PSYCHOSOCIAL EXPERIENCES AND COUNSELING NEEDS OF INDIVIDUALS THROUGHOUT THE BARIATRIC SURGERY PROCESS: A QUALITATIVE STUDY

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ABSTRACT

PSYCHOSOCIAL EXPERIENCES AND COUNSELING NEEDS OF INDIVIDUALS THROUGHOUT THE BARIATRIC SURGERY PROCESS: A QUALITATIVE STUDY

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Bariatric surgery is increasingly recognized as more than a medical intervention for weight loss, involving profound psychological, behavioral, and social changes throughout the process. Despite growing research, little is known about individuals' psychosocial experiences and counseling needs during this process, particularly in Türkiye. This study aimed to describe those experiences and needs.

This study employed a qualitative descriptive inquiry design. Ten individuals, six women and four men, who had undergone bariatric surgery, were interviewed using purposive sampling. Data was analyzed through inductive qualitative content analysis.

The findings showed that bariatric surgery was a complex psychosocial process extending beyond weight loss. Participants cited long-term physical and psychological burden, repeated failed weight-loss attempts, eating behavior difficulties, and weight-related stigma as factors driving their decision for surgery. The postoperative period involved significant physical, emotional, and behavioral adjustment, with inadequate psychological support. Over time, participants described reconstructing their relationship with food, developing greater self-regulation over their eating behaviors, building self-confidence, developing a more positive relationship with their bodies, and becoming more actively engaged in everyday life. In addition, gender emerged as one of the key motivations for surgery, recovery experiences, interpersonal relationships, and interpretations of change.

The findings suggest that bariatric surgery should be understood as a complex psychosocial life transition rather than solely a medical intervention for weight loss. The study highlights the importance of integrating psychological counseling into multidisciplinary bariatric care and contributes to the limited qualitative literature on the psychosocial experiences of bariatric surgery.

Keywords: Bariatric surgery, psychosocial experiences, counseling needs, qualitative content analysis, obesity.

ÖZ

BARİYATRİK CERRAHİ SÜRECİNDEKİ BİREYLERİN PSİKOSOSYAL DENEYİMLERİ VE PSİKOLOJİK DANIŞMANLIK İHTİYAÇLARI: NİTEL BİR ARAŞTIRMA

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Bariyatrik cerrahi, kilo vermeye yönelik tıbbi bir müdahalenin ötesinde, bireylerin yaşamında psikolojik, davranışsal ve sosyal değişimleri de beraberinde getiren kapsamlı bir süreçtir. Bariyatrik cerrahiye ilişkin araştırmalar giderek artmasına rağmen, bireylerin bu süreçteki psikososyal deneyimleri ve psikolojik danışma ihtiyaçları, özellikle Türkiye bağlamında, yeterince bilinmemektedir. Bu çalışma, söz konusu deneyimleri ve ihtiyaçları tanımlamayı amaçlamıştır.

Bu çalışma, nitel betimsel araştırma deseni kullanılarak yürütülmüştür. Amaçlı örnekleme yöntemiyle bariyatrik cerrahi geçirmiş altı kadın ve dört erkek olmak üzere on bireyle yarı yapılandırılmış görüşmeler gerçekleştirilmiştir. Veriler, nitel içerik analizi kullanılarak analiz edilmiştir.

Bulgular, bariyatrik cerrahinin kilo kaybının ötesine geçen karmaşık bir psikososyal süreç olarak deneyimlendiğini göstermiştir. Katılımcılar, uzun süreli fiziksel ve psikolojik yük, tekrarlayan başarısız kilo verme girişimleri, yeme davranışını düzenlemede yaşanan güçlükler ve kiloya bağlı damgalanma deneyimlerini ameliyat kararını şekillendiren başlıca etmenler olarak tanımlamışlardır. Ameliyat sonrası dönem, yetersiz psikolojik desteğin eşlik ettiği önemli fiziksel, duygusal ve davranışsal uyum süreçlerini kapsamaktadır. Zamanla katılımcılar, yemekle olan ilişkilerini yeniden yapılandırdıklarını, yeme davranışları üzerinde daha güçlü bir öz düzenleme geliştirdiklerini, öz güven kazandıklarını, bedenleriyle daha olumlu bir ilişki kurduklarını ve günlük yaşama daha aktif katılım göstermeye başladıklarını ifade etmişlerdir. Ayrıca toplumsal cinsiyet, ameliyat motivasyonlarını, iyileşme deneyimlerini, kişilerarası ilişkileri ve yaşanan değişimin anlamlandırılmasını etkileyen bir bulgu olarak ortaya çıkmıştır.

Bulgular, bariyatrik cerrahinin yalnızca kilo vermeye yönelik tıbbi bir müdahale olmaktan ziyade, karmaşık bir psikososyal yaşam geçişi olarak ele alınması gerektiğini göstermektedir. Çalışma, psikolojik danışmanın multidisipliner bariyatrik bakım sürecine entegre edilmesinin önemini vurgulamakta ve bariyatrik cerrahinin psikososyal deneyimlerine ilişkin sınırlı nitel literatüre katkı sağlamaktadır.

Anahtar kelimeler: Bariatrik cerrahi, psikososyal deneyimler, danışmanlık ihtiyaçları, içerik analizi, obezite.

Dedicated to my grandmothers Zöhre and Fatma; brave women who endured countless hardships so that future generations could dream bigger…

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CHAPTER 1

INTRODUCTION

This chapter introduces the conceptual and empirical foundations of the study. It then presents the study's purpose, research questions, and its overall significance. Lastly, key terms used throughout the study are defined.

1.1. Background to the Study

Bariatric surgery has become an increasingly widely chosen intervention for individuals with severe obesity, particularly when nonsurgical approaches have not produced sufficient or sustained weight loss. Also referred to as metabolic or obesity surgery and is considered as one of the most effective interventions for achieving substantial and durable weight loss and improving obesity-related health outcomes (Eisenberg, et al., 2022; Nieves-Khouw et al., 2009; Sarwer et al., 2008). Its growing use across different healthcare contexts also reflects the limited long-term effectiveness of conventional weight-management approaches for some individuals (Groven et al., 2015; Panteliou & Miras, 2017). Although bariatric surgery has become increasingly widespread in Türkiye, comprehensive national data on the annual number of bariatric procedures are not regularly reported in publicly available sources.

The clinical context of bariatric surgery is shaped by the complex and multidimensional nature of obesity. Obesity develops through interactions among genetic, physiological, behavioral, environmental, and social factors and should not be reduced to individual lifestyle choices alone (Ranzenhofer et al., 2019). Its consequences may include chronic health conditions, psychological distress, body-

image concerns, weight-related stigma, discrimination, and reduced quality of life (Sørensen et al., 2022; Tuthill et al., 2006; Gregory et al., 2013). These experiences may influence both the decision to undergo surgery and individuals' expectations regarding health, appearance, mobility, and social life.

Although bariatric surgery is primarily indicated for the treatment of severe obesity and obesity-related comorbidities, individuals may seek surgery for multiple and often overlapping reasons. Alongside improving physical health and metabolic functioning, appearance-related concerns, body image, self-confidence, quality of life, and social acceptance may also influence the decision to undergo surgery (Rajeev et al., 2023; Keyte et al., 2024). Nevertheless, the desire to lose weight or improve physical appearance alone does not constitute a clinical indication for bariatric surgery, and not every individual with obesity is considered an appropriate candidate for surgery. Eligibility is determined through comprehensive clinical assessment based on medical guidelines (Eisenberg et al., 2022).

Bariatric surgery is not limited to the production of weight loss. It initiates a demanding process of physical, behavioral, psychological, and social adjustment. Following surgery, individuals may need to adapt to changes in eating practices, bodily sensations, physical appearance, interpersonal relationships, and self-perception (Chan & Vartanian, 2024; Greenberg, 2003). Improvements in health and daily functioning may coexist with emotional difficulties, body-image concerns, shifting expectations, and changes in family or social relationships (Dionisi et al., 2025; van Hout et al., 2009). Surgical outcomes therefore cannot be evaluated solely through weight loss or changes in BMI.

This broader understanding of bariatric surgery highlights the importance of psychological assessment and psychosocial support throughout the treatment process. Psychological evaluation may help identify individuals' expectations, readiness for behavioral change, coping resources, eating-related difficulties, social support, and potential vulnerabilities affecting postoperative adaptation (Glinski et al., 2001). Rather than serving only to determine psychological suitability for surgery, such assessment should contribute to treatment planning, informed decision-making, and continuity of care. Understanding patients' postoperative experiences is therefore

essential for developing approaches that address not only physical outcomes but also psychological well-being, identity, relationships, and everyday adjustment.

Those who have undergone the surgery have also observed positive effects on many aspects of quality of life, including improvement or recovery from health-related illnesses and mobility, self-care, daily activities, pain, anxiety, and depression (Price et al., 2014). Similar findings have also been reported in Türkiye. In a one-year follow-up study, Türkoğlu-Dikmen et al. (2022) found significant reductions in body mass index and emotional eating following bariatric surgery. Bariatric surgery represents a profound psychological transition that often requires individuals to adapt emotionally, socially, and behaviorally (Greenberg, 2003; Keyte et al., 2024). Bariatric surgery can lead to a range of positive effects that influence both physical health and daily life (van Hout et al., 2009; Murtha et al., 2022).

Bariatric surgery offers the most powerful and durable outcome (Morton, 2013). Many scientific studies have shown that this surgery is the most effective method available for weight loss, improving health and longevity (Morton, 2013). For many years, bariatric surgery has been primarily focused on achieving weight loss. Following bariatric surgery, patients have experienced improvements in both physical health and psychosocial well-being, including reductions in eating disorder symptoms (Albadareen et al., 2025; Price et al., 2014). Some patients reported that their depression, self-confidence, self-esteem, and sense of control improved (Hardman & Christiansen, 2018).

However, despite these positive outcomes, bariatric surgery is not without drawbacks. Unfortunately, impressive results are not universal (Al-Kadi & Al-Sulaim, 2024; Sarwer et al., 2008). In addition, bariatric surgery is associated with a range of adverse effects beyond weight loss, including excess skin formation, malnutrition, and various intestinal problems (Groven et al., 2015). There are also some negative reports of psychosocial outcomes after bariatric surgery (Al-Kadi & Al-Sulaim, 2024; Sarwer et al., 2008). These findings align with other studies documenting additional psychosocial difficulties experienced after surgery.

In a study examining the psychosocial difficulties of patients after surgery, patients reported negative outcomes in terms of physical health and psychological functioning (Coulman et al., 2017). Patients who use food consumption as a psychological coping strategy after surgery can continue this behavior (Morton, 2013). This also indicates that surgery falls short in helping patients explore ways to manage their emotional challenges and overcome these problems, pointing to the need for alternative approaches to address mental health issues and enhance overall well-being (Keyte et al., 2024).

According to Neovius (2018), patients who underwent bariatric surgery were at significantly higher risk for suicide and self-harm than those who did not undergo surgery. Interestingly, an increased risk of suicide and self-harm was also found in a subgroup of people with no history of psychiatric disorders or self-harming behavior (Hardman & Christiansen, 2018). According to Hardman and Christiansen (2018) these patients have a significant risk of alcohol use disorder and eating disorder.

Studies conducted so far generally focus on the physical outcomes of surgery (Glinski et al., 2001). Understanding patient perceptions and processes during the preoperative/postoperative phase is crucial for supporting individuals in the long term (Keyte et al., 2024). In some patients, severe psychiatric symptoms, such as psychotic symptoms or active suicidal ideation, may impair the capacity to provide informed consent. These individuals are not completely excluded; surgery is usually postponed until their condition improves (Glinski et al., 2001).

Psychological problems related to obesity can be improved with surgery, and even if positive developments are observed in this regard, it can be said that surgeries and surgical methods are insufficient to solve the underlying psychological problems in some individuals. Some patients reported that low self-confidence persisted after surgery (Hardman & Christiansen, 2018). It is assumed that the extent of weight loss may be associated with improvements in body image. However, research exploring this relationship remains limited and the findings are inconsistent (Ivezaj & Grilo, 2018). While some studies, such as Leombruni et al. (2007), have reported a positive correlation, others, such as De Panfilis et al. (2007), have found no significant association. A review of 90 studies found that bariatric surgery was not a determining

factor in the long-term maintenance of positive psychological and social outcomes following surgery (Al-Kadi & Al-Sulaim, 2024). The study recommended *psychological interventions* and long-term monitoring to understand and address the psychological effects after bariatric surgery (Al-Kadi & Al-Sulaim, 2024).

Among patients awaiting or undergoing bariatric surgery, the most common mental health conditions were depression (19%) and binge eating disorder (17%) (Keyte et al., 2024). Research indicates high rates of psychopathology in bariatric surgery candidates. Approximately 20–60% of patients experience mood or anxiety disorders, and to a lesser extent, substance use disorders and personality disorders (Sarwer et al., 2008). These psychological issues can significantly impact surgical management and postoperative recovery outcomes (Sarwer et al., 2008). In some cases, it may be necessary to begin individual psychotherapy before surgery (Glinski et al., 2001).

Bariatric surgery experience is a transformative process that affects an individual's identity, mental state, self-image, interpersonal relationships, and social participation. Preoperative psychological evaluation, realistic goals, and long-term psychosocial follow-up are necessary for success (Kubik et al., 2013). The availability of postoperative psychosocial services also facilitates adaptation to the overall process and provides patients with a support network (Glinski et al., 2001). For example, bariatric surgery patients also typically want 'everything' before surgery. They expect significant changes immediately after surgery and in the medium to long term (Cowan, 1998). Expectation management and targeting dysfunctional thoughts emerge as two of the most essential components of the psychosocial support provided to bariatric surgery patients (Cowan, 1998).

Given these mixed physical and psychological outcomes, understanding patient expectations becomes essential. Curing the conditions that accompany being overweight and returning to a 'normal' weight are among their expectations. Additionally, they expect to live a long, happy life with minimal personal effort (Cowan, 1998). Patients often exhibit denial, difficulties regulating emotions and impulses, somatization, black-and-white thinking, and low self-esteem (Glinski et al., 2001). Zero errors, rapid recovery, and perfect results are expected both during and after the procedure. This unrealistic expectation may be compounded by society's

stigmatizing approach, which attributes obesity solely to a lack of willpower, laziness, or personal weakness (Cowan, 1998). Also, almost all individuals who seek bariatric surgery are those who have made repeated unsuccessful weight loss attempts. This situation creates an intense psychological burden on patients. (Greenberg, 2003). Also, bariatric surgery procedures require lifelong vitamin and iron supplementation, and patients are subjected to highly restrictive and strict liquid diets during the first weeks following the operation (Groven et al., 2015). Thus, this procedure requires psychological readiness and discipline. Because these psychological patterns can complicate eating behaviors and the post-surgical process, psychological counseling support is crucial during this process (Glinski et al., 2001). Not every patient may be psychologically ready for this process.

Bariatric surgery, by its nature, is quite restrictive and requires long-term behavioral changes (Snyder 2009). Patients are generally expected to undergo a comprehensive evaluation process, including a psychological evaluation, to determine their suitability for this procedure (Glinski 2001). Developing pre- and postoperative psychosocial-behavioral support plans is also crucial to prevent recurrence. Such a psychological support plan may also be beneficial for individuals exhibiting maladaptive eating patterns, such as emotional eating or binge eating (Keyte et al., 2024). However, a procedure with such serious psychological and social outcomes requires significant follow-up and evaluation both before and after. There is no standardized guideline for mental health professionals regarding which domains should be assessed or which methods should be used for the preoperative psychosocial assessment of bariatric surgery candidates. While some assessment recommendations exist in the literature, they are not yet definitive (Fabricatore et al., 2006). Fabricatore et al.'s (2006) study also highlights the lack of a systematic framework.

Integrating psychological support groups into preoperative and postoperative care for bariatric surgery is clinically recommended. Research shows that communication between individuals with similar experiences promotes psychological well-being. Interaction with others undergoing medical procedures has been associated with reduced anxiety and increased compliance (Keyte et al., 2024). Thus, psychological support in bariatric care should be situated within the broader social context, as

patients' emotional experiences are closely intertwined with societal stigma and culturally constructed body ideals.

