips, or bottom were out of proportion to the rest of my body.	2.52	1.58
4. I have ever been afraid of getting obese (or getting fatter).	3.61	1.29
5. I have been concerned that my skin isn't firm enough.	3.20	1.52
6. I have ever felt overweight after feeling full (for example, after consuming a big meal).	3.16	1.37
7. I have ever been so depressed about my appearance that i cried.	2.12	1.22
8. I have stopped running because of concerns about my flesh wobbling.	1.96	1.26
9. I have ever felt self-conscious about my body because thin women surround me.	3.01	2.88
10. I have ever been concerned about my thighs spreading out while i sit.	2.18	1.26
11. I have ever felt bloated after consuming even a small amount of food.	2.01	1.08
12. I have ever noticed how other women's bodies react to my own and felt self-conscious about it.	2.65	1.22
13. Worrying about my form made it difficult for me to focus (for example, when watching TV, reading, or listening to conversations).	1.62	1.06
14. Being naked, such as when taking a bath, made me feel fat.	2.77	1.40
15. I have stopped wearing clothing that draws my	3.40	1.45

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Item	Mean	SD
attention to my body's shape.		
16. I have ever considered slicing off chunks of my body.	2.31	1.29
17. I have ever felt bloated after consuming cookies, cakes, or other high-calorie foods?	2.53	1.26
18. I avoided social gatherings (such as parties) because I was self-conscious about my appearance.	1.55	.78
19. I have ever felt disproportionately big and rounded.	2.41	1.10
20. I have ever felt self-conscious about my appearance.	2.30	1.31
21. I have gone on a diet because of concerns about my appearance.	3.27	1.36
22. I have ever felt the most confident in my appearance when my stomach was empty (for example, in the morning).	3.17	1.51
23. I have ever considered that my present state of health is due to a lack of self-control.	2.81	1.34
24. I have been concerned about others seeing fat rolls around my waist or stomach.	2.94	1.28
25. I have ever thought it was unjust that other women were smaller than me.	2.11	1.06
26. I have ever vomited in order to lose weight.	1.49	.98
27. I have ever been concerned about taking up too much space in a group setting (for example, sitting on a sofa or a bus seat)?	1.88	1.22
28. I have ever been anxious about my skin being dimply.	2.04	1.13
29. I have ever felt self-conscious about my appearance when I saw myself in a mirror or a store window.	2.73	1.09
30. I have ever pinched myself to see how much fat I have.	2.91	1.33
31. I have avoided circumstances where others might see my body (for example, public locker rooms or swimming pools).	2.73	1.48
32. I have ever used laxatives to lose weight.	2.84	1.43
33. I have ever felt self-conscious about my appearance when around other people.	3.03	1.28
34. I have been compelled to exercise because of concerns about my appearance.	4.16	1.49

Source: Field Survey, (2020) Significant at $p < 0.05$

Table 6: Means and Standard deviation of Overall Level of Body Image Dissatisfaction among Obese women

Variable	Mean	SD
Overall level of Body Image Dissatisfaction	86.95	26.06

Source: Field Survey, (2020) Significant at $p < 0.05$

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The result from Table 5 and 6 was statistically significant at a significance level of 0.05. Results in Table 3 indicate that generally obese women in the Kumasi Metropolis were significantly satisfied with their body image. This is seen from the results of the mean and standard deviation which indicate a statistically significant difference between the criterion mean (119.0) and the obtained mean (*M* = 86.95, *SD* = -18.690). The overall obtained mean was less than the hypothesized/ criterion mean. The result reveals that the level of Body Image Dissatisfaction is statistically significantly low. The body shape questionnaire is scored based on the following categories; (not worried <81, slightly worried, 81-110, moderately worried, 111-140, and extremely worried, >140), hence, based on the scoring, it could be deduced that participants are slightly worried/concerned about their physical appearances. This revelation is also evident in Table 7 where the majority of respondents fall within the category of slightly worried.

Table 7: Body Image Dissatisfaction (Satisfaction) Among Obese Women

Item	**Frequency**	**Percentage**
Extremely worried	11	4.8
Moderately worried	28	12.1
Slightly worried	106	45.9
Satisfied	86	37.2
Total	231	100.0

Source: Field Survey, (2020).

Research Question Two: What is the perceived weight-based stigma among obese women?

The research question determined the perceived weight-related stigma among obese women in the Kumasi Metropolis. Participants responded to a scale which measures stereotypic situations that people encounter due to their

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weights and sizes. The 50-item scale was measured on a 10-Likert scale type ranging from 0 – 9. Participants were expected to indicate the extent to which they agree or disagree with each item that measures perceived weight-related stigma. A cut-off point of 5.5 was used as the criterion measure for each item. The cut-off point for overall perceived weight-related stigma was calculated by multiplying the number of items (50 items) by the cut-off point value (5.5). This gave a value of 275. The 275 being the criterion mean was compared to the overall obtained mean score of patients' perceived weight-related stigma mean. A higher score above the criterion mean (275) reflects a negative or threatening perceived weight-based stigma, whereas a lower score below the criterion mean reflects a positive perception of weight-related stigma. Table 8 presents the results of the mean and standard deviation of the general level of perceived weight-related stigma among obese women in the Kumasi metropolis.

Table 8: Means and Standard Deviation of General Level of Perceived Weight-related Stigma among Obese women

Variable	Mean	SD
General level of Body Image Dissatisfaction	36.29	45.619

Source: Field Survey, (2020) Significant at $p < 0.05$

When compared with the criterion mean, the results from Table 5 indicates that the perception of weight-related stigma is significantly low. This is evident from the fact that the overall obtained mean (M=36.29, SD=45.619) is significantly lower than the criterion or hypothesized mean (M=275). The result indicates that obese women in the Kumasi Metropolis perceived they are not significantly stigmatized due to their body weight and size.

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Research Question Three: What is the psychological well-being of obese women in the Kumasi Metropolis?

Research question three sought to find the level of psychological well-being among obese women in the Kumasi Metropolis. The responses of participants were measured using a 7 point Likert scale statements ranging from 1 (Strongly Agree) to 7 (Strongly Disagree). Participants were required to rank their responses on this Likert Scale type. Generally, a cut-off test value of 4.0 was used as the criterion measure for each item. The total psychological well-being score was calculated by reversing the scores for the following items 1, 2, 3, 8, 9, 11, 12, 13, 17, and 18.