A person who has a larger body may experience stigma, exposure to idealized body norms, gendered expectations, and pressure to conform to societal appearance standards. These experiences may contribute to internalized shame, low self-esteem, and mental health difficulties (Cowan, 1998). Cowan (1998) argued that people with severe obesity were often subjected to intense social stigma, moral judgment, and exclusion. Although these descriptions reflect the social attitudes documented at that time, they illustrate the extent of weight-related stigma rather than endorse such views. Stigma plays an important role in the lived experiences of individuals with larger bodies (Feister, 2012). Research also suggests that a large segment of society continues to hold stigmatizing beliefs about bariatric surgery, which is sometimes portrayed as an "easy solution," a treatment sought by individuals perceived as lacking willpower, or an "undeserved choice." Media representations may further reinforce these stereotypes by promoting unrealistic expectations regarding weight loss and appearance (Cowan, 1998). Such stigmatizing narratives may influence how individuals experience bariatric surgery, shape their expectations, and affect how they interpret the emotional and social challenges that follow (Feister, 2012).

To better understand these complex psychosocial experiences, the present study draws on Feminist Theory, Social Comparison Theory, and Basic Psychological Needs Theory as complementary theoretical frameworks. Together, these perspectives provide a broader conceptual basis for understanding participants' body image, identity reconstruction, and psychological adjustment throughout the bariatric surgery process. These theories are introduced below.

In contemporary societies, appearance-related expectations are deeply gendered, with women disproportionately subjected to objectifying and narrowly defined aesthetic standards. From a feminist perspective, body size can function as a mechanism of social control that affects women's sense of worth, relationships, and bodily autonomy. Feminist scholars have critically examined the gendered nature of bariatric surgery representations in media and marketing, highlighting the marked differences between women's and men's narratives (Groven et al., 2015). These experiences can also be

interpreted through Social Comparison Theory (Festinger, 1954), which suggests that individuals evaluate their bodies in relation to culturally dominant ideals. Such comparisons often occur upward toward idealized, socially valued images which can intensify dissatisfaction and heighten pressure to conform. Beyond gendered and sociocultural pressures, the emotional experiences surrounding bariatric surgery can also be understood through Basic Psychological Needs Theory (Deci & Ryan, 2000). According to this framework, people feel better when their basic needs for autonomy, competence, and relatedness are supported. When these needs are frustrated, individuals may continue to experience psychological difficulties even after losing weight. Conversely, people living with obesity may adapt more easily when they receive support that strengthens their autonomy, competence, and relationships. They may exhibit healthier behaviors and experience better well-being in the long term. As a result, bariatric surgery represents a complex psychological and social process shaped by body image, social comparison, gendered expectations, and basic psychological needs. Therefore, there is a clear need for research that examines bariatric surgery through these perspectives to better understand lived experiences and psychological needs.

Although the physical outcomes of bariatric surgery have been widely studied, the lived experiences of individuals who deal with postoperative side effects and complications have rarely been examined. In addition, knowledge about the long-term health and psychological effects of bariatric surgery is still limited. These gaps in the literature have led health authorities to call for more research on the long-term impacts of bariatric procedures. This call especially emphasizes the need for qualitative studies that describe the experiences of both women and men after surgery (Groven et al., 2015). In the Turkish context, examining the effects of bariatric surgery is particularly important because there is a clear lack of qualitative, person-centered research that investigates how individuals emotionally and socially process the changes brought by this procedure. Therefore, the present study aims to contribute to a more detailed, culturally sensitive, and holistic understanding of bariatric surgery outcomes in Türkiye. It focuses on the psychological counseling needs of individuals who have undergone surgery and on psychological dimensions such as emotions, coping strategies, social integration, and their overall mental journey. The study also aims to

support the development of stronger psychological care practices and assessment procedures as part of the standard treatment protocol in bariatric surgery.

1.2. Purpose of the Study

This study aims to explore the psychological counseling needs and psychosocial experiences of individuals undergoing bariatric surgery. Specifically, it seeks to examine the emotional, mental, identity, and social changes experienced by participants throughout the bariatric surgery process. The research aims to reveal how these changes occur before and after the operation and how they influence individuals' lives. While the study explores individuals' psychological journeys before and after bariatric surgery, it also aims to provide a more holistic understanding of obesity, health care, body image, and body dissatisfaction by emphasizing the psychological, social, and societal dimensions of bariatric surgery alongside its physical outcomes.

Although previous research has emphasized the importance of multidisciplinary care and psychological assessment in the bariatric surgery process (Choban et al., 2002; Sarwer et al., 2008), psychological assessment has become a standard component of most bariatric surgery programs. However, despite efforts to standardize these assessments, there are still no clear guidelines regarding what they should include (Snyder, 2009). Accordingly, this study focuses on understanding individuals lived experiences and identifying their counseling needs throughout the bariatric surgery process.

Especially in the context of Türkiye, research examining the psychosocial experiences of individuals undergoing bariatric surgery remains limited. Although recent Turkish studies have begun to explore individuals' experiences following bariatric surgery (Usta et al., 2025), research has primarily focused on postoperative experiences, leaving the broader psychosocial journey and counseling needs across the preoperative and postoperative process relatively underexplored. Therefore, this study aims to contribute to the literature by exploring individuals' psychosocial experiences and counseling needs within the Turkish cultural and healthcare context.

1.3. Research Questions

1. How do women and men describe their pre-operative and post-operative experiences of bariatric surgery?

2. What psychological, social, emotional, and bodily changes do they report during this process?

3. What counseling needs do participants identify before and after bariatric surgery?

1.4. Significance of the Study

This study is significant, first and foremost, because it highlights that bariatric surgery is more than a medical procedure but a major psychological and social transition. Although individuals experience profound changes in their emotions, identities, and interpersonal lives, these dimensions have not been sufficiently explored in the existing literature. Although bariatric surgery has become an established treatment for severe obesity, the existing literature has predominantly focused on its physical and medical outcomes rather than its psychosocial dimensions (Kubik et al., 2013; Keyte et al., 2024). Individuals often experience shifts in emotion, identity, and interpersonal relationships before and after surgery, yet these aspects remain understudied in the Turkish context. By directly focusing on how individuals make sense of these psychological processes throughout the surgical journey, this research aims to address this gap and provide a more holistic understanding of the psychosocial dimensions of bariatric surgery.

Examining the psychosocial and counseling needs of individuals considering or preparing for bariatric surgery is particularly important because successful adjustment depends not only on the medical outcome of the procedure but also on persons' capacity to understand, anticipate, and manage the long-term changes it requires. Before surgery, individuals may need support in examining their expectations, motivations, previous weight-management experiences, body-image concerns, eating patterns, coping resources, and available social support. These factors may influence their preparedness for the behavioral and emotional demands of the postoperative period. Identifying counseling needs at this stage may also help challenge the

expectation that weight loss will automatically resolve pre-existing emotional, relational, or identity-related difficulties. A clear understanding of these needs can inform counseling practices that promote realistic expectations, active engagement in treatment, and more sustainable psychosocial adjustment throughout the bariatric surgery process.

More specifically, existing studies have paid relatively little attention to how individuals cope with identity reconstruction, bodily transformation, changing eating behaviors, and social adjustment following surgery (Keyte et al., 2024). This study documents these needs from the perspectives of participants and offers foundational insights to improve psychological support before and after surgery. The findings are expected to contribute to the psychological counseling literature in Türkiye, where studies addressing patients' emotional needs and long-term psychosocial adjustment are still limited.

Moreover, weight-related stigma, discrimination, and gendered body expectations considerably shape how individuals experience bariatric surgery. Individuals undergoing bariatric surgery often face a wide range of social pressures and stigmas related to weight and body image (Greenberg, 2003; Cowan, 1998). These pressures may persist after substantial weight loss or may take new forms as individuals adjust to changes in their bodies and social identities. Societal judgments, anti-fat attitudes, and culturally constructed ideals of femininity and masculinity can affect body image, self-esteem, and emotional recovery (Grogan, 2022; Cash, 2004; Groven et al., 2015). Understanding these sociocultural pressures is essential for interpreting patients' pre- and post-operative experiences and for designing more sensitive, inclusive psychological interventions. Identifying how these sociocultural pressures shape individuals' needs may help counselors distinguish difficulties arising from postoperative adjustment from those associated with continuing stigma, gendered expectations, and social evaluation.

Finally, this study provides a culturally grounded, person-centered exploration of individuals' psychosocial experiences and counseling needs throughout the bariatric surgery process. The findings may contribute to the development of structured preoperative psychosocial assessments, postoperative counseling interventions, and

psychoeducational support tailored to the psychosocial needs of individuals undergoing bariatric surgery. In addition, they may inform multidisciplinary bariatric care teams by highlighting individuals' psychological needs, thereby supporting more comprehensive and patient-centered care.

1.5. Definition of Terms

Bariatric Surgery: Bariatric surgery is a medical operation that includes methods such as laparoscopic gastric banding and gastric bypass that offer significant and permanent weight loss (Snyder, 2009). Thre are a variety of surgical procedures that aim to help people living with obesity lose weight by reducing the size of the stomach or rerouting the digestive system to limit food intake and absorption (Snyder, 2009).

Body Mass Index (BMI): Body Mass Index (BMI) is a widely used screening measure that estimates body fat based on an individual's weight in kilograms divided by the square of their height in meters (kg/m^2). It is not a diagnostic tool but a practical indicator used to categorize individuals into weight-status groups such as underweight, normal weight, overweight, and obesity (WHO, 2021).

Obesity: According to the WHO (2021), obesity is a health condition marked by extreme body fat storage. Obesity is typically measured with the Body Mass Index (BMI), where a BMI of 30 or higher indicates obesity. BMI categories used as tools to define obesity vary based on age and gender in infants, children and adolescents.

Body Image: Cash and Pruzinsky (2002) define body image as a multidimensional psychological construct that encompasses individuals' perceptions, thoughts, feelings, and behaviors regarding their own bodies. It reflects satisfaction with one's appearance, the value attributed to the body, and the emotional responses associated with it. Cash (2012) describes body image as how individuals experience their own bodies. Body image in a broader sense can also include experiences of an individual's physical functional capabilities and biological integrity, such as health status, fitness, athletic skills, and coordination.

Body Dissatisfaction: Body dissatisfaction is a negative subjective evaluation of one's own body weight and shape. It is a condition that often leads to psychological distress.

This concept, defined as clinically significant body dissatisfaction or overestimation of weight and shape in relation to one's self-perception, is a required criterion for anorexia nervosa and bulimia nervosa in the Feeding and Eating Disorders section of the DSM-5 (American Psychiatric Association, 2013).

Weight Stigma: Weight stigma refers to the social devaluation, stereotyping, prejudice, and discrimination directed toward individuals because of their actual or perceived body weight. Individuals who experience weight stigma are often labeled with negative personal characteristics, devalued, excluded, or treated unfairly because their body size does not conform to socially accepted body ideals (Fruh et al., 2021)

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter reviewed the current literature on obesity, weight stigma, bariatric surgery, and its psychological, physical, and social outcomes, as well as preoperative and postoperative considerations. At this point, it is helpful to know that there are no very clear or strict boundaries between these concepts. As a situation in the literature review, preoperative experiences and the process of deciding to operate may differ for each individual. The reasons and results may vary depending on the individual; the situations mentioned in the literature review, preoperative and postoperative processes, affect the experiences of each individual differently, while they may not concern the experiences of other individuals in the same way.

2.1. Theoretical Framework

This research draws on three complementary theories to understand the psychological, social, and counseling experiences of individuals during the bariatric surgery process: Social Comparison Theory, Feminist Theory, and Basic Psychological Needs Theory.

2.1.1. Basic Psychological Needs Theory

According to Basic Psychological Needs Theory (Deci & Ryan, 1985; Ryan & Deci, 2000), the more social environments support individuals' basic psychological needs for autonomy, competence, and relatedness, the greater their overall well-being and sense of vitality become. It proposes that well-being and psychological functioning depend on the fulfillment of three basic psychological needs: autonomy, competence,

and relatedness. Autonomy refers to the need to feel that one's actions are carried out voluntarily and in alignment with one's personal values (Ryan, 1993). Competence represents the need to experience effectiveness, capability, and success in managing one's environment; tasks that provide an optimal level of challenge and positive feedback help fulfill this need (Deci & Ryan, 1985). Relatedness, on the other hand, reflects the need to feel accepted, valued, and connected to others, and is nurtured through warm and supportive social interactions (Baumeister & Leary, 1995; Deci & Ryan, 1985).

When these needs are satisfied, individuals experience greater well-being, exhibit higher intrinsic motivation, and demonstrate healthier psychological functioning and adjustment. Conversely, when these needs are thwarted, psychological distress, reduced motivation, and various emotional difficulties may emerge (Ryan & Deci, 2000). Again, when these basic psychological needs are satisfied, individuals tend to act in alignment with their internal values rather than seeking external approval. This internal grounding can strengthen their resilience against sociocultural pressures related to body image (Pelletier et al., 2004). For this reason, this theory can be a powerful conceptual tool for understanding the psychological processes experienced by individuals undergoing bariatric surgery.

Megías et al., (2018) a qualitative study of people living with obesity, demonstrates that three basic psychological needs (autonomy, competence, and relatedness) are systematically thwarted in the context of obesity. Research findings indicate that the need for relatedness is undermined by widespread stigma and exclusion. Physical limitations and feelings of inadequacy diminish the need for competence. The need for autonomy, however, can be affected by overeating and the directive attitudes of healthcare professionals. These findings demonstrate that the period before bariatric surgery is a period of profound psychosocial disruption, as well as medical. The theory helps explain both how the process of seeking surgery relates to need frustration and which needs need to be reinforced with counseling support in the postoperative period.

Empirical evidence also supports the protective function of psychological need satisfaction in the context of body image (Vansteenkiste & Ryan, 2013). When basic needs are met, individuals rely more on intrinsic values than appearance norms when

evaluating their bodies (Vansteenkiste & Ryan, 2013). Studies show that women with greater autonomy experience less decline in body satisfaction after exposure to thin-ideal images (Mask & Blanchard, 2011), and social support protects adolescent girls against body dissatisfaction after exposure to idealized media content (Stice, et al, 2001). Although these studies do not focus on bariatric populations, they show that satisfaction can lessen the psychological impact of sociocultural appearance pressures. This is a relevant insight for understanding body image and adjustment before and after bariatric surgery.

In the context of bariatric surgery, Basic Psychological Needs Theory can provide an explanatory framework for understanding how individuals' needs are met during the pre- and post-operative adjustment process. Because the surgical process often requires significant behavioral, identity, and lifestyle changes, it can challenge autonomy. Rapid physical transformations can impact perceptions of competence. Changes in social relationships and feedback from the environment can reshape the need for relatedness. Understanding at which stages these needs are satisfied or thwarted can provide a useful framework for interpreting the psychosocial experiences of individuals undergoing bariatric surgery and for identifying their emotional and counseling needs.

2.1.2. Social Comparison Theory

Social Comparison Theory, developed by Festinger (1954), posits that individuals evaluate their abilities, achievements, and self-worth by comparing themselves to others. Comparisons, especially with more "ideal" figures, can lower self-esteem and increase body dissatisfaction (Jones, 2001; Myers & Crowther, 2009). Studies show that people tend to compare themselves with others. It has been shown that they are particularly affected by socio-cultural pressures regarding their appearance (Wykes & Gunter, 2004). Social comparison was defined by Festinger (1954) as the tendency of an individual to compare themselves with others to form an opinion about themselves, and these opinions may impact their personal change. This theory is divided into two parts. These are upward social comparisons and downward social comparisons. Upward social comparisons refer to individuals comparing themselves with people they consider to be better off than themselves. Downward comparisons occur when

individuals compare themselves to situations and people, they consider worse off. Upward comparisons can have negative consequences, such as decreased self-esteem. It has been indicated that downward comparisons can have positive consequences, such as increased self-esteem (Festinger, 1954).

It is known that individuals who belong to a certain group and are members of the group often compare themselves with individuals who have similar attitudes. However, social comparisons are not limited to group members. People can also compare themselves with different models in their environment or those they know from the media (Wykes & Gunter, 2004).

People who are not satisfied with their bodies spend more time talking about their weight or body in their daily conversations. In other words, they engage in "fat talk" (Clarke et al., 2010). Bariatric surgery patients may compare their post-surgery bodies to societal or peer standards, which can lead to body dissatisfaction, especially if they have a history of being teased about their appearance (Thompson et al., 1999). Research shows that the negative effects of encountering body ideals are related to an individual's level of situational social comparison. These effects are particularly pronounced for individuals with a high tendency to compare their bodies with others (Betz et al., 2019). This process can lead to negative self-evaluations, especially regarding body image (Betz, et al., 2019).