The cut-off point for the criterion mean of the overall psychological well-being was calculated by multiplying the number of items (18 items) by the cut-off point value (4.0). This gave a value of 72. This 72.0 (criterion mean) was then compared with the overall (obtained) mean score for the respondents. A criterion mean lower than 72.0 reflects positive psychological well-being while a score higher than the criterion mean (72.0) reflects negative psychological well-being. Similarly, an analysis was conducted for the 6 subscales. Each subscale consists of 3 items. The criterion mean for the items was 12.0 (number of items, 3 multiplied by item mean, 4). A higher score reflects a more threatening view of the psychological well-being, whereas a lower score reflects a positive indicator of psychological well-being. Table 9 presents the mean and standard deviation of the psychological well-being level of obese women in the Kumasi metropolis.

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Table 9: Means and Standard deviation of Level of Psychological Well-being of Obese women in the Kumasi Metropolis

Variable	M	SD
Environmental Mastery		
4. The demands of everyday life often get me down	3.56	1.69
8. In general, I feel I am in charge of the situation in which I live	2.26	1.87
9. I am good at managing the responsibilities of daily life	1.75	1.25
Overall mean	**7.57**	**2.96**
Autonomy		
15. I tend to be influenced by people with strong opinions.	4.87	2.08
17. I have confidence in my own opinions, even if they are different from the way most other people think	2.06	1.65
18. I judge myself by what I think is important, not by the values of what others think is important	1.85	1.50
Overall mean	**8.78**	**3.32**
Personal Growth		
11. For me, life has been a continuous process of learning, changing, and growth.	1.75	1.46
12. I think it is important to have new experiences that challenge how I think about myself and the world	1.68	1.23
14. I gave up trying to make big improvements or changes in my life a long time ago.	5.18	2.24
Overall mean	**8.58**	**2.81**
Positive Relations		
6. Maintaining close relationships has been difficult and frustrating for me.	4.63	2.13
13. People would describe me as a giving person, willing to share my time with others.	2.11	1.66
16. I have not experienced many warm and trusting relationships with others.	4.60	2.12
Overall mean	**11.34**	**3.32**
Purpose in Life		
3. Some people wander aimlessly through life, but I am not one of them.	1.88	1 .74
7. I live life one day at a time and don't really think about the future	3.93	2.50
10. I sometimes feel as if I've done all there is to do in life	4.44	2.18
Overall mean	**10.24**	**3.844**
Self-Acceptance		
1. I like most parts of my personality	2.29	1.42
2. When I look at the story of my life, I am pleased with how things have turned out so far	2.42	1.33
5. In many ways I feel disappointed about my achievements in life	4.94	2.12
Overall mean	**8.72**	**2.99**

Source: Field Survey (2020) Significant at $p < 0.05$

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Table 10: Means and Standard Deviation of Composite Psychological Well-being among Obese women

Variable	Mean	SD
Composite of Psychological Well-being	56.16	11.79

Source: Field Survey, (2020) Significant at $p < 0.05$

The results from Table 7 reveal a significant positive psychological well-being among obese women. This is because the criterion mean (72.0) is greater than the obtained mean (M=56.16, SD=11.79). The result implies that although participants are obese, their psychological well-being has not been affected by their weight or size. In other words, being obese has not affected the psychological health of obese women in the Kumasi Metropolis.

Research Hypothesis One:

H_o: There is no statistically significant relationship between body image perception and perceived stigmatization of obese women.

H1: There is a statistically significant relationship between body image perception and perceived stigmatization of obese women

This research hypothesis intended to determine the association between Body image Satisfactions and perceived weight-related stigma. To test this hypothesis, a Pearson Moment Correlation Coefficient was used. This Statistical tool is useful in determining the relationship among variables with continuous data. The analysis aided in identifying the direction and degree of the relation among the variables under consideration. Before computing the correlation analysis, an assumption was tested to verify the Pearson Moment Correlation Coefficient. Linearity among the variables was estimated using a scatter plot. Figure 3 presents the scatter plot normality test of the study variables.

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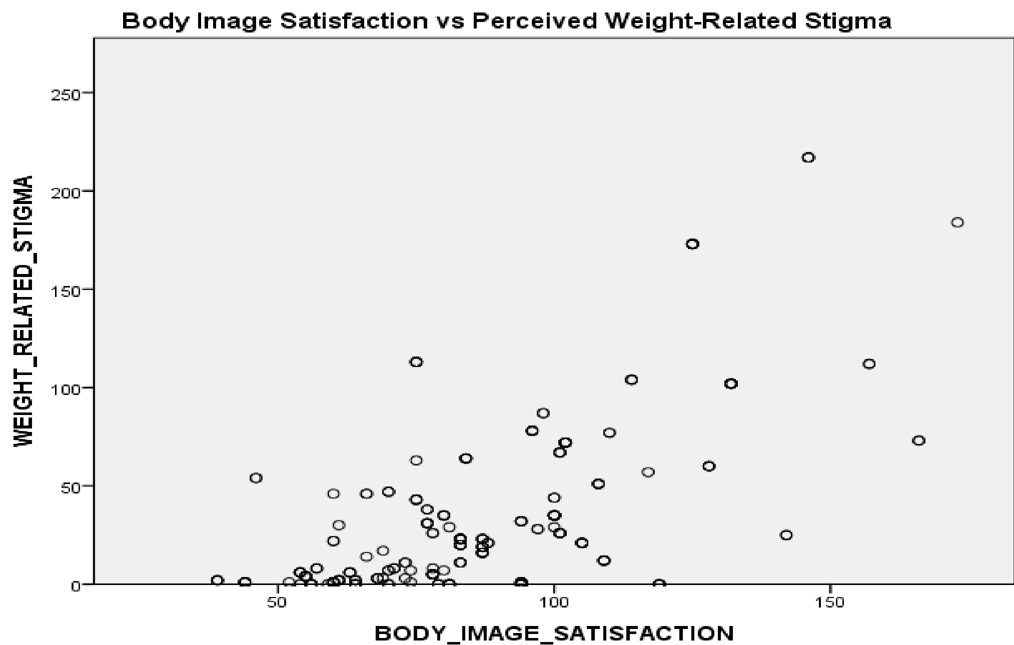

Figure 3: – Scatter plot of Linearity

Source: Field Survey, (2020)

The result of the linearity (linear relationship) as presented by the scatterplot indicated that there was a positive linear relationship between body satisfaction and perceived stigma. This was because the direction of the plots was tilted from left to right. The use of Pearson Moment Correlation is supported by this finding and the continuous nature of the data. Table 11 presents the analysis of Pearson Moment correlation coefficients of body satisfaction and perceived stigma.

Table 11: Pearson Moment Correlation of Body Image Perception and Weight-Related Stigma

VARIABLES		Body image Satisfaction	Perceived Stigmatization
Body Image Satisfaction	Pearson Correlation	1	.659**
	Sig. (2-tailed)		.000
	N		231
Perceived Stigmatization	Pearson Correlation		1
	Sig. (2-tailed)		
	N		

Source: Field Survey, (2020). ** Correlation is significant at 0.01 level (2-tailed)

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The results from the Pearson Moment Correlation Coefficient showed a significant positive relationship between body image perception and perceived stigmatization (r =.659) at a 1% level of significance. The positive relationship implied that both variables increased and decreased at the same time in the same direction. Judging from the direction of the statements and the direction of responses in the two scales, the positive correlation between body image and perceived stigma implied that body image satisfaction was related to a decrease or absence of weight-based stigma. The assertion is supported by the preceding analysis which shows that obese women in the Kumasi Metropolis have a positive body image perception and lower perceived weight-related stigma. The magnitude of .659 shows that there is a strong correlation between the level of body image satisfaction and perceived stigmatization. The findings of the study support the hypothesis that there is a significant relationship between body image perception and weight stigma. Hence, the null hypothesis is rejected in favour of the alternative hypothesis.

Research Hypothesis Two:

H_0: There is no statistically significant influence of body image on the psychological well-being of obese women.

H1: There is a statistically significant influence of body image on the psychological well-being of obese women.

Hypothesis two examines the impact of body image on the psychological well-being of obese women in the Kumasi Metropolis. Specifically, the hypothesis intended to address the effect and role of body image on the psychological health of obese women. Simple linear regression was used to test this assumption. This statistical tool is useful for assessing the

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extent to which an independent variable predicts or impacts a dependent variable. In this analysis, the independent variable is body image and the dependent variable is the psychological well-being. The results of the analysis are presented in Table 12 and 13.

Table 12: Simple Linear Regression Analysis of influence of Body Image on Psychological Well-being among Obese Women

Model	Standardized Coefficients	Unstandardized Coefficients		t-value	p-value
	Beta	B	Std. Error		
(Constant)		57.534	2.714	21.203	.000
Body Image	- .035	-.016	.030	-.527	.599

Source: Field Survey, (2020) Dependent Variable = Psychological Well-being

Table 13 - Result of Regression Analysis of the influence of body image on Psychological well-being of Obese Women.

Variables	*df*	Sum of Squares	Mean square	*F*	Sig.	*R*	R^2
Regression	1	38.777	38.777	.278	.599	.035	.001
Residual	229	31978.972	139.646				
Total	**230**	**32017.749**					

Source: Field Survey, (2020) Significant $p < 0.05$

The results from Table 13 revealed that body image perception has no significant effects on the psychological well-being of obese women (β = -.035, p =.599). As shown in Table 12, body image predicted less than 1% of variances in the psychological well-being of obese women (R^2 = .001, t = .035, p = .599); however, this value was insignificant because the significant

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value (p-value) was greater than 0.05. The result implies that body image is insignificant at explaining variation in the psychological well-being of obese women. Hence, the null hypothesis which states that there is no significant influence of body image on the psychological well-being of obese women is accepted against the alternative hypothesis.

Research Hypothesis Three:

H_0**:** There is no statistically significant influence of weight-based stigma on the psychological well-being of obese women.

H1: There is a statistically significant influence of weight-based stigma on the psychological well-being of obese women.

Hypothesis three resolves to investigate the influence of weight-related stigma on the psychological well-being of obese women in the Kumasi Metropolis. A simple linear regression analysis was considered appropriate to analyze this hypothesis. This statistical tool is best used to identify the extent of impact or effect that an independent variable has on a dependent variable. In this hypothesis, the independent variable is weight-related stigma and the dependent variable is psychological well-being. The results of the linear regression analysis are presented in Table 13 and 14.

Table 13: Result of Coefficients Analysis of influence of Weight-related Stigma on Psychological well-being of Obese Women

Model	Standardized Coefficients	Unstandardized Coefficients		t	Sig.
	Beta	B	Std. Error		
(Constant)		55.531	.993	55.939	.000
Weight-Related Stigma	.068	0.17	.017	1.025	.307

Source: Field Survey, (2020) Dependent Variable = Psychological Well-being

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Table 14: Result of Regression Analysis of influence of Weight-related Stigma on Psychological well-being of Obese Women

Variables	*df*	Sum of Squares	Mean square	*F*	Sig.	*R*	R^2
Regression	1	146.082	146.082	1.050	.307	.068	.005
Residual	229	31871.667	139.178				
Total	**230**	**32017.749**					

Source: Field Survey, (2020) Significant $p < 0.05$

The results of the regression analysis in Table 14 indicate that, generally, perceived weight-related stigma does not significantly influence psychological well-being of obese women in the Kumasi Metropolis ($\beta = .068$, $p = .307$). As shown in Table 15, perceived weight-related stigma explained less than 1% variance of Psychological well-being, yet was insignificant because of the sig. the value was greater than ($R^2 = .005$, $f = 1.050$, $P = .307$) of obese women. This finding suggests that perceived weight stigma has no significant impact on the psychological well-being of obese women. Given this, the alternative hypothesis (H_1) which states that there will be a significant influence of perceived weight-related stigma on the psychological well-being of obese women in the Kumasi Metropolis was rejected in support of the null hypothesis (H_o).

Discussion of Findings

Obesity is found to have a significant impact on body image perception and overall well-being. The primary goal of this study was to assess the influence of body image and weight-related stigma on the psychological well-being of obese women in the Kumasi Metropolis. The first research question

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sought to identify the level of body image satisfaction among obese women. The results of the study revealed that obese women in the Kumasi Metropolis were significantly satisfied with their body image. The finding implied that irrespective of their body size and weight, obese women in the Kumasi Metropolis were generally satisfied with their body image. In terms of percentages, it was revealed that a majority of the women were slightly dissatisfied with their body image. The findings could be attributed to the preference of Africans for an average and fat body. Among Ghanaians, weight gain is equated to prosperity and good living. Agyemang, et al (2016), demonstrated that there is a presumed cultural valuation of fatness as a sign of good health, fertility, wealth, and beauty. Similarly, Aryeetey (2016) opined that whilst extreme obesity is undesirable among Ghanaian women, some level of weight gain is admirable and seen as good signs of living.