From a counseling perspective, understanding these comparison processes is crucial. Social comparison processes may help identify unrealistic self-evaluations and body dissatisfaction patterns that may persist after surgery. Counselors can support clients in developing healthier comparison targets and self-compassion. Addressing social comparison in therapy can therefore play a vital role in promoting psychological well-being and sustained adjustment following bariatric surgery.

2.1.3. Feminist Theory

Feminist theory provides a critical lens through which women’s experiences with their bodies, weight, and medical interventions such as bariatric surgery can be examined. Feminist researchers have argued that body weight is interpreted differently by men and women (Bordo, 2004). According to feminist researchers, obesity is not just a

matter of health or aesthetics; it is an area where gender, class, race and power relations converge (Boling, 2011). The female body has been transformed into a project of discipline and control. Modern culture presents thinness as a moral virtue while framing fatness as a personal failure or a lack of willpower (Bordo, 2004). American feminist philosopher and cultural theorist Susan Bordo is known for her analyses of the body, gender, beauty ideals, and representations of women in modern culture. Bordo (1993) explored the social and psychological dynamics behind this phenomenon, asking, "Why are we so obsessed with the shape and size of our bodies?" According to her, when people feel helpless because of wars, environmental crises, terrorism, and inequality, they try to control their bodies because they cannot control these problems.

Examining the concept of "politics of appearance," Bordo (1993) emphasizes that bodies, especially women's bodies, have become one of the most powerful tools of cultural control (Bastos et al., 2020). The modern woman's body is not just biological but deeply politically regulated by patriarchal and capitalist ideals (Weiss, 2024). Social relations are closely intertwined with the meanings attributed to the body, and the meanings shape the body itself. For instance, the bodies of a thin Black woman, an obese Black woman, and a white woman are interpreted differently; such variations reinforce social inequalities and prejudices (Bastos et al., 2020).

In contemporary Western societies, body image stands at the center of ideals surrounding aesthetics, health, well-being, and social status (Temple Newhook et al., 2015). This has led to a growing emphasis on transforming the body through various "body projects," including surgical interventions. The obsessive pursuit of beauty often blurs the boundary between health-oriented self-care and pathological bodily modification. Although rates of overweight and obesity are higher among men, approximately 80% of individuals seeking bariatric surgery are women. This clearly illustrates the powerful influence of social pressures, beauty norms, and bodily standards imposed on women (Bastos et al., 2020).

From a counseling perspective, feminist theory emphasizes the importance of understanding how societal pressures and gendered beauty norms shape individuals' psychological needs, self-perception, and emotional well-being after bariatric surgery.

Within this framework, bariatric surgery can be understood as a medical procedure that is simultaneously shaped by socially constructed beauty standards and cultural expectations. Feminist theory allows the exploration of how women internalize these norms, how medical systems reinforce them, and how undergoing bariatric surgery may both challenge and reproduce gendered expectations surrounding body image, control, and worth. Within this theoretical framework, the present study aims to describe how patients make sense of their bodies and psychological needs throughout the bariatric surgery process and how feminist-informed counseling approaches can better support post-surgical adaptation.

2.2. What is Bariatric Surgery?

Bariatric surgery is widely recognized as one of the most effective clinical interventions for managing obesity and related metabolic conditions (Morton, 2013). It is an efficient method for individual who have severe or moderate obesity. With these methods, clinicians aim to observe weight loss and reduction of accompanying diseases (Kushner & Sorensen, 2015). Bariatric surgery candidates consist of individuals diagnosed with morbid obesity, who are at low medical risk for surgery, and who are determined to be stable in psychological evaluation (Choban et al., 2002). Respected health authorities, such as the American Heart Association, recommend surgery as the first-line treatment option for individuals with a BMI of 40 kg/m² and above (Choban et al., 2002).

Bariatric surgery is recommended as an effective operation for weight loss and has provided 27% weight loss in the last 15 years (Keyte et al., 2024). In addition, it is considered the most effective weight loss treatment when compared to behavioral weight management alone (Murtha et al., 2022). Individuals seeking bariatric surgery typically have tried dieting and medication-assisted weight loss at least six times throughout their lives. However, these individuals have not been successful in the long term (Choban et al., 2002). The primary benefit of the operation is sustained and permanent weight loss. Depending on the procedure performed, patients lose 40% to 75% of their weight. (Choban et al., 2002).

Since the early 2000s, the mortality and complication rates in people living with obesity have gradually decreased after bariatric surgery (Murtha et al., 2022). Mortality rates were significantly lower in patients who underwent surgery compared to those who were medically fit but did not undergo surgery (28% vs. 9%). The risk of death per year of follow-up was 1% for those who underwent surgery, compared to 4.5% for those who did not undergo surgery. Additionally, an increase in labor force participation rates was observed after surgery; indeed, 18 of 40 patients (45%) who received government assistance before surgery began working full or part-time after surgery (Choban et al., 2002).

More important than weight loss in this procedure is the impact of bariatric surgery on obesity-related health problems. For example, resolution of type 2 diabetes, normalization of blood sugar tolerance, decreased medication requirements in approximately half of patients with hypertension (though not as much as in type 2 diabetes), improved heart function, decreased heart wall thickness and volume, and normalization of blood lipid levels have been frequently reported (Klair et al., 2023; Nieves-Khouw et al., 2009). Additionally, 70% of patients experienced a significant reduction in sleep apnea episodes, with 40% experiencing complete resolution. Patients reported significant improvements in physical activity, sexual interest, and perceived health (Choban et al., 2002). Patients see more improvement in health problems that accompany obesity. Quality of life is increased with this operation (Murtha et al., 2022).

Beyond these physical improvements, bariatric surgery has also been associated with psychological benefits. Even though it positively affects people's physical health, studies in the literature reveal that its psychological benefits generally last for about 2 years. It is stated that some people who have undergone bariatric surgery return to their pre-operative condition after two years (Keyte et al., 2024). This underlines the importance of ongoing psychological support and counseling interventions following surgery.

Given these mixed psychological outcomes, careful patient selection and preparation become particularly important. Beginning the process of bariatric surgery is a major step. Patients should be thoroughly informed by their specialists about the relative

risks, possible problems, and benefits. It is stated that specialists should ideally select patients who are likely to benefit significantly from the operation before the operation (Libeton, et al., 2004).

In general, the risk factors for bariatric surgery is like those seen in other planned surgeries. Certain health or psychological conditions may preclude the procedure (Choban et al., 2002). Psychologically unstable individuals may not be considered suitable candidates because they may have difficulty managing the surgical procedure and the subsequent adjustment period (Choban et al., 2002). Furthermore, eating disorders such as anorexia nervosa or bulimia nervosa can worsen post-operative symptoms, so it's recommended that these individuals seek psychiatric treatment first (Choban et al., 2002).

There is increasing interest in investigating the factors that can reliably predict the success of bariatric surgery, or perhaps more critically, the failure of surgery (Libeton et al., 2004). These results show that preoperative interventions are very important. The psychological support and behavioral interventions that the person receives before the surgery are vital in facilitating the adaptation process to the physiological changes that the person will experience in the subsequent process and to their life after the surgery (Keyte et al., 2024). Many results such as insufficient weight loss, intolerance to surgery, or major complications are seen as failure or unsatisfactory results. However, it is very difficult to predict these situations (Libeton et al, 2004). Therefore, comprehensive preoperative psychological assessment and appropriate behavioral interventions are essential for improving pre- and postoperative adjustment, adherence, and psychosocial well-being.

2.3. Understanding Obesity Beyond Weight: A Multifactorial Condition

Bariatric surgery cannot be understood without considering the complexity of obesity. The World Health Organization (WHO) defines obesity as the accumulation of fat in the body to an abnormal or excessive extent, which may negatively affect health (WHO, 2024). People with larger bodies, which occurs when they store excess fat, may be at increased risk of adverse effects on physical and psychological health and social life (Sørensen et al., 2022). Although many aspects remain not fully understood,

significant progress has been made in understanding overweight and obesity in recent decades (James & Gill, 2022). Obesity has also been associated with physiological, endocrinological, psychological, and sociological problems (Kocatepe et al., 2025).

Obesity is increasing in the world, and it is a substantial health risk for adults, especially in the Western world (Lingvay et al., 2024). According to figures from 2022, 2.5 billion adults aged 18 and over are obese or overweight. This means that in 2022, 16% of adults worldwide (i.e., ages 18 and over) were obese (World Health Organization, 2024). Obesity as a health problem is more common in women than in men (Lingvay et al., 2024).

Accurate assessment of obesity is important for planning appropriate treatment and intervention (Aronne, 2002). The most widely used method for assessing obesity is Body Mass Index (BMI) (Aronne, 2002). Although BMI has several limitations, it continues to be widely used. According to BMI criteria, a person is classified as obese when their BMI is ≥30 kg/m² (Lingvay et al., 2024). However, the use of BMI and universal BMI thresholds has been criticized because they may not accurately reflect differences across racial and ethnic groups. In particular, the standard BMI thresholds were largely developed based on White populations, raising concerns about their accuracy and applicability across diverse populations (Lingvay et al., 2024). BMI has also been criticized by researchers and activists because of its historical and racial limitations. Despite these debates surrounding BMI, increases in body size and their potential public health consequences remain an important concern.

Being a plus-size individual has a wide and varied impact on people. Briefly, its effects can be classified as follows: metabolic, anatomical, and psychological (Lingvay et al., 2024). Higher BMI and obesity have also been associated with chronic health conditions as well as social prejudice, discrimination, stigmatization, and psychological difficulties (Gregory et al., 2013). Recent research shows that being overweight is not just about eating too much. It is also about how the body stores and uses energy. Some individuals may be more prone to storing energy as fat, which can cause them to gain weight even without consuming excess calories (Friedman et al., 2024; Ludwig, 2023). The underlying reasons may be biological, socio-cultural, behavioral, economic, psychological, and environmental (Lingvay et al., 2024). Today,

rising food consumption and accessibility, food prices, portion sizes, and energy levels are among the causes of excess weight. In addition, insufficient sleep, stress, and social and environmental changes are also among the causes (Lingvay et al., 2024). Additionally, in today's modern world, sitting at a desk and inactivity during work activities have increased. Accordingly, obesity is increasingly understood as the result of multiple interacting factors rather than a single cause.

Based on current scientific evidence, psychological factors are implicated in obesity (Tomiyama, 2019). Stress and metabolic processes are intricately interconnected. Studies have shown the relationship between obesity and conditions such as depression, anxiety disorders, eating disorders (binge eating, overeating, loss of control, eating without feeling hungry), hyperactivity, and aggression (Karakitsiou et al., 2024). Obesity has also been associated with psychological distress, poorer body image, and reduced quality of life (Tuthill et al., 2006). For this reason, psychological evaluation and psychosocial interventions are also important for individuals living with obesity (Glinski et al., 2001).

Finally, beyond its global prevalence, overweightness and obesity also have deep-rooted biological, psychological, and socio-cultural determinants that shape individuals' experiences of their bodies. A multidimensional understanding of obesity may help explain why some individuals seek medical interventions such as bariatric surgery when conventional weight-loss approaches prove insufficient.

2.4. Overweight and Discrimination: Fatphobia, Thin Privilege and Sizeism

Living with obesity often means dealing with social reactions as well as health-related challenges. **S**tatistical studies revealed that individuals with above-average weight relative to their height had shorter life expectancies. As a result, these individuals were classified as uninsurable by insurance companies. With these developments, the desire to find a practical index to measure relative body weight has gained momentum. This situation resulted in important epidemiological studies conducted after World War II. Thus, the Body Mass Index (BMI) was first used in the 1960s. The Body Mass Index (BMI) originates from Auguste Quetelet's 1832 statistical model of the "average man," which used weight–height ratios to characterize populations (Eknoyan, 2007). This

ratio is still questioned and criticized today. Quetelet's concept of the "average person" was derived almost entirely from anthropometric data collected on white, Western European men, a limitation that prevents it from representing broader human diversity (Goldman, 2022).

More accurate methods of measuring body fat were costly and difficult to access. This has limited the widespread use of these methods. Therefore, obesity is generally defined as excess weight accumulation, not excess fat accumulation (Turkish Endocrinology and Metabolism Association, 2019). This has led to the widespread use of BMI in obesity classification. As discussed earlier, classifying obesity solely according to BMI is problematic for this reason. In addition, BMI has been criticized for its limited applicability across different racial and ethnic populations and for overlooking differences in body composition and health risk. Because obesity has many subtypes, including normal-weight obesity, metabolically healthy obesity, and metabolically unhealthy obesity (De Lorenzo et al., 2019), despite its widespread use, BMI has increasingly been criticized for oversimplifying the relationship between body size and health.

Public discourse often relies on simplified assumptions that equate larger bodies with poor health and thinner bodies with good health. Methods used to measure body size (such as BMI - Body Mass Index) can be problematic, as these measurements can be misleading, especially when evaluated individually. In other words, it's not always accurate to determine a person's health based solely on their weight or height-to-weight ratio (Gregory et al., 2013). Beyond measurement issues, individuals living in larger bodies often experience significant social consequences that extend far beyond physical health.

Being overweight can have devastating social consequences for an individual. These consequences are not physical health consequences as commonly thought. Research shows that societal bias against obesity is widespread, persistent, and invisible (Greenberg, 2003). Overweight is closely related to problems such as social stigma, impaired social relationships, and even bullying due to weight (Karakitsiou et al., 2024). Western societies encourage slimness in both men and women. Women are expected to be thin, slim, and shapely, while men are expected to be slim and muscular

(Grogan, 2022). Overweight children and adolescents are excluded by their friends. They are made fun of, discriminated against, and humiliated. These individuals who are bullied in their peer circles are the least preferred people (Capella & Capella, 2003). These people may be labeled simply because of their appearance (Matacin & Simone, 2019). For example, one may be labeled as dirty, not clean or pure, lazy, a liar, ugly, stupid, or messy (Capella & Capella, 2003). Anti-fat stigma and weight stigma are affecting these individuals' lives deeply (Matacin & Simone, 2019). These experiences are reinforced by broader sociocultural ideals that define which bodies are considered desirable and socially acceptable.

In the age of technology, where perceptions of beauty are imposed on modern society and social media, and certain standards of appearance have increased, discrimination and singularization of individuals who are oversized and have "appearances that do not conform to beauty standards" are also increasing (Pokorski & Głuch, 2022). Society's tendency to favor thin bodies is well documented. At the heart of this shift is the media's consistent portrayal of the ideal body as one of thin figures. Women have largely internalized this "thin ideal," yet many fail to achieve these standards (Lin & Kulik, 2002).

Being overweight is considered unattractive for both men and women and is associated with negative personality traits (Grogan, 2022). Unrealistic body image ideals in the media contribute to body dissatisfaction, even after significant weight loss (Cash, 2002; Dionisi et al., 2025). Individuals who do not conform to this ideal face negative social consequences. These individuals often feel excluded or despised, so they do not have a sense of belonging, and it is difficult for them to attend physical education classes, make social connections with people, or make friends (Capella & Capella, 2003). Discrepancies between actual body image changes and internalized perceptions may slow psychological recovery. (Dogan et al., 2024). Studies show that despite physical transformations, many bariatric patients struggle with lingering body dissatisfaction due to fat phobia or the desire for further aesthetic changes (Varns et al., 2018; Proczko et al., 2022). Within this sociocultural context, appearance-based ideals often evolve into prejudice and discrimination toward individuals living in larger bodies.

Anti-fat prejudice is very common, and we may explain it as an unfavorable mindset and negative attitude, manners, or thoughts toward people who are perceived as fat (Matacin & Simone, 2019). These stigmatizing attitudes may become particularly visible in discussions surrounding obesity treatment and bariatric surgery. Some individuals view bariatric surgery as an unfair privilege reserved for those unable to change their lifestyles. This perspective reinforces the stereotype that people with morbid obesity lack willpower and are irresponsible. This perception of "undeserved imperfection" can lead to social exclusion, humiliation, and various forms of discrimination against individuals with obesity. Consequently, these prejudicial attitudes, known as "fat-ism," lead to people living with obesity being stigmatized and isolated in modern society, effectively relegating them to the status of modern-day lepers (Cowan, 1998).

Society often uses judgments against overweight individuals, such as "If he just stayed away from the table, he'd be fine," "If he just shut his mouth, he'd lose weight," and "How did he get himself into this situation?" (Cowan, 1998). Ironically, many of those who express harsh opinions about individuals living with obesity are themselves naturally predisposed to experience satiety with standard food portions thanks to genetic or biological advantages that regulate their weight without conscious effort. Society, however, often legitimizes these biased perspectives. The reality is that adults with morbid obesity typically do not experience fullness as easily and, for the vast majority, sustaining weight loss through voluntary lifestyle changes alone proves nearly impossible in the long term (Cowan, 1998).