This assertion justifies why obese women in the present study were generally satisfied with their body image. The findings of this study are inconsistent with that of Radwan et al (2019). Their study explored body image perception among university students. Findings revealed that 81% (58.2% females and 41.8% males) were significantly dissatisfied with their body image. Similarly, Shin and Shin (2008) assessed the association among dissatisfaction with body image, self-worth, and depression among elementary school children in Korea. Their results are at variance with the findings of my current study. The findings revealed that obese children were highly dissatisfied with their body image. Although the study of Shin and colleague was among children, it gives us evidence of the extent to which body image is of significance importance across all age categories.

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Cash and Hicks (1990) observed that most females and about one-fourth of males who are objectively normal weight tend to perceive themselves to be overweight. In their study, it was observed that whatever weight a person assigned to him/herself had a strong relationship to their attitudinal body image, weight concerns, behaviours, and overall psychosocial well-being. In a related study, Zaccagni, Rinaldo, Bramanti, Mongillo and Gualdi-Russo (2020) conducted a survey to evaluate perceived body image and body composition among adults in India. The study found that women, compared with men, showed higher body dissatisfaction. Majority of women in the study perceived they were fat and needed to lose weight. Weinberger, Kersting, Riedel-Heller and Luck-Sikorski (2016) also investigated the degree of body dissatisfaction in people with obesity relative to normal-weight people. Findings showed that obese person demonstrated greater discomfort than the average person. Meta-regression revealed a significant association between female sex and higher body unhappiness. In conclusion, the findings show that people with obesity and particularly women have a great deal of body dissatisfaction.

Based on the discussion, it could be realized that the majority of the studies discussed concerning the current study found that body image dissatisfaction is higher among many groups of individuals. Whiles this is not certainly true for the findings of my study, it could be asserted that the differences are due to the cultural beliefs, social environment, and the type of the participants who were recruited for the study.

The aim of research question two was to determine the extent of perceived weight-related stigma among obese women in the Kumasi

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Metropolis. Findings indicated that obese women in the Kumasi Metropolis perceived they were not stigmatized due to their body image and size. The findings defy the assertion that weight-related stigma is prevalent in recent times (Bookwala & Boyar, 2008). It has been noted that weight-related stigma persists because people do not consider the genetic, illness, and injury factors related to obesity, but instead dwell strictly on extensive food consumption and sedentary lifestyle. The role of the media in projecting thin and slim body as desired body image also increases weight-related stigma in our society. In Ghana, obese people are popularly referred to as '*okesei*', '*obolo*', '*maame agbo*'. This name-calling' can hurt the self-concept of obese people in general. However, in this study, weight-related stigma was not an issue among obese women in the Kumasi Metropolis.

Inconsistent with my findings regarding weight-related stigma, Aryeetey (2016) studied the views and experiences related to overweight among women in Ghana. They revealed that overweight women were highly stigmatized. In the same way, Andreyeva, Puhl, and Brownell (2008) explored changes in perception of weight stigmatization among Americans. The study took place in two separate time frames from 1995 to 2004 and from 2004 to 2006. The study revealed that stigma associated with weight rose from 7% to 12%. The study concluded that weight discrimination is highly prevalent among Americans. Magallares, Morales, and Rubio (2011) in their study, focused on weight-based discrimination in the workplace and noted that it affects millions of people in industrialized societies. They observed that discrimination was meted to individuals due to their body size and thus generates a decline in the psychological wellbeing of obese people since

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aspects such as self-esteem and life satisfaction are affected by social exclusion. Macedo, Portela, Palamira, and Mussi (2015) pointed out that whilst stigma may not be completely eradicated, obese people have to come to terms with either living with the stigma from people or accepting themselves by dealing with the negative body image expression which comes with it.

Likewise, Thiel, John, Carl and Thedinga (2020) examined the extent to which life experiences influence obesity and related weight stigma. Thirty (30) adults were recruited for the study. It was observed that weight-related stigma is very prevalent among adolescents and moderate in adults. The results seem to connote that adults are no more overly stigmatized due to their weight than adolescents are. As far as my study shows, obese women in the Kumasi Metropolis were not stigmatized as a result of their body. The assertion that adolescents significantly suffer from weight-related stigma will need further studies for clarification.

In research question three, the goal was to determine the psychological well-being among obese women. Findings indicated that obese women had significant positive psychological well-being. The result suggests that the psychological health of obese women is seemingly not affected by their obese nature. The results could be because in the African context, having more weight and being a bit "fat" is seen as a sign of good living and better life. It also signifies that the individual is living well under almost all circumstances. A study by Giuli et al. (2014) considered the quality of life of obese, overweight, and normal weight older adults. The study found that the quality of life of obese and overweight was significantly low. Their findings disagree with the results of this study stating that obese women in the Kumasi

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Metropolis have positive psychological well-being. Although quality of life and psychological well-being are two distinct constructs, the comparison is beneficial to our understanding of the extent to which obesity can impact the overall well-being of affected persons.

Similarly, Bookwala and Boyar (2008), studied gender differences in relation to body mass index (BMI) and psychological well-being. The results revealed that increased BMIs predict poorer psychological well-being among women. In terms of gender, women demonstrated poorer mental well-being than men in the overweight and obese categories when participants were split into 5 BMI groups. Gray and Leyland (2008) examined correlations in the sex, in the social, lifestyle and contextual variables between adolescents with psychical distress and those who are overweight. Findings indicate that overweight is connected to psychological distress in teenage girls but not boys. Effects are not mediated in psychological, lifestyle and contextual variables.

Sabik (2012) conducted an exploration study to assess body image and psychological wellbeing among ageing women in America. Findings suggest that older women are primarily concerned with aspects of the body related to functionality, and significant variations emerged between ethnic groups on the effect of social comparison on body perception. Further, bodily function and appearance was negatively associated with depression. It was concluded that body perceptions affect health, psychological well-being, and quality of life. Reddy and Crowther (2007) found that South Asian American women experienced maladaptive eating attitudes due to body image dissatisfaction. According to Vander Wal and Thelen (2000) being overweight predicts body dissatisfaction and disordered eating behaviour. Carrol and Spangler (2001)

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as well as Spangler (2002) also observed that perception of obesity is associated with body dissatisfaction and decreased psychological wellbeing.