In the long term, experiences of exclusion, discrimination, and loneliness may contribute to serious body image concerns and leave lasting psychological scars on individuals (Capella & Capella, 2003). These experiences are reinforced by sociocultural environments that glorify thinness while portraying larger bodies negatively. In many Western societies, thin body ideals are widely promoted through media and popular culture, despite often being unattainable for most people. The pressure to conform to these appearance standards can increase body dissatisfaction and further marginalize individuals living in larger bodies (Matacin & Simone, 2019). Understanding these sociocultural influences is particularly important when

examining the experiences of individuals undergoing bariatric surgery, as weight-related stigma and body image concerns may continue even after substantial weight loss.

2.5. Being an Oversized Individual and Its Psychological Effects

Living with obesity often involves experiences that extend beyond stigma and influence psychological well-being. People who live in larger bodies are often subjected to stigma, discrimination, and negative stereotypes about their weight and appearance. Obesity is associated with complex biological, psychological, and environmental factors, yet they are often viewed as lacking self-control, lacking willpower, lazy or individually responsible for their weight. Such stigmatizing experiences are not confined to social interactions and may adversely impact one's overall quality of life and psychological well-being (Cowan, 1998; Lingvay et al., 2024).

Weight-related prejudice is widespread and may occur in both overt and subtle forms. Individuals living in larger bodies often encounter discrimination in various domains of life, including education, employment, healthcare, and interpersonal relationships (Lingvay et al, 2024). Such experiences contribute to social inequalities and may limit opportunities for social participation.

Research has established a consistent association between obesity and psychological distress. People with obesity have a lower quality of life and poorer physical and mental health outcomes than those in lower-weight bodies (Lingvay et al., 2024). Depression is usually thought of as a risk factor for obesity, but the relationship seems to be reciprocal. Experiences associated with obesity, particularly discrimination and social exclusion, may also contribute to the development or worsening of depressive symptoms.

Recent research suggests that viewing obesity merely as a biological or medical problem is not enough. Obesity-related stigmatization has been linked to negative consequences for both physical and psychological health, including healthcare avoidance, delays in seeking care, and deterioration of the physician-patient relationship (Hazlehurst et al., 2020). These findings from Hazlehurst et al. (2020)

suggest that the psychological burden of obesity may arise not solely from body weight itself, but from the social experiences associated with living with obesity.

Taken together, the literature suggests that the psychological consequences of obesity are far-reaching and extend beyond the physical health domain. Stigma, discrimination, social exclusion and negative stereotypes may have a significant impact on individuals' emotional well-being, self-esteem, and quality of life. These psychological consequences are particularly relevant when looking at individuals seeking bariatric surgery, as many enter the surgical experience with years of experience of weight stigma and body image issues.

2.6. Pre-Bariatric Surgery Experiences

The decision to undergo bariatric surgery develops within this psychological and social context. In cases of morbid obesity, the low success rate of nonsurgical approaches and the urgency of serious health complications caused by obesity accelerate the process of doctors making surgical decisions (Choban et al., 2002). After accepting the need for bariatric surgery, people living with obesity developed a strong sense of optimism about the postoperative period. This suggests that surgery is perceived as a different and more effective option than other weight-loss interventions (Keyte et al., 2024). But the time before surgery can be filled with several practical and psychological difficulties.

Previous qualitative studies have identified access to surgery and being on a waiting list as a significant psychosocial concern before bariatric surgery. Gregory et al (2013) investigated patients' perceptions of bariatric surgery waiting in Canada and noted that financial and logistical barriers profoundly impact individuals before surgery. Many participants reported that private surgery options were prohibitively expensive. The financial burden of additional costs like travel, accommodation, and time off work often creates frustration for prospective patients. The perception that wealthier acquaintances have easier access to surgery reportedly leads to frustration and a sense of inequality among prospective patients (Gregory et al., 2013). In the same study, participants reported difficulty coping with food cravings, fear of gaining weight, and

anxiety about developing diabetes, hypertension, and cardiovascular disease. Some even expressed fear of dying while awaiting surgery (Gregory et al., 2013).

Candidates preparing for bariatric surgery undergo a preoperative mental health evaluation, and they tend to believe that this evaluation is intended to screen them out of the surgery. For this reason, patients may try to downplay their psychological state and reflect positively during these evaluations (Sarwer et al., 2008). Therefore, mental health professionals should inform patients about the necessity of these evaluations. Also, they should emphasize that they are conducted for the patients' benefit rather than as an exclusionary process. A study conducted in Türkiye suggested that preoperative psychological adjustment may play an important role in postoperative adaptation. Furthermore, bariatric surgery candidates were reported to use adaptive coping strategies, such as active coping, planning, and positive reinterpretation, more frequently. (Şahin Can et al., 2024)

Before bariatric surgery, the expectations of patients, their families, and even society from this operation are often at impossible levels. Patients with morbid obesity often expect "everything" from their operation. Many patients expect the bariatric surgeon to solve all obesity-related problems. Cowan (1998) described this tendency as idealizing the surgeon as a "compassionate magician" or "savior," reflecting the unrealistic expectations that some patients hold before surgery. Surgeons are critical to the often-unrealistic expectations of perfect results that bariatric surgery candidates have (Cowan, 1998). While surgeons possess dexterity and skill, they don't perform magic. Most patients, however, want to find the "best" surgeon and expect miracles. Therefore, surgeons must offer complete openness and a completely realistic, documented approach to patients' humane but unrealistic expectations (Cowan, 1998).

However, society doesn't want to accept or believe that patients are experiencing a problem beyond their control, despite these expectations. Individuals may be skeptical of any solution beyond their "self-control," and those around them may perceive bariatric surgery as a sign of "weakness." (Cowan, 1998). Finally, some individuals may approach the surgical process with hope while simultaneously experiencing shame, guilt, or concerns about how others will perceive their decision.

2.7. Post Bariatric Surgery Experiences

The challenges do not end with surgery. The postoperative period brings a new set of experiences. The results of the surgery are quite impressive for many patients. The average weight loss over the 20 years following surgery is around 25%-60% (Keyte et al., 2024). On the other hand, bariatric surgery does not completely cure obesity. It has a palliative effect. Nutritional education plays a key role in guiding patients on the right path to weight maintenance (Choban et al., 2002). Therefore, maintaining weight loss is still a concern even after surgery (Choban et al., 2002). 21% of patients experience increased weight regain following initial weight loss (Keyte et al., 2024). Many patients blame themselves when they regain weight and long to return to their leanest state (Keyte et al., 2024).

For surgical treatment to be considered successful, the patient's excess weight must be maintained at a 50% reduction for at least five years (Choban et al., 2002). Although the mechanisms underlying weight regain are not fully understood, it is accepted that the process results from the interaction of biological, psychological, and lifestyle factors (Keyte et al., 2024).

Weight loss progress varies among individuals; some may not lose weight or even gain it. Therefore, healthcare professionals should clearly explain to patients that some initial loss may be regained, and that everyone’s weight loss process will be different (Keyte et al., 2024). This section is crucial for effective expectation management. Research shows that failure to meet expectations can negatively impact postoperative treatment satisfaction, weight loss success, emotional stability, and the sustainability of an individual's behavior. However, in some cases, such expectations can also be a motivator for individuals to maintain weight control (Price et al., 2014).

Loose and sagging skin in the breast, abdomen, hips, and arms, seen in some patients after bariatric surgery, leads to body image dissatisfaction. More than 66% of patients consider this a negative outcome of the surgery. This dissatisfaction drives many individuals to seek body contouring procedures. The most common procedures are breast reduction and extended abdominoplasty. However, evidence on the psychological effects of these procedures is still limited (Sarwer et al., 2008).

Some problems after bariatric surgery may be subtle. The team must be prepared to detect them. Post-operative incompatibility is to be expected. Symptoms such as depression, sleep disturbances, irritability, crying, self-deprecation, suicidal thoughts, and fatigue may be more common than expected in post-operative patients (Cowan, 1998).

Individuals living with obesity are frequently perceived as solely responsible for their condition, as if it is entirely self-inflicted. As a result, any complications that arise from bariatric surgery are often judged more harshly than those from other procedures with similar risk levels (Cowan, 1998). Unlike in other medical contexts, where complications are generally viewed as unfortunate but acceptable outcomes, complications in bariatric care are sometimes used to discredit the surgery itself. This stigmatizing view extends even to the surgeon when complications occur; some critics shift blame onto the provider, suggesting that "these people should not have been operated on in the first place." In this way, both the patient and the surgeon are unfairly positioned as culpable (Cowan, 1998).

In the postoperative period, some partners and family members may have emotionally challenging reactions (Cowan, 1998). The patient's physical and psychological transformation can lead to a shift in balance, particularly in domestic relationships. During this process, feelings such as jealousy and intolerance of increased attention may be observed (Cowan, 1998). Among married participants, the cumulative incidence of separation or divorce was approximately 13% within five years after bariatric surgery (King et al., 2022).

Taken together, these findings show that the postoperative period involves much more than just physical recovery and weight loss. Individuals may also face challenges related to body image, psychological adjustment, stigma, and changing interpersonal relationships after surgery.

2.8. Psychosocial Effects of Bariatric Surgery

The ultimate goal of bariatric surgery extends beyond reducing weight and obesity-related comorbidities to include improvements in psychosocial functioning and quality of life (van Hout et al., 2006). A comprehensive review by Kubik et al. (2013) found

that bariatric surgery is associated with reductions in physical comorbidities, depression, and anxiety, as well as improvements in self-esteem, body image, and health-related quality of life. Consistent with these findings, a prospective study conducted in Türkiye reported that one year after bariatric surgery, patients experienced improvements in body image, while depressive symptoms decreased from borderline or moderate levels to mild levels (Gezer et al., 2023). However, not all patients experience these psychological benefits. Despite optimism about life after surgery, the wait for bariatric surgery can be an emotionally challenging time (Keyte et al., 2024).

Although bariatric surgery is considered one of the most effective treatments for severe obesity, it should not be regarded as a universal solution for all patients. Despite the substantial improvements observed in physical health and psychosocial functioning, some individuals continue to experience psychosocial difficulties after surgery. These difficulties may include maladaptive eating behaviors, substance use disorders, limited social support, excess skin-related body image concerns, and weight regain. Furthermore, although depressive symptoms often improve during the first years after surgery, these psychological benefits may diminish over time in a subgroup of patients. Some individuals may develop new-onset depression or experience a recurrence of depressive symptoms (Kalarchian & Marcus, 2019), and evidence has also suggested an increased risk of self-harm and suicide among postoperative patients (Müller et al., 2019). These findings highlight the importance of long-term multidisciplinary follow-up and ongoing psychosocial support (Kalarchian & Marcus, 2019; Müller et al., 2019).

Limited weight loss, weight regain, and postoperative bodily changes (e.g., sagging skin) can particularly perpetuate body image dissatisfaction. The presence of severe preoperative psychopathology and unrealistic expectations of a "complete life change" are significant risk factors that negatively impact the sustainability of psychological well-being (Kubik et al. 2013).

As mentioned earlier, society often stigmatized being fat as a sign of "lack of willpower," "laziness," or "lack of self-control" (Greenberg, 2003). Although bariatric surgery is recognized as an effective medical intervention, it continues to be

significantly stigmatized at the societal level. Individuals undergoing surgery are often accused of choosing the “easy way” to lose weight and may be associated with a lack of willpower (Trainer & Benjamin, 2017; Wolff & Maydell, 2024). Therefore, even after the operation, bariatric surgery patients can experience feelings of shame, guilt, and self-blame (Greenberg, 2003).

Findings revealed that individuals struggled to accept the need for bariatric surgery and often blamed themselves for their inability to lose weight, viewing it as a personal failure. Their frustration suggests that participants internalized the social stigma and guilt associated with obesity, rather than viewing it as a chronic disease (Keyte et al., 2024). In response to these stigmatizing attitudes, patients may attempt to defend themselves by framing obesity as a biological and medical condition and positioning bariatric surgery as a legitimate health intervention (Throsby, 2012; Trainer & Benjamin, 2017).

There is a need for studies examining how contemporary psychology can contribute to the preoperative preparation processes of individuals living with obesity and planning bariatric surgery (Keyte et al., 2024). Although psychosocial interventions alone have not been shown to produce long-term weight loss, they remain essential. They should be integrated into every patient’s weight management process, particularly in the context of bariatric surgery (Nieves-Khouw et al., 2009).

In addition, the need for integrating support groups into the bariatric surgery process has been highlighted (Keyte et al., 2024). The British Obesity & Metabolic Surgery Society has published guidelines emphasizing the importance of psychological therapy alongside social support in bariatric surgery. These guidelines recommend that all patients undergo a psychological assessment 6–9 months after surgery to identify the need for psychological intervention and reduce the negative consequences of eating disorders and mental health problems. Studies showed that despite high demand for services in this field, resources in psychology are limited. Therefore, psychological services for bariatric surgery must be strengthened through training, common practice standards, and adequate resource support (Ogden et al., 2019).

Therefore, comprehensive preoperative psychological assessment, expectation management, and long-term postoperative psychosocial support processes are critical to preserving the psychological gains of bariatric surgery (Kubik et al. 2013). These results showed the importance of understanding the psychological journey of bariatric surgery and the psychological needs of patients.

2.9. Eating Behaviors and Dietary Adjustments

Changes in eating behaviors are among the most significant adjustments following bariatric surgery. Experts state that when active weight loss is initiated after bariatric surgery and during the long-term weight maintenance process, a structured weight loss program that includes dietary interventions, exercises and significant behavioral changes should be used as an accompaniment to the operation (Abu Dayyeh et al., 2017). Portion size and food choices are prominent issues affecting the weight of patients and prospective patients. Before bariatric surgery, individuals often chose to consume calorie-dense, palatable foods (Keyte et al., 2024).

Additionally, some patients may eat inappropriately or, due to increased energy, become overly active and complain of fatigue (Cowan, 1998). Studies have shown a significant relationship between stress and BMI (Tomiyama, 2019). A meta-analysis of longitudinal studies showed that higher stress levels predict greater increases in adiposity over time, suggesting a prospective link between stress and weight gain (Wardle et al., 2011). A significant portion of bariatric surgery patients have been found to have emotionally motivated pre-operative eating behaviors. Eating has been found to provide temporary relief and pleasure, particularly during times of stress, sadness, or distress (Keyte et al., 2024).

Following bariatric surgery, individuals can lose up to 50% of their body weight, which often leads to a shift in their relationship with food. Eating gradually becomes less of an obsessive focus and more of a functional, need-based behavior (Sicilia et al., 2026). Some individuals may stop using food as a coping tool in the post-surgical period and instead develop new but maladaptive coping mechanisms. This may be decisive for weight management and psychological well-being (Keyte et al., 2024). Research showed that while bariatric surgery alters the digestive system physiologically, it does

not automatically transform individuals' emotional and behavioral relationships with food (Winberg & Heijmans, 2025). This further highlights the importance of psychological support and long-term psychosocial interventions throughout the bariatric surgery process (Winberg & Heijmans, 2025). These results indicate that changes in eating behavior following bariatric surgery cannot be explained solely by physiological adaptation. Long-term success often relies on individuals' ability to develop healthier coping strategies, adjust their relationship with food, and receive adequate psychological support throughout the process.

2.10. Bariatric Surgery and Identity Change

Bariatric surgery extends beyond weight loss and improvements in physical health, encompassing changes in identity, social acceptance, and psychosocial well-being (Sicilia et al., 2026). Kamps and Berman (2011) emphasized that body image plays a significant role in the process of identity formation and identity-related distress. Identity is closely linked to body image, social interactions, and self-concept, and may be challenged and reconstructed throughout the bariatric surgery process.

According to Burr (2015), an individual's identity is constructed through discourses shared within society. Obesity is perceived by society as a psychological and social problem, often associated with certain negative personality traits (Wolff & Maydell, 2024). As a result, labels such as "obese," "overweight," and "fat" can gradually become intertwined with individuals' self-perceptions and identities (Wolff & Maydell, 2024). According to Goffman (1969), experiences of stigmatization and marginalization reinforce individuals' perceptions of themselves as inadequate and as possessing a "spoiled" identity. This process often leads individuals to internalize these perceptions at an unconscious level, accepting them as something they deserve or are expected to encounter.

Following bariatric surgery, rapid physical changes may disrupt this established identity. Some individuals report increased confidence, improved self-esteem, and a renewed sense of self. Also, bariatric surgery appears to have a positive effect, which may be linked to improvements in body image satisfaction (Cherick et al., 2019). However, these positive outcomes do not necessarily eliminate body image concerns.

While bariatric surgery is generally associated with positive physical and psychological outcomes, studies suggest that body image challenges do not necessarily disappear (Sicilia et al., 2026). Internalized anti-fat attitudes may persist despite substantial weight loss and contribute to identity struggles in which individuals continue to perceive themselves in terms of their former bodies (Sicilia et al., 2026). Moreover, individuals may experience difficulties reconciling their former identity with their post-surgical self, as losing a long-standing identity associated with living in a larger body may evoke feelings of grief and loss (Perdue et al., 2020). At the same time, some individuals may continue to perceive themselves as "obese" despite significant weight loss and may continue to experience difficulties related to body image (Wolff & Maydell, 2024).

As a result, from a counseling perspective, identity reconstruction emerges as a central aspect of post-bariatric adaptation. Supporting individuals in integrating their past and present selves, developing a coherent identity, and building self-worth beyond physical appearance is crucial for bariatric surgery patients.

2.11. Body Image and Well-being

Body image is closely linked to the physical and psychological changes experienced after surgery. The core feature of Body Dysmorphic Disorder is an intense preoccupation with a slight or even non-existent defect in one's appearance (American Psychiatric Association, 2013). Body image disturbance refers to an individual's inability to perceive their body size accurately, misjudgment of body part proportions, excessive preoccupation with physical appearance, or unrealistic determination of an attainable body size (Adami et al., 1999; Pingitore et al., 1997; Valtolina, 1998). Expectations about body shape and the discrepancy between one's current and ideal body are two key components of body image disturbance (Schilder, 1935; Williamson et al., 1993). Individuals living in larger bodies often report greater body image disturbance and lower self-esteem (Karakitsiou et al., 2024). Research findings demonstrate a significant improvement in body image disturbance after bariatric surgery (Price et al., 2014). This positive change has been consistently reported, even

when studies vary in patient samples, measurement tools, and research designs (Price et al., 2014).

Generally, researchers note that the relationship between weight loss following bariatric surgery and body image is complex (Sarwer et al., 2008). They also noted that this change, together with changes in eating behaviors, may contribute to this relationship. (Sarwer et al., 2008; Ivezaj et al., 2018). Previous research has shown that unrealistic weight loss expectations are common in both surgical and non-surgical interventions (Sarwer et al., 2008). This pattern was also highlighted by Price et al. (2014), who noted that such expectations are particularly prevalent among younger, white women with higher BMI levels who tend to idealize thinner body shapes. Despite the significant relationship between negative body image, weight, and bariatric surgery, the number of studies on these topics is surprisingly small (Alleva et al., 2023).

In general, existing findings on body image after bariatric surgery suggest that it improves body image in at least some aspects. However, negative body image remains high in patients compared to the general population (Ivezaj & Grilo, 2018). Some individuals may even experience persistent or increasing negative effects on their body image due to post-operative side effects such as scarring, sagging soft tissue, or loose skin (Ivezaj & Grilo, 2018).

One of the primary motivations for women undergoing bariatric surgery is negative body image. These individuals have negative thoughts and feelings about their own bodies (Makarawung et al., 2020; Munoz et al., 2007). Studies indicated that reductions in BMI following surgery will improve body image, assuming that women's bodies will approach the culturally idealized "thin body" standard prevalent in society (Jumbe et al., 2017). Research showed that individuals with body dysmorphic disorder often tend to pursue surgical or non-surgical cosmetic procedures in an effort to correct the physical flaws they perceive (Seekis & Barker, 2022). People with body dysmorphic disorder often experience greater dissatisfaction and worsening symptoms after the procedure (Bowyer et al., 2016). Additionally, one of the most common concerns for women considering cosmetic procedures is the risk of potential complications. Individuals may be more likely to pursue cosmetic procedures. This

can further be exacerbated by the fact that beauty and aesthetic practices are largely unregulated (Seekis & Barker, 2022).

These findings suggest that although bariatric surgery often improves body image, some individuals may still experience concerns about their appearance and body dissatisfaction. This highlights the complex relationship between physical change and psychological well-being.

2.12. Gender and Bariatric Surgery

Gender plays a significant role in shaping individuals' experiences of bariatric surgery, influencing motivations, expectations, and psychological outcomes. For example, research consistently shows that 80% of bariatric surgery patients are women, highlighting the strong connection between gendered body norms and the decision to undergo surgical weight loss (Gregory et al., 2013). These findings indicate that bariatric surgery is not just a medical intervention, but a gendered experience, constructed through social expectations, body norms and cultural values.

Women tend to experience greater concerns related to body image, higher levels of depressive symptoms and perceived stress, as well as more unhealthy behaviors associated with body image (Kochkodan et al., 2018). Numerous studies of young women have shown that exposure to appearance-focused content on social media, such as selfies, celebrity posts, or "fitspiration" images, is linked to various body image issues (Seekis & Barker, 2022). Viewing such content has been shown to specifically increase body dissatisfaction and reinforce the desire for a thin body (Seekis & Barker, 2022). Furthermore, after the operation women experience body dysmorphic symptoms more intensely than men (Malcolm et al., 2021). In addition, for women, societal expectations—particularly those related to motherhood—may affect individuals' capacity for self-care and increase the burden associated with treatment following bariatric surgery (Winberg & Heijmans, 2025). These complex psychosocial dynamics may help explain the gender differences observed in the utilization of bariatric surgery for obesity treatment (Kochkodan et al., 2018).

Men remain underrepresented in bariatric surgery research as well as in qualitative health research more broadly (Affleck et al., 2013). Approximately 20% of patients

undergoing bariatric surgery are male (Kochkodan et al., 2018). Research suggests that men's interpretations of postoperative bodily changes may be closely connected to broader norms of masculinity (Winberg & Heijmans, 2025). For example, some men are reported to hesitate to seek help even when experiencing serious side effects (Kochkodan et al., 2018). In addition, research suggests that men tend to perceive their bodies as a less central component of their self-definition (Kochkodan et al., 2018). These results indicate that male patients may experience bariatric surgery differently from women and highlight the importance of examining these experiences within a gendered context.

Studies examining gender differences have shown that male patients tend to present with a greater disease burden and may experience more surgical complications, less weight loss, and lower rates of improvement in comorbid conditions following bariatric surgery (Kochkodan et al., 2018). In contrast, female patients appear to report fewer comorbidities and physical complications, yet significantly higher rates of psychological diagnoses and lower overall body image scores (Kochkodan et al., 2018). Male bariatric surgery candidates tend to have significantly higher BMI levels compared to women. In contrast, female candidates are more likely to report histories of depression, anxiety, and previous psychotherapy treatment (Mahony, 2008). These findings suggest that gender represents an important variable in the assessment of bariatric surgery candidates (Mahony, 2008).

From a counseling perspective, it is essential to adopt a gender-sensitive approach when working with bariatric surgery patients. Understanding how gendered expectations shape individuals' experiences can help counselors provide more personalized and effective support. Addressing issues such as internalized beauty standards, gender roles, and relational dynamics is crucial for promoting psychological well-being and long-term adjustment.

2.13. Body Positivity, Body Appreciation and Fat Activism

Recent perspectives encourage looking beyond weight and appearance. Body images refer to how individuals perceive their physical appearance, as well as the thoughts, feelings, and attitudes they hold toward their bodies. (Cash & Pruzinsky, 2002). In this

context, positive body image is understood not merely as the absence of body dissatisfaction, but as a broader construct involving body appreciation, acceptance, respect, gratitude, and caring attitudes toward the body (Tylka & Wood-Barcalow, 2015). This perspective shifts the focus from appearance-based evaluation to a more holistic and compassionate understanding of the body.

Sicilia (2026) notes that several critical perspectives challenge the dominant medical discourse surrounding the "obesity epidemic" and weight-loss surgery. Within these perspectives, fat activism is described as promoting body diversity, resisting normative body ideals, and reclaiming the term "fat" as a positive identity (Morris, 2019). At the same time, some fat activist perspectives have criticized individuals who undergo bariatric surgery, portraying them as having internalized dominant body norms and medicalized ideals (Sicilia et al., 2026). Rather than viewing larger bodies as inherently problematic, fat activists emphasize acceptance and challenge the social structures that produce weight stigma (Morris, 2019).

Research suggests that although many individuals report increased body satisfaction following significant weight loss, body image concerns may persist even after bariatric surgery. Factors such as excess skin, surgical scars, and unmet expectations regarding appearance may contribute to continued dissatisfaction (Ivezaj & Grilo, 2018). Therefore, weight loss alone does not necessarily result in the development of a positive body image.

In this context, building a positive body image after bariatric surgery requires more than physical transformation; it involves psychological adjustment and identity-related processes. From a counseling perspective, supporting individuals in developing a more flexible, accepting, and compassionate relationship with their bodies is essential.

2.14. Counseling Needs of Patients and Role of the Counselor

The findings presented throughout this chapter highlight the importance of psychological support across the bariatric surgery process. Much of the literature on overweight has focused on its physical effects and harms to the body. The emotional effects of being overweight and the effects of treatments are less well understood. Studies show that approximately 25% of overweight or people living with obesity have

mental health problems and that these should be treated (Simon et al., 2006). Numerous studies emphasize the need to include psychosocial dimensions in the evaluation of the risks and benefits of bariatric surgery (Price et al., 2014). Mental health professionals play a central role in evaluating bariatric surgery candidates (Eisenberg et al., 2022; Sarwer et al., 2008).

Psychosocial conditions in bariatric patients include depression, somatization, problems in interpersonal relationships, low social adjustment, and low self-esteem (Sarwer et al., 2008; van Hout et al., 2006). However, counselors should not automatically assume that an individual has mental health or psychological problems because they are overweight or obese (Puhl & Brownell, 2006). Significant improvements are seen in depression and anxiety symptoms, health-related quality of life, self-esteem, and body image, especially in the first year after surgery (Dionisi et al., 2025; van Hout et al., 2006). Many of these benefits appear to persist for up to four years, but longer-term psychosocial outcomes remain largely unknown (Sarwer et al., 2008; van Hout et al., 2006).

The most common indications for postoperative psychological treatment are compliance problems, non-compliance with dietary rules, and eating disordered behaviors (Sarwer et al., 2008). The majority of the literature indicates that the psychological benefits of bariatric surgery are limited to approximately two years. After this period, they return to pre-surgical levels (Keyte et al., 2024). These findings show that postoperative adaptation is psychologically complex.

It is believed that the diet and psychology of the individual are inextricably linked for successful long-term weight loss and maintenance in patients after bariatric surgery (Song & Fernstrom, 2008). When patients perceive the outcome of surgery as unsuccessful, this can negatively impact on their psychological and emotional well-being. Therefore, it is important to address this issue through counseling and psychoeducation-based interventions (Price et al., 2014).

Clinical observations showed that support groups can improve weight loss and postoperative adjustment by providing emotional and social support to people who have undergone bariatric surgery. (Glinski et al., 2001). Hildebrandt (1998) noted that

patients who participated in group therapy tended to lose more weight, and that those who attended meetings more frequently lost more weight. More recent systematic evidence suggests that participation in bariatric support groups is associated with improved postoperative weight loss, self-management, and treatment adherence. However, additional high-quality research is still needed to address methodological limitations and to determine whether in-person, hybrid, and virtual support group formats differ in their effectiveness (Rigby et al., 2026) In addition, a study by Gregory et al. (2013) emphasized the need for both individual and family-based psychological counseling throughout the process. Early involvement of spouses and children in the treatment process was recommended to strengthen emotional support and facilitate postoperative adjustment.

When weight-related biases are not addressed during counseling, individuals may feel judged rather than supported. This can increase feelings of isolation and shame (Loewy, 1998). Some mental health professionals conduct support groups or offer individual psychotherapy during the postoperative period. However, because there is no standard mental health practice for preoperative assessments, there is no consensus on which psychological interventions are most effective (Sarwer et al., 2008).

Psychological interventions also help individuals develop adaptive coping strategies for stressors such as weight-related stigma. A thorough understanding of bariatric surgery candidates' goals and expectations is crucial for their psychological well-being. This is also crucial for improving patient treatment outcomes (Price et al., 2014). Psychological support can help individuals maintain weight loss and adapt to the physiological changes following surgery (Keyte et al., 2024).

The integration of psychology and psychiatry into the bariatric surgery process remains limited. Postoperative assessments and psychological interventions before and after surgery are still infrequently implemented, despite evidence suggesting that such programs could enhance surgical success rates (van Hout et al., 2006). While cognitive-behavioral therapies (CBT) are thought to be beneficial for individuals experiencing eating disorders or body image issues, empirical studies are limited. Therefore, developing and scientifically testing postoperative-specific mental health

interventions is a priority for mental health professionals working with bariatric surgery patients in the future (Sarwer et al., 2008).

Beyond school settings, counselors may encounter individuals undergoing or having undergone bariatric surgery in a wide range of professional contexts, including hospitals, primary care settings, rehabilitation centers, community mental health centers, university counseling centers, and private practice. The counseling profession encompasses mental health, wellness, educational, and career services across diverse settings (Kaplan et al., 2014). As members of multidisciplinary bariatric care teams, counselors can contribute through psychosocial assessment, psychoeducation, emotional support, behavior change interventions, and counseling focused on body image, treatment adherence, and pre- and postoperative adjustment (Eisenberg et al., 2022; Price et al., 2014). In collaboration with surgeons, physicians, dietitians, psychiatrists, psychologists, nurses, and social workers, counselors can help promote long-term psychological adjustment and improve overall treatment outcomes.

Counselors play a crucial role in supporting the development of emotional stability, treatment adherence, and sustainable coping strategies throughout the surgical process, particularly because individuals with obesity frequently experience weight-related stigma and discrimination (Feister, 2012; Ogden et al., 2019). Studies have indicated that people with weight problem are most frequently discriminated against by family members, doctors, classmates, friends, coworkers, teachers, and nurses (Puhl & Brownell, 2006). Prejudice and discrimination toward individuals with weight issue have been documented even among helping professionals, including psychologists, psychology students, social workers, and counselor trainees (Feister, 2012). High school counselors are less likely to support students with issues in applying to university. Also, universities are less likely to admit equally qualified fat applicants. Early research suggested that parents may provide less financial support for the college education of daughters with higher body weight (Crandall, 1991), a finding that has received some support in more recent research (Incollingo Rodriguez et al., 2019). School professionals, including teachers and counselors, play a crucial role in promoting healthy body image and preventing eating disorders and obesity (Yager & O'Dea, 2005). School counselors have a significant role in identifying and supporting

students with body image concerns and eating disorders. Early intervention and comprehensive psychosocial support are critical to this understanding (Omizo & Omizo, 1992).

Finally, mental health providers, including psychologists and counselors, can benefit from this study to provide more inclusive, comprehensive pre- and post-bariatric care. By highlighting the psychological impact of the process, this study will help counselors plan more effective interventions to support patients in coping with emotional and mental health challenges.

2.15. Summary of the Literature Review

This chapter reviews the literature on bariatric surgery and the psychosocial experiences of individuals undergoing it. It also examines the role of psychological counseling throughout the bariatric surgery process and highlights existing gaps in the literature that informs the current study.

Bariatric surgery is one of the most effective methods for weight loss and is used to treat obesity (Keyte et al., 2024). Obesity is a growing problem worldwide and a significant health risk, particularly for adults in the Western world (Lingvay et al., 2024). Individuals who have lived with obesity and undergo bariatric surgery often also experience various health problems associated with obesity. Surgery leads to improvements in overall health, including these health problems, and an increase in quality of life (Murtha et al., 2022). Beyond physical improvements, bariatric surgery has also been associated with psychological benefits. Bariatric surgery can also impact on individuals' psychological well-being (Keyte et al., 2024).

While the literature shows that bariatric surgery leads to significant weight loss and improvements in physical health, it has also been revealed that the postoperative period involves significant psychological, behavioral, and social adjustment processes (Keyte et al., 2024; Sarwer, 2008). Previous studies have documented changes in eating behaviors, body image, identity, interpersonal relationships, emotional well-being, and quality of life, demonstrating that surgery represents more than just a medical intervention (Abu Dayyeh et al., 2017; Cherick et al., 2019; Choban et al., 2002; Keyte et al., 2024).