The aim of the research hypothesis one was to identify the relationship between body image and weight-related stigma. The results showed that body image had a significant positive relationship with weight-related stigma. In this study, the positive relationship connotes that body image satisfaction is related to a decrease or absence of weight-based stigma. In other words, the less obese women are discriminated against, the higher their body image satisfaction. This assertion and explanation are based on the direction of the statements and the direction of responses in the scales which assessed body image and weight-related stigma. Similar to this finding, Latner, Barile, Durso, and O'Brien (2014) observed a moderate positive relationship between body image and weight-related discrimination. Essayli, Murakami, Wilson, and Latner (2017) assessed the impact of weight labels on body satisfaction, weight-related stigma, and other variables among college women. Findings showed that weight labels and related stigma had a significant negative impact on body image satisfaction. This result connotes the existence of a relationship between body image and weight-related stigma.

Satghare, Mahesh, Abdin, Chong, and Subramaniam (2019) explored the relative associations of Body Image Dissatisfaction (BID) among psychiatric outpatients in Singapore. A prevalence of 30.9% of BID was established among psychiatric out-patients in Singapore. Being female, having higher BMI scores, binge eating behaviour, eating disorders, and those diagnosed with depression were positively associated with BID. The study concluded that BID is prevalent among those with psychiatric illnesses which

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could lead to a higher degree of psychological distress and the emergence of eating disorders. Another study by Ciciurkaite and Perry (2018), which considered weight stigma and mental health among women, reported that the effect of weight-based discrimination on psychological wellbeing is highly contingent on social status. Specifically, the psychological consequences of discrimination on women are significantly greater relative to controlling for obesity status and self-rated health. These results suggest that weight stigma has an adverse impact on psychological well-being due to socio-economic status.

In other related study, Jung, Spahlholz, Hilbert, Riedel-Heller, and Luck-Sikorski (2017) investigated the impact of weight-related discrimination, body dissatisfaction and self-stigma on the desire to weigh less. Regression analysis reveals that being female, having a higher BMI, being younger, and trying to lose weight was related to a greater discrepancy between current weight and desired weight. The discrepancy between current weight and desired weight was greater when participants reported discrimination due to their weight as well as internalized stigma and body image concerns.

Research hypothesis two examines the influence of body image satisfaction on the psychological well-being of obese women in the Kumasi Metropolis. Analysis of data revealed that body image has no significant effect on the psychological well-being of obese women. The study implies that the perception of being obese has no impact on the psychological health among women in the Kumasi Metropolis. These surprising findings defy the assertions of many studies that obesity is associated with psychiatric disorders. According to Stunkard, Faith, and Allison (2003), the psychological impact

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becomes significant when obese women become increasingly worried about their body image and become preoccupied with weight loss. In this current study, obese women showed satisfaction with their body image. Based on these findings the results that body image perception did not influence participants make statistical sense. Consistent with these findings, Rodino, Byrne, and Sanders (2016) explored the relationship between psychological well-being and obesity among women with infertility problem. In the study, obesity had no relationship with psychological well-being among women.

However, the study of Michels and Amenyah (2017) is at variance with the finding of this study. Their study investigated the relationship between desired body image and dissatisfaction, and the role of media, personality, and well-being. The study results indicated that negative body image perception was related to low well-being. Likewise, Yazdani, Hosseini, Amini, Sobhani, Sharif, and Khazraei (2018), using a cross-sectional survey, studied the relations between body image and psychological well-being among obese patients. The study discovered that body image dissatisfaction was associated with overall psychological well-being and its subscales. It implied that body image deficiencies due to obesity could result in negative psychological well-being in many patients. In a related study, Dotse and Asumeng (2015) sought to identify the effects of body image satisfaction on the psychological health of persons from 9 different countries in Africa. The results of the analysis indicated that body image had a significant association with psychological well-being. The study of Dotse and Asumeng also identified that the value system of the African adequately downplays the relation between body image and psychological well-being.

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Lastly, Hypothesis three investigates the influence of weight-based stigma on the psychological well-being of obese women. Findings indicated that generally, perceived weight-related stigma does not significantly influence the psychological well-being of obese women in the Kumasi Metropolis. The results suggest that among obese women in the Kumasi Metropolis, weight-stigma has no significant impact on their psychological well-being. Concerning the findings of this study, that obese women had positive psychological well-being and perceived that they are not stigmatized due to their body image or size, the findings of this hypothesis are understandable. However, according to some studies, obese and overweight people suffer some psychological effects mainly due to the discrimination and stereotypic attitude meted out to them and not due to their obese nature (Muennig, 2008; Carr & Friedman, 2005). Notwithstanding, Puhl and Huer (2009) discovered that weight-related stigma is significantly associated with depression, low self-esteem, poor body image, suicidal ideas and low likelihood of attaining educational and occupational heights. My findings cast a doubt on earlier results that weight-related stigma is associated with psychological health problems. Likewise, the discovery of Emmer, Bosnjak, and Mata (2020), in a related study, deviate from the finding of this study. In a meta-analysis, the authors examined the association between weight-related stigma and psychological problems. A higher perceived weight-related stigma is associated with mental health problems.

Consistent with this study, Ciciurkaite and Perry (2017) assessed the relationships among body weight, stigma, and mental health among women. The study dwelt on the modified labeling approach. Analysis of weight-related

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stigma has no direct effect on the psychological well-being among women; rather the influence of other factors, such as socioeconomic elements, makes the effect of body stigma and weight significant. According to Ciciurkaite and Perry, failure to control these influential factors and their relationship to body weight, related stigma, and psychological well-being, will also produce biased results.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Overview of the Study

The study was a quantitative survey and it investigated the influence of body image and perceived stigmatization on the psychological well-being of obese women in the Kumasi Metropolis. Specific objectives of the study were to: determine the level of body image satisfaction and perceived weight-related stigma, examine the relationship between body image and perceived stigmatization of obese women, and explore the influence of body image and perceived weight-related stigma on psychological well-being among obese women.

The study area was the Kumasi Metropolis, Ashanti Region. The Metropolis is made up of ten (10) Sub-Metropolitan District Councils which are Asokwa, Suame, Bantama, Kwadaso, Manhyia, Oforikrom, Subin, Asawase, Tafo and Nhyiaso. The target population of the study constituted obese women in the Kumasi Metropolis. Participants were selected from health shops and the gym or fitness centres in the metropolis. Overall, two hundred and thirty-one (231) participants were selected through a simple random sampling technique.

Descriptive statistics, such as mean and frequency, were employed to assess the level of body image perception, weight-related stigma, and psychological well-being among obese women in the Kumasi Metropolis. A pearon Correlational analysis was deployed to analyze the relationship

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between body image satisfaction (dissatisfaction) and perceived stigmatization. Simple Linear Regression was employed to examine the influence of body image and weight-based stigmatization on psychological well-being among the obese women in the Kumasi Metropolis. The tests were conducted for significant differences at a significance level of 0.05.

Summary of Key Findings

1. The study found that generally obese women in the Kumasi Metropolis were significantly satisfied with their body image. Further, the analysis revealed that approximately 46% were slightly worried about their body image.
2. Perceived weight-related stigma among obese women in the Kumasi Metropolis was significantly low.
3. Obese women in the Kumasi Metropolis had a positive or healthy psychological well-being in spite of their body size.
4. Findings revealed that there is a positive relationship between perceived stigmatization and the level of body image satisfaction among obese women in the Kumasi Metropolis. The magnitude of the correlation coefficient indicated a strong correlation between perceived stigmatization and the level of body image satisfaction.
5. Body image satisfaction has no significant effects on the psychological well-being of obese women.
6. Perceived weight-related stigma does not significantly influence the psychological well-being of obese women in the Kumasi Metropolis.

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Conclusions

Based on the findings, the following interpretations were made.

1. Obese women in the Kumasi Metropolis are not disturbed by their 'plus size" body image.
2. People in Kumasi Metropolis do not subject obese women to discriminative and stigmatizing behaviors.
3. Being obese woman in the Kumasi Metropolis has no adverse effect on the their psychological wellbeing.
4. Body image satisfaction is related to a decrease or absence of weight-based stigma.
5. Among obese women in the Kumasi Metropolis, body image satisfaction and weight-related stigma are not determinants of psychological wellbeing.

Implications for Counselling

The influence of body image and perceived stigma on the psychological wellbeing of the obese does have some counselling implications. The need for tailored intervention such as Individual, group, and family counselling have been shown in studies to be effective for a wide range of client concerns (Sexton, Whiston, Bleuer, & Walz, 1997). Both prevention and intervention strategies are needed to help women realize body image problems and to help professionals appropriately recognize the symptoms that may be overlooked. Counselling could result in behaviour change, successful experiences, and mastery for parties involved.

From the study, majority of obese women in Kumasi were satisfied with their body. This is reflective in their high self-esteem and standard of

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living. As a result, they show little concern about how their body size impacts negatively significant others. As such, counsellors are to counsel and address specific behaviours (e.g., binge eating, dieting, and exercising) and to draw their attention to the obese so they don't overlook the effects of their obesity on the important people around them.

The study also revealed some level of stigmatization obese women go through. Though majority do not experience this, there is the possibility those who experience stigma have a range of unhealthy behaviours and cognitive distortions that could lead to symptoms of depression and low self-esteem (Kimmel & Mahalik, 2004; Raevuori et al., 2008; Wade, George, & Atkinson, 2009). Given this, Counsellors can help clients acknowledge and normalize the concept of body image dissatisfaction their clients experience. They can also create a supportive collaborative counselling relationship through family and group counselling.

The study also found that body image dissatisfaction and weight-based stigmatization reduce the psychological well-being of obese women. The study, therefore, recommends that family members of obese women who are dissatisfied with their body image should engage services of counsellors and psychologist to offer them therapy in order to have a positive mentality about their interaction with their social environment.

Recommendations

The following recommendations are given based on the findings of the study:

1. The findings revealed that the majority of obese women are slightly dissatisfied with their body. It is recommended that counsellors, clinical psychologists and other mental health professionals prioritize and tailor make

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their therapeutic practices and public lectures to enable concerned obese women to overcome their body dissatisfaction.

2. Additionally, family members and spouses of obese women should be trained and encouraged to appreciate their body image if it is physically impossible for them to reduce their weight. Again, family, health professionals, and stakeholders should advocate and encourage obese women to partake in physical exercises to lose or maintain body image and sizes.

3. Obese women should be encouraged by family, religious organizations and their health professionals to see dieticians and appropriate authorities to plan their eating style to suit their genetic makeup since most obese people have issues with worry over their diet patterns and suffer undue stress as results.

4. The study also found that body image dissatisfaction and weight-based stigmatization reduce the psychological well-being of obese women. The study, therefore, recommends that family members of obese women who are dissatisfied with their body image should engage services of social welfare department and psychologist to offer them psychological therapy to have a positive mentality about their interaction with their social environment.

Suggestions for Further Research

The following are suggestions for future research:

1. Finally, the study recommends that future studies could examine the mediating role of body image on the relationship between psychological well-being and weight-based stigmatization in Ghana.
2. The study found a significant correlation between body image and perceived stigmatization. However, statistically speaking, correlation does not imply causality. The study recommends that future studies

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could examine the influence of body image on perceived stigmatization among obese women with the use of multiple regression analysis.

3. Only scales were used to collect information from participants. It would be appropriate for future research to gather data using alternative data collection methods such as qualitative sources and clinical observations.

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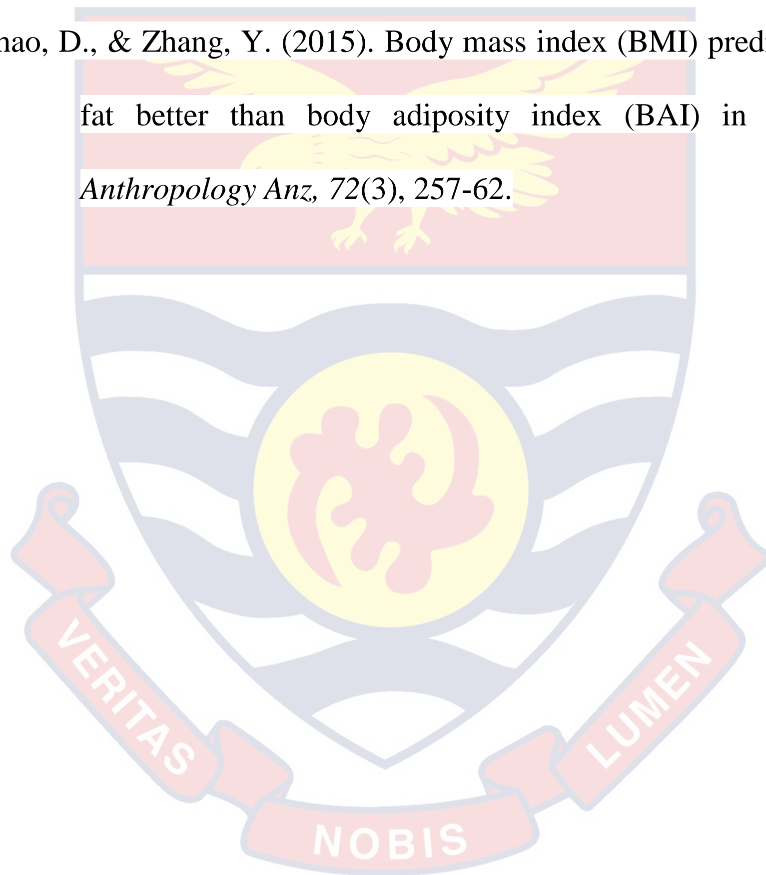

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APPENDICES

APPENDIX A: Questionnaire

I am Harriet Afriyie-Adjimi a Guidance and Counselling MPhil student from the University of Cape coast. I am writing to ask for your participation in a survey about the influence of body image and perceived stigma and how this could affect the psychological wellbeing of the obese.