Although bariatric surgery positively affects people's physical health, studies indicate that its psychological benefits generally last about 2 years (Keyte et al., 2024). At the same time, some individuals may continue to perceive themselves as "obese" despite significant weight loss and may continue to experience difficulties with body image (Wolff & Maydell, 2024). Some individuals may experience lasting or increasing negative impacts on their body image due to postoperative side effects (such as scarring, sagging soft tissue, or loose skin) (Ivezaj & Grilo, 2018).

It has been reported that some individuals who undergo bariatric surgery return to their pre-operative state two years later (Keyte et al., 2024). This highlights the importance of ongoing psychological support and counseling interventions after surgery. The review also emphasizes the importance of psychological counseling throughout the bariatric surgery process. Studies indicate that despite high demand for services in this area, resources in psychology remain limited. Therefore, psychological services for bariatric surgery need to be strengthened through training, common practice standards, and adequate resource support (Ogden et al., 2019).

While the current literature has made significant contributions to understanding the outcomes of bariatric surgery, some gaps still exist (Ogden et al., 2019). Despite the significant relationship between negative body image, weight, and bariatric surgery, the number of studies on these issues is surprisingly small (Alleva et al., 2023). Much of previous research has focused on physical outcomes or isolated psychological variables (Glinski et al., 2001). Studies examining the entire bariatric surgical process from a qualitative perspective are fewer in number. Particularly in the Turkish context, research examining individuals' psychosocial experiences, counseling needs, and gender-based experiences in the pre- and post-operative periods is limited. Therefore, this study aimed to investigate individuals' psychosocial experiences and counseling needs throughout the bariatric surgical process using a qualitative content analysis approach. By examining participants' experiences at different stages of their surgical journey, the study aimed to contribute to the existing literature and offer implications for psychological counseling and multidisciplinary bariatric care.

CHAPTER 3

METHODOLOGY

In this chapter, the study's methodology is presented. The research design, sampling strategy, and criteria for identifying participants who underwent bariatric surgery are explained. Then, detailed information about the participants is given. The data collection procedures, development of the semi-structured interview protocol, and ethical considerations are also described. Additionally, the data analysis process, based on inductive qualitative content analysis, is described, along with strategies to ensure the study's trustworthiness. Finally, the chapter includes the researcher's reflexivity statement and discusses the research's methodological limitations.

3.1. Research Design

This study employed a qualitative descriptive design (Sandelowski, 2000). It explored individuals' psychosocial experiences before and after bariatric surgery and their counseling needs throughout the surgical process. Specifically, the study aimed to examine participants' pre-operative and post-operative experiences, the psychological, emotional, social, and bodily changes they reported, and the counseling needs they identified during different stages of the bariatric surgery journey.

Bariatric surgery is associated with substantial psychological and social changes extending beyond physical weight loss. Individuals may experience changes in body image, self-perception, interpersonal relationships, emotional adjustment, and daily functioning throughout the surgical process. Because the purpose of this study was to describe these experiences from participants' own perspectives without imposing

predetermined categories, a qualitative descriptive design supported by inductive qualitative content analysis was considered appropriate. This approach allows researchers to organize rich qualitative data into meaningful categories and themes while remaining closely connected to participants' descriptions (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). The theoretical framework adopted in this study was not used to guide the coding process or the development of categories and themes. Instead, codes, categories, and themes were developed inductively from the interview data. The theoretical framework was used only during the discussion stage to interpret and contextualize the findings (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004).

3.2. Context of the Study

According to the Türkiye Health Survey (2022), 20.2% of individuals aged 15 years and older in Türkiye are obese. The prevalence of obesity is higher among women (23.6%) than men (16.8%). In addition, 30.9% of women and 40.4% of men are classified as pre-obese. These findings underscore the substantial burden of obesity on public health and healthcare resources in Türkiye.

Behavioral changes, diet, exercise, medications, and surgical interventions are among the reported treatment options for obesity treatment. Surgical intervention called "bariatric/obesity surgery" is among the other treatment options for moderately to severely people living with obesity (Taskın et al., 2000). The Social Security Institution (SGK), the largest health insurance payment institution in Türkiye, reimburses obesity surgery at a fixed fee under the Health Implementation Circular, without considering patients' severity or comorbidities (http://www.sgk.gov.tr). The first morbid obesity surgery in Türkiye was performed in 1990 at Cerrahpaşa Faculty of Medicine (Taskın et al., 2000). Since the first bariatric surgery was performed, the annual number of bariatric procedures has grown, reflecting both clinical demand and improved accessibility.

Although bariatric surgery is widely recognized for promoting significant weight loss and reducing medical comorbidities, the procedure also brings profound psychological and psychosocial changes. In this context, this study investigates how individuals undergoing bariatric surgery in Türkiye experience the process, how they cope with it,

their psychological experiences before and after surgery, and their counseling needs throughout the surgery. Despite the increasing number of bariatric procedures in Türkiye, research focusing on the psychological and emotional aspects of the surgery process remains limited. Given this gap, the present study seeks to deepen understanding of how individuals in Türkiye experience and interpret the bariatric surgery.

3.3. Participants

A total of 10 participants who had undergone bariatric surgery were included in this qualitative study. The study required detailed, experience-based narratives about the psychological and psychosocial aspects of the bariatric surgery process. Therefore, purposive criterion sampling was employed to recruit individuals who could provide rich, meaningful, and relevant insights (Palinkas et al., 2015). Criterion sampling, a form of purposive sampling, was used to identify eligible participants (Palinkas et al., 2015).

In addition, snowball sampling was used to reach a broader, more diverse group of participants. Sensitive issues such as weight, body image, stigma, and emotional experiences can make individuals hesitant to participate in research. Therefore, snowball sampling was particularly effective in reaching individuals who were not easily reached through clinics or social media networks.

The recruitment process began with individuals within the researcher's academic and social networks who met the inclusion criteria. These participants later provided referrals to other individuals who had undergone bariatric surgery. A total of 19 individuals were approached during the recruitment process. Of these, 13 agreed to participate. One participant completed a pilot interview, and two participants completed cognitive interviews to evaluate the interview guide. These three interviews were not included in the final analysis. The remaining 10 participants completed the main study interviews and constituted the final study sample. The remaining individuals either did not respond to the invitation, declined participation because of time or personal reasons, or did not meet the inclusion criteria.

The inclusion and exclusion criteria were developed to recruit participants who could provide rich descriptions of their psychosocial experiences following bariatric surgery. Individuals who had undergone bariatric surgery between one and eight years before the interview were included because the study aimed to explore experiences beyond the immediate postoperative period while also capturing longer-term psychosocial adjustment following surgery. Including participants from different postoperative stages enabled the study to capture a range of psychosocial experiences and counseling needs across the bariatric surgery journey (Palinkas et al., 2015; Sarwer et al., 2008).

The inclusion criteria for this study were established as follows:

1. Being over 18 years old.
2. Having undergone bariatric surgery between one and eight years before the interview.
3. Willing to share their psychological, emotional, and bodily experiences.

The exclusion criteria for this study were established as follows:

1. Being younger than 18 years of age.
2. Having undergone bariatric surgery less than one year or more than eight years before the interview.
3. Being unwilling or unable to participate in an interview or share personal experiences related to the bariatric surgery process.

Interviews were conducted via video call based on participants' availability. Audio recordings were transcribed verbatim for analysis. Information that could compromise participants' privacy was omitted from the findings. Only participants' general characteristics are reported.

3.3.1. Background of the Participants

The study included 10 participants who had undergone bariatric surgery. All participants were adults, with ages ranging from 53 to 22 years. The sample consisted of 6 women and 4 men. Participants had diverse educational and occupational backgrounds. Their education levels ranged from primary school to master’s degree,

and they were employed in various professions, including the service sector, education, and self-employment.

Table 3.1. *Personal Information of Participants*

Participant	Age	Gender	Education	Occupation	Marital Status	Time Since Surgery
P1	42	Female	MA	Counselor	Married	5 years
P2	22	Female	BA	Student	In a relationship	3 years
P3	31	Female	High School	Homemaker	Married	3 years
P4	53	Female	Middle School	Cook	Married	3 years
P5	53	Male	MA	Retired	Married	8 years
P6	41	Female	BA	Teacher	Divorced	3 years
P7	41	Female	BA	Teacher	Married	1.5 years
P8	38	Male	BA	Sales Manager	Married	4 years
P9	34	Male	BA	Teacher	Married	1 year
P10	34	Male	High School	Self Employed	Married	1 year

P1

P1 was a 42-year-old married woman working as a psychological counselor. She held a master's degree and was pursuing doctoral studies at the time of the interview. She underwent bariatric surgery in November 2020. Before surgery, she weighed 91 kg and aimed to reach 60 kg. Her lowest postoperative weight was 69 kg, and her current weight ranged between 69 and 70 kg.

P2

P2 was a 22-year-old psychology student who was in a committed romantic relationship. She underwent bariatric surgery in July 2023. Before surgery, she weighed 120 kg and hoped to reduce her weight to approximately 75–76 kg. Her lowest postoperative weight was 79 kg, and her current weight is 81 kg.

P3

P3 was a 31-year-old married homemaker with two children. She underwent bariatric surgery in January 2023. Before surgery, she weighed 150 kg, having previously reduced her weight from 170 kg through her own efforts. Her goal was to reach a weight below 80 kg. She weighed 72 kg at the lowest and 75 kg at the time of the interview.

P4

P4 was a 53-year-old married female cook with a middle school education. She underwent bariatric surgery in June 2023. Before surgery, she weighed 100 kg and aimed to reach 72 kg. The lowest weight she achieved after surgery was 67 kg, and her current weight ranges from 71 to 72 kg.

P5

P5 was a 53-year-old married retired male with a master's degree. Before retiring, he had worked as a regional manager for 26 years. He underwent bariatric surgery in July 2018. Prior to surgery, he weighed 120.4 kg and hoped to reach a target weight of 85 kg. The lowest weight he achieved following surgery was 79.8 kg, and his current weight at the time of the interview was 91 kg.

P6

P6 was a 41-year-old divorced female teacher with a master's degree. She underwent bariatric surgery in July 2023. Before surgery, she weighed 130 kg and hoped to reach a weight between 80 and 85 kg. The lowest weight she achieved following surgery was 77 kg, and her current weight is 86 kg.

P7

P7 was a 41-year-old married female teacher with a bachelor's degree. She underwent bariatric surgery in July 2024 after struggling with obesity since childhood. At the time of surgery, she weighed 108 kg and successfully reached her target weight of 65 kg, which she maintained at the time of the interview.

P8

P8 was a 38-year-old married man with a bachelor's degree working as a sales manager. He underwent bariatric surgery in August 2022 after years of unsuccessful weight-loss

attempts despite professional dietary support. Before surgery, he weighed 123 kg and aimed to reach 75 kg. He exceeded this goal, reaching the lowest weight of 60 kg and maintaining a current weight of 70 kg at the time of the interview.

P9

P9 was a 34-year-old married male physics teacher with a bachelor's degree. He underwent bariatric surgery in July 2025 after experiencing obesity-related health concerns, including hypertension, insulin resistance, and reduced physical functioning. Before surgery, he weighed 177 kg and aimed to reach 86 kg. At the time of the interview, his weight had decreased to 123 kg, representing the lowest weight he had reached since surgery.

P10

P10 was a 34-year-old married male who was self-employed and had completed high school education. He underwent bariatric surgery in February 2025 after experiencing obesity-related physical limitations, including joint pain, shortness of breath, and difficulties performing daily activities. Before surgery, he weighed 167 kg and he weighed approximately 95 kg at the time of the interview, representing his lowest postoperative weight.

3.4. Data Collection Instruments

The data were collected through the semi-structured interview form “Psychosocial Experiences and Counseling Needs in the Bariatric Surgery Process” developed by the researcher. The interview questions were prepared based on the literature on bariatric surgery, obesity, and psychological experiences, as well as the researcher’s personal observations and experiences in the field. The interview protocol was designed to obtain rich and detailed descriptions of participants' psychosocial experiences before and after bariatric surgery, as well as their counseling needs. Open-ended questions encouraged participants to describe their experiences in their own words while allowing flexibility to explore issues relevant to each participant (Kallio et al., 2016).

The interview guide underwent a structured expert review before data collection. Three experts from different disciplines evaluated the interview protocol to enhance its clarity, relevance, and content validity. A bariatric surgeon reviewed the medical

accuracy and clinical relevance of the questions, a registered dietitian evaluated the nutrition- and lifestyle-related content, and an academic specializing in psychological counseling and qualitative research assessed the questions in terms of conceptual clarity, appropriateness for qualitative interviewing, and alignment with the research aims. Based on their recommendations, several revisions were made to the wording, sequencing, and probing questions. For example, demographic questions were clarified, several questions were reworded to improve comprehensibility, additional probe questions were added where needed, and the organization of some sections was revised before the cognitive interviews were conducted.

Before the main data collection, one pilot interview was conducted with an individual who met the study's inclusion criteria but was not included in the final sample. The pilot interview was carried out to evaluate the overall flow of the interview, interview duration, and the feasibility of the interview procedure. No major problems were identified during the pilot interview.

Following the pilot interview, two cognitive interviews were conducted with one female and one male participant who met the study's inclusion criteria but were not included in the final sample. The cognitive interviews were conducted to evaluate the clarity, comprehensibility, and relevance of the interview questions (Willis & Artino, 2013). Participants answered each question and were asked whether the wording was clear and easy to understand. Overall, the interview guide was found to be clear and understandable. Based on participants' feedback, only minor revisions were made to the wording of a few questions, particularly those related to emotional experiences.

The final interview schedule consisted of eight sections: (1) demographic information and weight history; (2) pre-surgery psychological and bodily experiences; (3) the surgery day and early postoperative period; (4) current body image, identity, and self-perception; (5) social, cultural, and relational experiences; (6) eating behaviors, emotion regulation, and transfer of compulsions; (7) psychological counseling needs; and (8) closing reflections.

The interviews were semi-structured, allowing flexibility for participants to elaborate on their experiences while enabling the researcher to ask follow-up questions when

necessary. These probing questions encouraged participants to provide richer and more detailed accounts of their experiences. For example, participants were asked to clarify the meaning of a particular statement, describe how a situation affected them, explain what a specific experience meant to them, reflect on the emotions they experienced at that moment, and discuss how the experience influenced different aspects of their lives.

All interviews were conducted in Turkish, and the original interview protocol is presented in Appendix D. Ethics committee approval is presented in Appendix A. Each interview began with verbal consent. The introductory monologue included greetings and acknowledgments, an introduction to the research, an explanation of research ethics and participant rights, and finally, the participant's decision to continue. After the questions were completed, all participants were asked if they had anything to add, and a verbal debriefing was given.

3.5. Data Collection Procedure

Prior to the data collection procedure, the ethical approval was obtained from the Middle East Technical University (METU) Human Subjects Ethics Committee (HSEC), with a protocol number *080-ODTÜİAEK-2026.* The approval document is presented in Appendix A.

Potential participants, who have undergone bariatric surgery, were invited to participate in the study via the announcement text in the Appendix B, via bariatric surgery clinics, hospitals, and social media platforms focused on obesity and bariatric surgery. Interested individuals were contacted, and the study's purpose, interview content, data collection, and data storage processes were explained in detail. Individuals who agreed to participate in the study were scheduled for interviews. Participants were reminded that the interview would be recorded, about their privacy principles and their right to interrupt the interview, and recordings began with the participants' permission.

Before the interviews, participants signed an informed consent form. This form is provided in Appendix C. Through this form, participants were informed about the purpose of the study, the importance of their contributions, how the data collected

would be used and stored, and their right to terminate the interview at any time. In addition, the researcher's contact information was shared with the participants.

After the interviews were completed, the researcher transcribed the audio recordings and prepared them for analysis. The total recording time was 538 minutes. Interviews lasted an average of 50 minutes, with the shortest interview being 36 minutes and the longest being 86 minutes. All interviews were conducted via video call, depending on participants' preferences and availability.

Data collection continued until sufficient information had been obtained to address the research aims. As data collection and preliminary analysis progressed, participants' accounts became increasingly repetitive, and no substantially new codes or categories emerged. This indicated that the data were sufficiently rich to support the analysis. Consistent with Saunders et al. (2018), data adequacy was evaluated throughout the data collection and analysis process. The final analysis consisted of ten participants.

Information that could compromise participants' anonymity was intentionally omitted from the reporting. Finally, to protect confidentiality, each participant was assigned a unique identification code (e.g., P1, P2) and identifying details were altered or omitted.