The purpose of the survey is to create awareness on the effects of weight-based stigma and help combat it. The study would also enhance psychological support for the obese woman and help the individual and institutions/ firms rendering weight loss services to improve implementation of their services and overall performance.

You are free to decide if you want to be in this research. Your participation is entirely voluntary. If you consent to answering these questions, all the information that you give will remain confidential and protected to the best of our ability.

If you have any questions or comments about this survey, please feel free to contact us on 0244684078.

Part A: Demographic characteristics

1. Age (Years) …………..

2. Gender: Male Female

3. Educational level – what is your highest level of education achieved?

A. None B. Primary C. JHS/JSS D.SHS/Voc/Tech E. Tertiary E. Other please state …………………

4. What is your occupation?……………………………………………………

5. Marital Status…… A. Married B. Single C. Divorced D. Widowed

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Part B: Anthropometric measurements

1. Height (cm)……… B. Weight (Kg)…… C. Waist circumference(cm)…… D. Hip circumference(cm)…… BMI……….

Part C: Stigmatizing Situations Inventory (Myers & Rosen, 1999)

A list of situations that people face as a result of their weight is given below. Indicate whether or not each of these conditions occurs often for you. Fill in the blanks with the number that best represents how often you experience each scenario. Make use of the scale below:

0------------1------------2-----------3-----------4----------5----------6------------7-----------8--------9

0	1	2	3	4	5	6	7	8	9
Never	Once in your life	Several times in your life	About once/yr.	Several times/yr.	About once a month	Several times/mo.	About once/wk.	Several times/wk.	Daily

1. A child coming up to you and saying something like, "You're fat!" ………

2. A doctor citing the weight for unrelated physical conditions ………….

3. You've been nagged by a parent or other relative to lose weight.. ………….

4. Because of your weight, your spouse or girlfriend is calling you names.. ….

5. A girlfriend or spouse advising you to lose weight in order to be more desirable. ....

6. Having a kid making fun of you because of your weight as an adult……………..

7. Because of your weight, you were ridiculed, called names, and laughed at as a boy……….

8. Being chastised or threatened by other passengers on the bus for taking up "too much" space…………………………

9. Because of your weight, you are being hit, beaten up, or physically abused…………………

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10. Because of your size, strangers are offering you fashion advice.… …….

11. Being passed over for a promotion, given poor assignments, or subjected to other forms of discrimination at work …………………

12. Being sexually assaulted as a result of your weight (cat-calls, wolf-whistles, etc.). ……………

13. Being picked out by a teacher, school nurse, or other adult because of your size as a child.…………..

14. Being stared at in public. ………………….

15. At a family meeting, being the only heavy person, or the heaviest person. ....

16. Even if you are in good health, a doctor can tell you that your weight is a health issue.. ……………

17. "All you really need is a little willpower," I was advised.………………

18. Being unable to find a date due to your weight. ....

19. Children make loud remarks to others about your weight. ....

twenty-first. Your presence is being criticized by relatives, colleagues, employers, and others. ....

20. twenty-first. In public, groups of people pointing and laughing at you. ....

21. Making a doctor make negative comments about you, insult you, or call you names. ....

22. Even if you didn't come in to talk about weight loss, a doctor will prescribe a diet. ....

24. Having a romantic partner take advantage of you because he or she thought you were "desperate" and willing to put up with it. ……

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25. Making a spouse or girlfriend feel guilty for being with you..............

26. Making members of your family feel humiliated or ashamed of you. ....

27. Finding friends who don't notice your weight loss or who don't support you in your attempts to lose weight. ....

28. Having someone think you diet or overeat because you are overweight... ....

29. People assuming you have mental issues because you are overweight is number ....

30. Making people make food recommendations to you. ....

31. Making strangers photograph you as though you were a work of art. ....
....
....

32. Being teased or insulted because of your weight by your children. ....

33. Making people mock or make remarks about the food choices in the supermarket. ....

34. Being fired from a job because of your weight. ....

35. Being unable to find suitable clothing. ....

36. Being unable to locate medical equipment in a size that matches your needs. ....

37. Being unable to locate sports equipment in a size that is appropriate for you. ....

38. Not being able to fit into bus or airplane seats, into small cars, or into standard seatbelts. …………….

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39. Inability to find a seat in restaurants, theaters, or other public locations.

40. Being unable to pass through turnstiles, ride amusement park rides, or go to other locations not stated previously.

41. Being turned down for a job because of your weight, shape, or height.

42. Others' low expectations of you as a result of your weight.

43. Overhearing others in public make negative comments about you.

44. Relatives or parents telling you that if you lost weight, you'd be more beautiful.

45. People telling you that unless you lose weight, you can never find a girlfriend.

47. Having obese people ridiculed on bumper stickers, t-shirts, commercials, etc.

48. Strangers inquiring about your weight in an invasive and personal manner.

47. Strangers making derogatory comments about you (e.g., calling you gross or claiming you don't deserve to live).

48. Being told "You really shouldn't be eating that" while eating in public.50. When walking outside, having people drive by and laugh or shout insults.

Part D: Psychological Wellbeing Scale.

Instructions: indicate the number by the statement to indicate how much you agree or disagree.

1--------------2----------3---------4------------5---------------6----------------7

Strongly agree	Somewh at agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

1. ...ke most aspects of my .....

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2. Looking back on my life, I'm happy with how things have turned out so far....

3. Some people go through life aimlessly, but I am not one of them.............

4. *The pressures of daily life sometimes depress me.............

5. In many respects, I am dissatisfied with my life accomplishments......

6. It's been difficult and painful for me to maintain close relationships. I live life one day at a time and don't really think about the future……..