3.6. Data Analysis

Data were analyzed using inductive qualitative content analysis, a method that allows researchers to systematically organize qualitative data into codes, categories, and themes while remaining grounded in participants' descriptions (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). An inductive approach was adopted because the study aimed to describe participants' psychosocial experiences and counseling needs without applying predetermined categories.

Since bariatric surgery involves substantial psychological, emotional, social, and behavioral changes beyond physical weight loss, inductive qualitative content analysis was considered appropriate for systematically describing participants' experiences and counseling needs.

First, all interviews were transcribed verbatim by the researcher. The transcripts were read repeatedly to gain a comprehensive understanding of the data and become familiar with participants' descriptions (Elo & Kyngäs, 2008).

During the open coding stage, the transcripts were examined line by line, and meaningful units relevant to the research questions were assigned descriptive codes. When appropriate, more than one code was assigned to a segment to capture different aspects of participants' experiences. The coding process was conducted using MAXQDA 2022. An example of the coding process in MAXQDA is presented in Appendix E.

Following open coding, conceptually similar codes were grouped into subcategories and categories by comparing their similarities and differences. This process involved continuous comparison across participants to ensure that the categories adequately reflected the data. Through abstraction, related categories were further organized into broader themes that summarized recurring patterns across participants' accounts (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). An example of the development of codes into categories and themes is presented in Appendix F.

Theme names were refined through repeated review of the grouped categories and the original transcripts to ensure that each theme accurately represented its underlying conceptual meaning and participants' experiences.

Throughout the analysis, the researcher repeatedly returned to the original transcripts to ensure that the categories and themes remained consistent with participants' descriptions. Revisions were made whenever necessary to improve the clarity and coherence of the coding structure.

The developing codes, categories, and themes were also discussed regularly with the thesis supervisors. During these meetings, the researcher presented the current coding framework and theme structure and received feedback on the organization of the codes, category boundaries, theme names, and the overall structure of the analysis. Based on this feedback, revisions were made to the codes, categories, and themes where necessary. When different interpretations emerged, the original transcripts were reviewed again and discussed until the interpretation that best reflected the data was

agreed upon. These discussions helped improve the clarity of the coding structure and strengthened the credibility of the analysis.

Finally, the findings were organized under themes and categories and presented with representative participant quotations to illustrate the identified patterns.

3.7. Trustworthiness/Transferability

As reported by Lincoln and Guba's Evaluation Criteria (1981), four main elements determine reliability in qualitative research. These are credibility, transferability, dependability, and confirmability.

Credibility was supported by prolonged engagement with the data. The researcher read the interview transcripts repeatedly to gain a comprehensive understanding of participants' experiences. Representative participant quotations were used to support the findings and enhance the credibility of the analysis. To enhance credibility, the initial coding of the first three interviews was reviewed by a researcher experienced in qualitative research. The coding was discussed, and the feedback received was used to refine the coding framework before the remaining interviews were analyzed. In addition, the developing codes, categories, and themes were discussed regularly with the thesis supervisors throughout the analysis. These discussions helped refine the coding structure, consider alternative interpretations, and ensure that the findings remained grounded in the interview data.

Transferability was strengthened through detailed descriptions of the participant characteristics and the sampling process. This allows readers to assess the applicability of the findings to similar contexts. Because qualitative research does not aim for statistical generalization, the findings should be considered transferable only to contexts with similar participant characteristics and settings.

Dependability was ensured through transparent documentation of each stage of the research process, including participant recruitment, data collection, coding, categorization, and analysis. This documentation enabled the analytical process to be followed clearly.

Finally, *confirmability* was enhanced by maintaining an audit trail throughout the study. The audit trail included interview transcripts, coding records in MAXQDA 2022, the development of categories and themes, and regular discussions with the thesis supervisors regarding analytical decisions. These records increased the transparency and consistency of the analysis. These procedures increased the transparency and consistency of the analysis.

3.8. The Role of the Researcher

The researcher's personal experiences and observations significantly influenced the motivation and perspective of this study. During the early twenties, the researcher noticed that many women in her social circle were undergoing various aesthetic surgeries—such as rhinoplasty, bariatric surgery, labiaplasty, botox, lip fillers, breast augmentation and lifts, and facelifts—reflecting widespread body dissatisfaction. In particular, observing several close friends undergo such procedures, including bariatric surgery, provided the researcher with a closer view of how individuals experience and make sense of major changes in their bodies. These experiences also raised the researcher's awareness that decisions about body-related procedures may be shaped by personal, psychological, and social factors. This observation was coupled with the awareness that many individuals viewed aging as undesirable and strived to maintain a youthful and 'natural' appearance, often comparing themselves to others.

The researcher holds a bachelor's degree in Guidance and Psychological Counseling and was pursuing a master's degree in the same field while conducting this study. Through academic coursework, supervised counseling practice, and research training, the researcher developed knowledge and skills related to interviewing, active listening, ethical practice, and qualitative data analysis. This education also increased the researcher's awareness of body image, stigma, psychosocial well-being, and the importance of supporting individuals from vulnerable groups. It further emphasized the counselor's role in promoting psychological well-being, advocacy, and respect for individuals' lived experiences. This academic and professional background helped the researcher approach participants with empathy, conduct the interviews ethically, and remain attentive to personal assumptions throughout the research process.

Over the past year, while balancing intensive academic and professional responsibilities, the researcher became more aware of personal changes related to body weight. This experience heightened the researcher's awareness of body image concerns, weight-related stigma, and the psychological challenges associated with weight management. Recognizing that these experiences could influence the research process, the researcher engaged in ongoing reflexive practice by critically examining personal assumptions and remaining attentive to their potential influence on data collection and interpretation.

Furthermore, the researcher noted the powerful influence of social media platforms, where trends like "fitspiration," "skin-tok," "clean girl," "Barbie body," "curvy body," skincare routines, and shared experiences of aesthetic procedures proliferate, shaping societal standards of beauty and body image. These factors sparked a deep interest in exploring the psychological experiences of individuals undergoing bariatric surgery, particularly within the context of contemporary cultural pressures related to body aesthetics.

Motivated by both personal and social observations, the researcher decided to focus on this topic, aiming to better understand the psychosocial experiences of individuals before and after bariatric surgery. These experiences increased the researcher's awareness of the topic and facilitated rapport with participants during the interviews. Throughout the research process, the researcher remained aware of personal assumptions, approached the data systematically, and documented analytical decisions to enhance the trustworthiness of the findings.

3.9. Limitation of the Study

This study faced several limitations that should be acknowledged when interpreting the findings. First, recruiting participants was challenging because of the sensitive and emotionally charged nature of bariatric surgery. Issues such as body weight, obesity, and the stigma and discrimination associated with these conditions may have deterred some potential participants from volunteering, resulting in a limited pool of volunteers. Moreover, during the interviews, participants may have felt reluctant to disclose particularly sensitive experiences despite assurances of confidentiality. Consequently,

some experiences may have remained unspoken, potentially limiting the depth and the richness of the data.

Second, although maximum variation sampling was used, achieving diversity across age, gender, socioeconomic status, educational backgrounds, and postoperative experiences remained challenging. Consequently, some perspectives may not have been adequately represented within the dataset.

Third, participants were interviewed at different postoperative stages. Bariatric surgery is a dynamic process, and individuals may have different psychosocial experiences and counseling needs at different stages of recovery. Although the inclusion of participants from different postoperative stages provided insight into different periods of the process, the cross-sectional design may have limited the ability to understand how these experiences and needs change over time within the same individuals. Future longitudinal qualitative studies could follow the same individuals across different stages to better understand how their psychosocial experiences, counseling needs, and adjustment evolve throughout the bariatric surgery process.

Finally, although reflexive practices were used throughout the analysis, the researcher's perspectives may still have shaped the interpretation of the findings. To minimize this potential influence, the developing codes and interpretations were discussed regularly with the thesis supervisors. These discussions helped the researcher consider alternative interpretations and enhance the credibility of the analytical process.

CHAPTER 4

RESULTS

The inductive qualitative content analysis generated five overarching themes that reflect participants' experiences: (1) *The Journey Toward Bariatric Surgery*, (2) *Early Postoperative Challenges*, (3) *The Need for Lasting Change,* (4) *Transforming Life After Bariatric Surgery*, and (5) *How Gender Shapes the Bariatric Surgery Experience*. Within each theme, subthemes and categories were developed to capture the shared and diverse experiences of participants.

The findings are presented by first introducing each theme, followed by a detailed presentation of its subthemes and categories. To support the findings, representative quotations from participants are provided for each category. An overview of the thematic structure identified in this study is presented in Figure 4.1 below.

4.1. Theme 1. The Journey Toward Bariatric Surgery

‘’The Journey Toward Bariatric Surgery’’ identified as the first theme from the data analysis. Rather than describing a single decision, participants described this journey as a cumulative process shaped by the physical and psychological burden of obesity, repeated unsuccessful attempts to lose weight, experiences of weight stigma, evolving relationships with food, and the influence of family members, healthcare professionals, and the broader social environment. The findings also demonstrate how participants gradually evaluated obesity, bariatric surgery, and their future expectations before reaching the point of deciding on surgery. The subthemes and categories are presented in Figure 4.2.

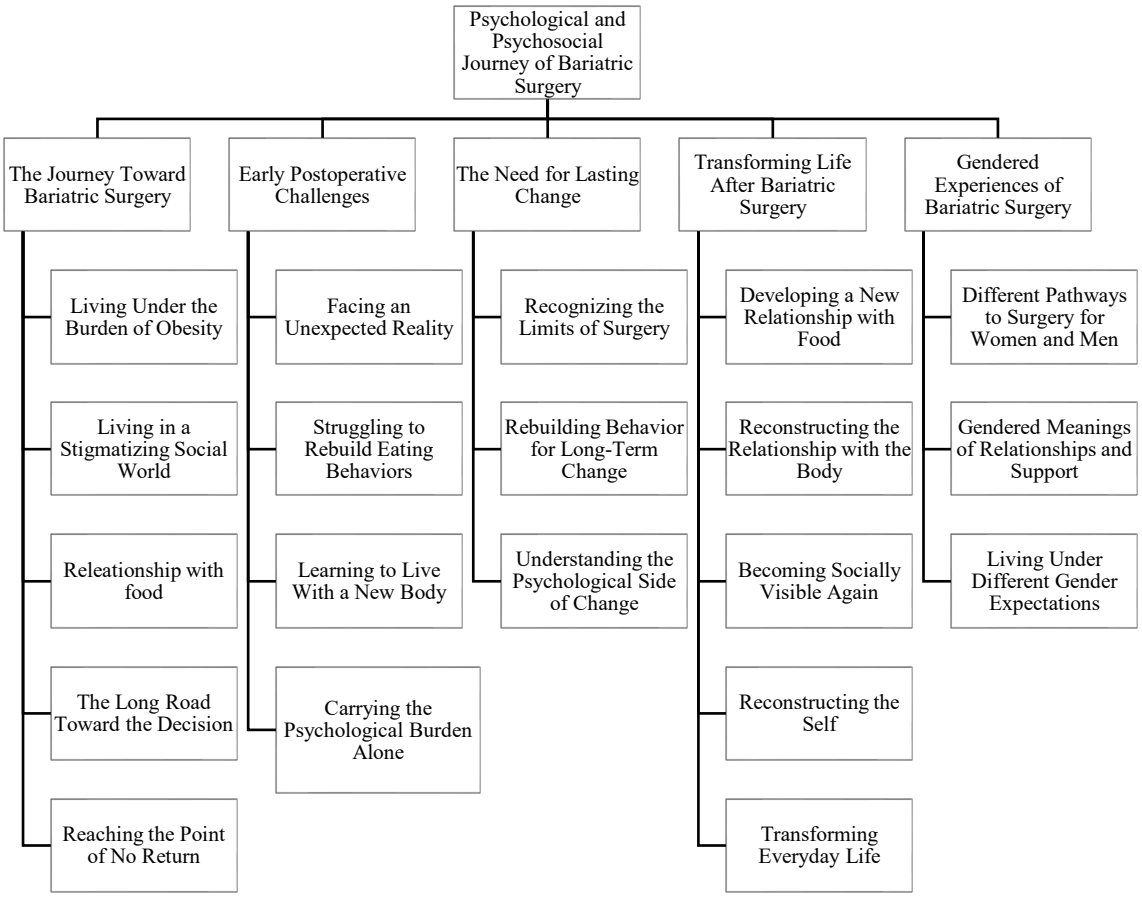

Figure 4.1. *Flowchart of the results: Themes and Subthemes*

4.1.1. Living under the Burden of Obesity

Living with obesity was identified as a long-term and pervasive experience that shaped participants' lives well before they considered bariatric surgery. Across participants, obesity was viewed as far more than excess body weight; it was experienced as an ongoing burden that gradually restricted physical functioning, affected emotional well-being, and interfered with everyday roles, relationships, and social participation. Rather than describing isolated difficulties, participants' accounts reflected how these interconnected experiences accumulated over time, ultimately becoming an important force driving the decision to undergo surgery.

Reflecting on this long-term struggle, one participant explained:

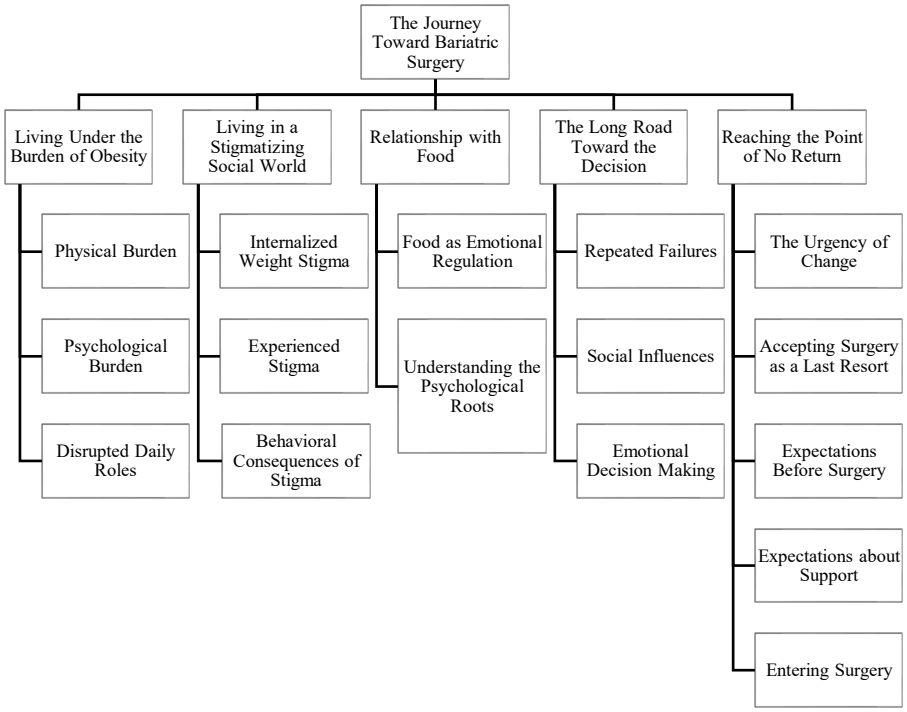

Figure 4.2. *The Journey toward Bariatric Surgery*

> Çocukluğumdan beri kilo sorunu yaşıyordum. Eşlik eden, hipotiroidim gibi ve erken menopoz gibi kilo vermemi zorlaştıran sağlık durumlarım da vardı. İki yıl boyunca bebek emzirdiğim, bebek büyüttüğüm ve hamilelikten sonra evde olduğum, bu iki yılın içinde de maalesef pandemiye denk geldiğim için başka şekilde kilo veremeyeceğimi düşünüp çok ümitsiz bir aşamadayken ve çok olumsuz bir beden algısı içindeyken bu ameliyatı olmaya karar verdim ve gerçekleştirdim. *(P1)*
>
> I had struggled with weight problems since childhood. I also had accompanying health conditions, such as hypothyroidism and early menopause, that made it harder for me to lose weight. During the two years when I was breastfeeding my baby, raising my baby, and staying at home after pregnancy, and unfortunately during those two years the pandemic occurred, I thought that I would not be able to lose weight in any other way. While I was in a very hopeless stage and had a very negative body image, I decided to undergo this surgery and did so. *(P1)*

Physical burden. Physical limitations were among the earliest and most consistently reported consequences of living with obesity. Difficulties finding suitable clothing, restricted mobility, chronic health problems, and reduced physical functioning were repeatedly described as experiences that gradually reinforced the belief that lasting weight loss would be difficult to achieve without surgery.