7. In general, I feel in command of the situation in which I find myself....................

8. I'm great at juggling day-to-day duties..................

9. I sometimes feel as if I've achieved everything there is to do in life....................

10. Life has been a constant phase of learning, evolving, and development for me....................

11. I believe it is important for me to have new experiences that question my views of myself and the world. People would describe me as a giving person, willing to share my time with others……………

12 I gave up trying to make major changes or adjustments in my life a long time ago...........

13 I am motivated by people who have strong views................

14 I haven't had many friendly and trusting relationships with others...............

15 I am confident in my own thoughts, even though they vary from the majority of people's......

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16 I evaluate myself based on my own beliefs rather than the values of others............

Part E: BSQ-34

Never- 1 | Rarely- 2 | Sometimes-3 | Often- 4 | Very often-5 | Always-6

1. I have ever been bored and thought about my body shape.....................
2. I have been so concerned with my appearance that i've been compelled to diet...
3. I have ever felt like my legs, hips, or bottom were out of proportion to the rest of my body ....
4. I have ever been afraid of being obese (or getting fatter) ....
5. I have been concerned that my skin isn't firm enough ....
6. I have felt overweight after feeling full (e.g. after eating a large meal)........
7. I have been so depressed about my appearance that i cried....................
8. I have stopped running because i'm concerned about my flesh wobbling
9. *I have ever felt self-conscious about my body because i'm surrounded by thin women ....
10. I have ever worried about my thighs spreading out while i sit……..
11. I have ever felt bloated after consuming even a small amount of food.......
12. I have ever compared my form to that of other women and thought it was unfavorable ....

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13. Thinking about my shape interfers with my ability to concentrate (e.g. while watching television, reading, listening to conversations)...............
14. I have ever felt overweight when fully nude, such as when taking a bath…..
15. I have stopped wearing clothes that draw attention to my body's shape...
16. I have ever considered chopping off chunks of my body.....................
17. I have ever felt fat after eating cookies, cakes, or other high-calorie foods
18. I have avoided social events (e.g. parties) because i'm self-conscious about my appearance.
19. I have ever felt disproportionately big and rounded …………..
20. I have ever felt self-conscious about my appearance.....................

21. I have gone on a diet because I'm worried about my appearance ....

22. I have ever felt the most confident in my appearance when my stomach was empty (for example, in the morning)....................................

23. I have ever considered that my current physical condition is due to a lack of self-control ....

24. I have ever worried about other people seeing rolls of fat around my waist or stomach...

25. I have ever felt that it is not fair that other women are thinner than me….

26I have ever vomited in order to lose weight ....

1. I have ever been concerned about taking up so much space in a community environment (for example, sitting on a sofa or a bus seat)? ....
2. Have you ever been concerned about your skin being dimply..................

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3. I have ever felt self-conscious about my appearance after seeing myself in a mirror or a store window ....

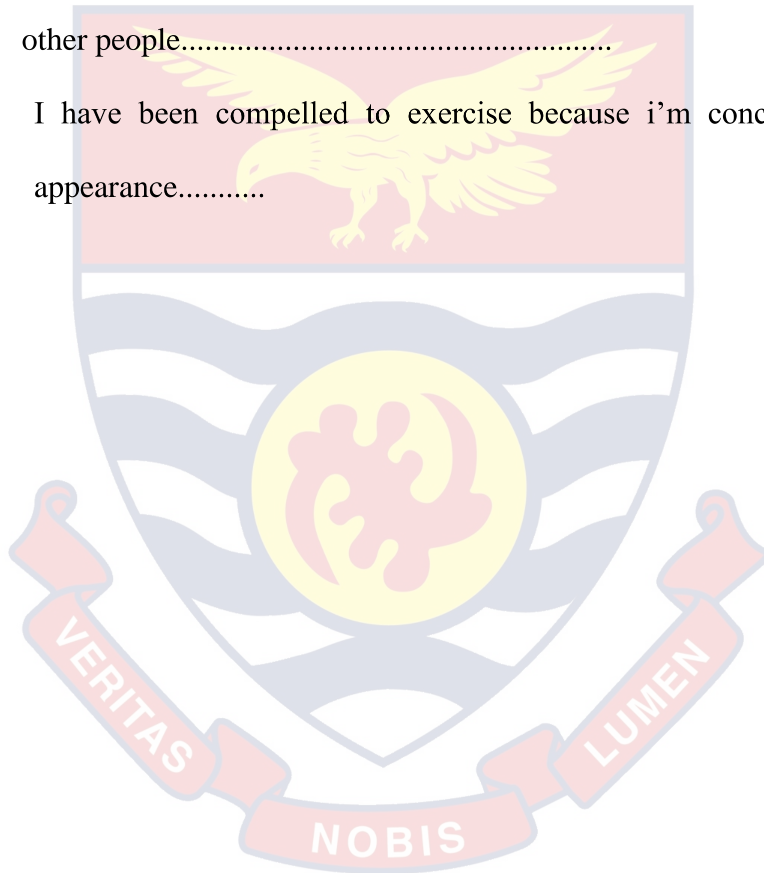
4. I have ever pinched yourself to see how much fat you have.......................

5. I have avoided situations where people could see my body (e.g. communal changing rooms or swimming baths)................................

6. I have ever taken laxatives in order to lose weight................................

7. I have been self-conscious about my appearance when in the company of other people..

8. I have been compelled to exercise because i'm concerned about my appearance...........



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APPENDIX B

INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
DEPARTMENT OF GUIDANCE AND COUNSELLING

Telephone: 0332091854
Email: dgc@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DGC/L.2/VOL.1/120

Your Ref:

May 15, 2020

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION

We introduce to you, Harriet Afriyie Adjimi a student pursuing an M.Phil Programme in Guidance and Counselling at the Department of Guidance and Counselling of the University of Cape Coast. As a requirement, she is to submit a Thesis on the topic: ***"Influence of Body Image and Perceived Stigmatization on the Psychological Wellbeing of Obese Women in the Kumasi Metropolis".*** We are by this letter affirming that, the information she will obtain from your Institution will be solely used for academic purposes.

We would be most grateful if you could provide her the necessary assistance.

Thank you.

Dr. Stephen Doh Fia
HEAD OF DEPARTMENT

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APPENDIX C

ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/837
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

12TH NOVEMBER, 2020

Ms. Harriet Afriyie-Adjimi
Department of Guidance and Counselling
University of Cape Coast

Dear Ms. Afriyie-Adjimi,

ETHICAL CLEARANCE – ID (UCCIRB/CES/2020/81)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research titled **Influence of Body Image and Perceived Stigmatization on Psychological Wellbeing of Obese Women in the Kumasi Metropolis.** This approval is valid from 12TH November, 2020 to 11th November, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

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