One participant vividly described how these everyday difficulties accumulated into what he experienced as a deeply distressing part of daily life:

> İş yeri değiştirdim. Arabam da yoktu. Dolmuşla gidip gelirken mesela dolmuşta bir buçuk koltukluk yer kaplıyordum. Bu benim için travma gibi bir şeydi. Ayakkabımı bağlayamıyordum. Kendime kıyafet bulamıyordum. Hareket edemiyordum. Merdiven çıkamıyordum. Kendime kıyafet bulamıyordum. *(P5)*
>
> I changed my workplace. I didn't have a car either. For example, when I was commuting by minibus, I was taking up one and a half seats on the minibus. It was traumatic. I couldn't tie my shoes. I couldn't find clothes for myself. I couldn't move. I couldn't climb stairs. I couldn't find clothes for myself. *(P5)*

Psychological burden. Predominantly, participants described the psychological burden of obesity as a lifelong experience rather than a consequence of excess body weight alone. For many, negative body image, shame, self-criticism, and emotional distress had developed gradually through repeated experiences that often began in childhood and continued into adulthood. Rather than being linked to isolated events, these experiences became deeply embedded in how participants perceived themselves and their place in the world.

Across interviews, body dissatisfaction was described as a long-standing experience that developed over many years and became part of how participants viewed themselves. Reflecting this pattern, one participants recalled:

> Hem psikolojik danışman olarak hem de yetişkin bir kadın olarak düşündüğümde, beden algım hep olumsuzdu ve temelleri çoğunlukla çocukluğumdaki tecrübelerime de dayanıyordu diye düşünüyorum. Çünkü ben bebekliğimde dâhil, çocukluğumda, ergenliğimde, genç kızlığımda ve yetişkinliğimde her zaman normal kilonun üstünde bir kişiydim. Yani hiçbir zaman ideal bir kiloda değildim. Bu konuyla barışık olduğum bir dönem hayatımda hiç olmadı. Her zaman o kiloyu vermem gerektiği, ancak ondan sonra normal bir insan olabileceğime dair bir düşüncem vardı. O yüzden de bu ameliyata karar verdiğimde, çok yüksek kiloya ulaştığım dönemin öncesinde de hep o düşünceler vardı. Arka alanımda çocukluğumdan beri gelen böyle bir düşünce ve onun beraberinde getirdiği olumsuz beden algısına dair olumsuz duygular vardı. Çünkü kendimi aynada beğenmiyordum. *(P1)*

> As a psychological counselor and as an adult woman, I think that my body image was always negative, and I think its foundations were mostly based on my childhood experiences. From my infancy through my childhood, adolescence, young adulthood, and adulthood, I was always above normal weight. I was never at an ideal weight. There was never a period in my life when I was at peace with this issue. I always had the thought that I had to lose that weight and that only then could I become a normal person. When I decided to have this surgery, even before the period when I reached my highest weight, I always had those thoughts. I mean, in the background, there had always been such a thought coming from my childhood, and the negative feelings about the negative body image that it brought with it. Because I did not like myself in the mirror. *(P1)*

***Disrupted daily roles*.** Participants also described obesity as affecting their ability to fulfill important family, social, and occupational roles. Many described feeling unable to be the parent, partner, or active individual they wanted to be, as physical limitations increasingly interfered with daily responsibilities.

For these participants, the decision to undergo surgery became closely linked to their inability to support a growing family:

> Ameliyat olmamdaki en büyük sebeplerden biri, eşimin ikinci çocuğa hamile olmasıydı. Bir yere çıkarken yetişemiyordum. Yani eşime yardımcı olamıyordum. İkinci çocuk olacak, olmuyordu… *(P10)*

> One of the biggest reasons for having the surgery was that my wife was pregnant with our second child. When we were going somewhere, I couldn't keep up. I mean, I couldn't help my wife. We were going to have a second child, and it wasn't working… *(P10)*

Several participants described life transitions, such as marriage, pregnancy and parenthood, as periods during which the impact of obesity became more apparent in their daily lives. One participant explained:

"Evlilikten ve doğumdan sonra da bu artık beni çok rahatsız etmeye başladı. Şu açıdan, çocuğum küçük olduğu için onunla aktif aktivitelerde zorlandım. Onun bakımında kendimi yavaş ve ağır buldum." *(P7)*

"And after marriage and childbirth, this started to bother me a lot. In this respect, because my child was young, I had difficulty participating in active activities with my child. In taking care of my child, I found myself slow and heavy." *(P7)*

4.1.2. Living in a Stigmatizing Social World

Many participants reported living in environments where body size shaped how they were perceived, treated, and valued by others. Excess weight was frequently associated with negative stereotypes such as laziness, lack of self-control, and unattractiveness, while thinness was viewed as a symbol of beauty, competence, youth, and social acceptance. Over time, these repeated experiences extended beyond isolated comments and became embedded in participants' everyday interactions, influencing how they perceived themselves and their place in society.

Experiencing weight stigma. Another recurrent experience involved direct encounters with weight-related stigma across multiple social contexts. Participants described being judged, excluded, stereotyped, and reduced to their body size in family relationships, workplaces, healthcare settings, and everyday social interactions.

While describing these experiences, some participants spoke with noticeable frustration and anger, reflecting the lasting emotional impact of weight stigma. One participant explained:

> Şimdi yine toplumun bir yaftası var. Bir ortamda yemek yeniyorsa, orada kilolu birisi varsa, oradan biri çıkar ve der ki, "Bütün her şeyi sen yiyorsun." Mesela. Benim lise yıllarımdan beri maruz kaldığım bir şey bu. Bunu söyleyenleri var ya, böyle gırtlaklamak, öldürmek istiyorum. O kadar söylüyorum yani. Nefret ediyorum o insanlardan. *(P9)*

> Now, society has another label. If people are eating in a place and there is an overweight person there, someone will come out and say, "You are the one eating everything." For example. This is something I have been exposed to since my high school years. You know the people who say this? I want to grab them by the throat and kill them. That's how much I mean it. I hate those people. *(P9)*

Weight-related stigma was also evident in professional settings, where participants described being identified, evaluated, and remembered primarily through their body size rather than their personal or professional qualities.

> Mesela bir veli geliyor diyelim ki sizin sıra dışı bir saç renginiz yoksa, adımı da bilmiyorsa ne diyecek? "Şişman olan öğretmen." Bu şekilde tanımlıyor. Yani şimdi ya adımı gerçekten öğrenmeyi önemsiyor ya da başka türlü adlandırıyor. Ama "şişman öğretmen" sınıfından çıkmış olmayı önemli buluyorum. İş görüşmelerinde de aynı şekilde; dış görünüşte genç görünmek, daha dinamik görünmek, daha güzel görünmek önemli. *(P7)*

> For example, let's say a parent comes. If you don't have an unusual hair color and they don't know my name either, what will they say? "The fat teacher." That is how they describe me. Now, they either care enough to learn my name, or they call me something else. But I find it important that I am no longer in the "fat teacher" category. It is the same in job interviews as well: in terms of appearance, looking younger, more energetic, and more attractive is important. *(P7)*

Internalizing weight bias and appearance ideals. Another recurring finding was the gradual internalization of societal beliefs about body weight and appearance. Over time, many participants came to view thinness as a symbol of beauty, health, youth, success, and even personal worth, whereas living in a larger body became associated with failure, unhappiness, and social undesirability.

These beliefs were often described not as external judgments but as assumptions participants eventually adopted about themselves.

> Kilolu bireyler, mutsuz bireyler. (...) Kendilerini yemeğe verdiklerinden dolayı aldıkları kilonun oluşturduğu düzensiz yapıyla oluşan bir şey. Mutsuz insanlar, kilolu insanlar. Bakın, bugün insanın, "Ya ben seviyorum, çok güzel, kardeş, erkek etli olur, butlu olur, tatlı olur." gibi şeyler söylemesi tamamen insanların veremedikleri kiloyu beyinlerine tatlı gösterme çabasıdır. Bunun başka hiçbir açıklaması yok, inanın samimiyetime. Hiçbir açıklaması yok. Bu kadar fazla kiloyu taşıyorsanız bununla barışık yaşamak zorunda kalıyorsunuz. *(P8)*

> Overweight people are unhappy people. (...) It is something that is formed by the unhealthy condition created by the weight they gain because they turn to food. Unhappy people, overweight people. Look, today when people say, "I like it, it is very nice, my friend, men should be big, have thick thighs, be cute," things like that are completely an attempt by people to make the weight they cannot lose seem pleasant in their minds. There is no other explanation for this; believe my sincerity. There is no explanation at all. If you are carrying this much weight, you have to live at peace with it. *(P8)*

For some participants, these internalized beliefs gradually became so deep. As societal ideals of thinness were increasingly accepted as personal truths, participants described reaching a point where becoming thin came to represent a fundamental life goal rather than simply losing weight.

For some participants, the desire to become thin developed gradually over time rather than emerging suddenly. Reflecting on this gradual process, one participant stated:

“Yavaş yavaş bu bana yerleşti. Ben artık şey dedim, "Yeter ya, yeter. Ölmeden bir de ben zayıf olayım.” *(P6)*

“Little by little, this settled into me. I finally said, "Enough, enough. Let me be thin once before I die.” *(P6)*

Social and interpersonal consequences. Beyond shaping how participants viewed themselves, weight stigma also altered how they behaved in everyday social life. Over time, anticipating negative judgments became part of their daily interactions, influencing relationships, social participation, and overall sense of belonging.
Many described avoiding social situations, concealing eating behaviors, or feeling constantly evaluated by others.

> “Mesela önceden bir şey yerken, demek ki hatırlıyorum, saklanıyordum. İnsanlardan kaçıyordum. Mesela toplu olarak öğle yemeğinde, kahvaltıda ya da akşam yemeğinde değil de arada bir şey yiyecek olursam saklanıyordum.’’ *(P9)*

> “For example, when I was eating something before, I remember that I used to hide. I used to avoid people. For example, not during lunch, breakfast, or dinner with everyone, but if I was going to eat something in between, I would hide.’’ *(P9)*

Although participants differed in how they perceived their own weight, many described anticipating negative evaluations from others in social situations. These concerns often influenced how they behaved and contributed to feelings of discomfort during everyday interactions. The following quotations illustrate this experience:

“Önceden sosyal bir ortama geleceğim zaman, eğer hiç tanımadığım birisi varsa, birazcık kendimi huzursuz hissedebiliyordum. "Benim hakkımda ne düşünür?" Hep kafamda dönüyordu.’’ *(P2)*

“Before, when I was going to enter a social environment, if there was someone I did not know at all, I would feel a little uncomfortable. "What will they think about me?" It was always going through my mind.’’ *(P2)*

4.1.3. Relationship with Food

Participants described food as serving multiple psychological and social functions beyond satisfying physical hunger. Eating was frequently described as a way of regulating difficult emotions, experiencing pleasure, rewarding oneself, coping with emotional emptiness, and maintaining social connections. Many participants explained

that eating had become intertwined with their emotions, daily routines, and coping strategies long before considering bariatric surgery.

Food as emotional regulation. Eating was frequently described as a way of regulating emotions, seeking comfort, rewarding oneself, and coping with emotional distress. Rather than responding to physical hunger alone, participants often described eating as an automatic response to a wide range of emotional experiences.

> Benim yemekle öyle bir ilişkim vardı ki inanamazsınız. Üzüldüğümde yemek yerdim, sevindiğimde yemek yerdim. Canım sıkıldığında yemek yiyordum. Aç olmasam bile ağzıma bir şeyler atıştırmak istiyordum. Sürekli olarak bir şeyler yeme isteğim vardı. *(P2)*

> I had such a relationship with food that you wouldn't believe it. I ate when I was sad, and I ate when I was happy. I ate when I was bored. Even when I wasn't hungry, I wanted to put something into my mouth and snack. I constantly had the desire to eat something. *(P2)*

Making sense of the psychological origins of obesity. Participants reflected on the psychological factors underlying their obesity and eating behaviors. Rather than attributing obesity solely to eating habits, many described their relationship with food as connected to unmet emotional needs, psychological distress, or attempts to cope with difficult life experiences.

> Benimki beslenmek değildi. Benimki başka bir şeydi. Yediklerimi düşündüğümde... Bu başka bir şeydi. Gerçekten bir boşluğun kapanması için. Benim kilomun ya da kilo veremememin, yani kilolu hâlimin devam etmesinin sebebi kesinlikle oydu. Artık yemekten ne umuyorsam ya da yemek bana ne hissettiriyorsa, o yüzden olmuş. *(P7)*

> It wasn't about eating for nourishment. Mine was something else. When I think about what I used to eat... It was something else. It was really to fill a void. That was definitely the reason for my weight, or for not being able to lose weight, or for my remaining overweight. Whatever I was expecting from food, or whatever food was making me feel, that was why it happened. *(P7)*

4.1.4. The Long Road Toward the Decision

For almost all participants, the decision developed gradually through years of unsuccessful weight-loss attempts, increasing physical and psychological burden, and changing perceptions of surgery. As conventional approaches repeatedly failed, surgery was no longer viewed as an immediate choice but as a realistic response to an increasingly unmanageable situation.

> Gerçekten hep mücadele verdim. Maddi anlamda o kadar çok ürün aldım, kullandım; kendi bedenimle uğraştım. Ramazan'da kendime bir plan yaptım. Saat dokuzdan ona kadar, YouTube'daki fitness videolarıyla bir saat, hatta bir buçuk saat yoğun egzersiz yapıyordum. O zaman da kırklı yaşlarımdaydım. Vücudum şekil alıyor, kilo veriyordum ama sonra tekrar alıyordum. İşte en büyük sıkıntım buydu. (…) Evet, kendi kendime çaylar, aptalca ürünler... Bunların hepsine para vererek 15–20 yılım geçti, yemin ediyorum. Kilo vermek için çok ciddi paralar harcadım. Verdim, aldım; verdim, yine aldım. *(P4)*
>
> I really struggled all the time. Financially, I bought and used so many products. I struggled with my own body. During Ramadan, I made a plan for myself. From nine to ten, using fitness videos on YouTube, I exercised intensely for one hour, sometimes even one and a half hours. At that time, I was in my forties. My body was taking shape, and I was losing weight, but then I would gain it back again. That was my biggest problem. *(P4)*

Repeated failures. Repeated unsuccessful attempts to lose weight arose as one of the most frequently coded findings across participants' narratives.

“Ben hayatım boyunca kilo vermeye çalışmışım ama verememiş ve artık bunu kabul edip bununla yaşayan bir çocuktum.” *(P2)*

“I've spent my whole life trying to lose weight but never managed to, and eventually I accepted it and became someone who simply lived with it.” *(P2)*

Almost all participants described years of persistent efforts to lose weight through dieting, exercise, nutritional counseling, commercial weight-loss products, and various alternative methods.

“Daha önceki bütün beslenme danışmanlığı deneyimlerimde hep başarısız olmuştum. Verilen diyetlere çok uyum sağlamama rağmen hiç düzgün kilo verememiştim.” *(P1)*

“I had always been unsuccessful in all of my previous nutrition counseling experiences. Even though I complied with the prescribed diets very well, I had never been able to lose weight properly.” *(P1)*

Despite considerable commitment, these attempts were commonly described as temporary or unsuccessful, reinforcing feelings of frustration, exhaustion, and hopelessness over time.

“Psikolojik olarak yıllarca mücadele ettim. Başarılı olamadım.” *(P4)*

“I struggled psychologically for years. I couldn't succeed.” *(P4)*

Social influences. Participants emphasized that the decision was both shaped by personal experiences and also by influences from family members, partners, healthcare professionals, and others who had undergone bariatric surgery.

Reflecting on the influence of family, one participant recalled:

> Aslında babam hep istiyordu. Yani ben ameliyat olmadan önce de bunu istiyordu. Sonunda yıllardır babamın istediği ameliyatı olmuş oldum. Çünkü artık diyetisyene gittim, bir sürü şey denedim ama olmadı. *(P2)*
>
> Actually, my father had always wanted me to have the surgery. He wanted it even before I decided to undergo it. In the end, it became the surgery he had been hoping for over the years. By that point, I had already seen a dietitian and tried many different things, but nothing had worked.*(P2)*

Some participants also described their partners as actively encouraging surgery:

“Evliyken çok fazla ameliyat olmamı istedi. Çok fazla teklifte bulundu…” *(P6)*

“When we were married, he really wanted me to have the surgery. He brought it up many times.” *(P6)*

Emotional decision-making. Beyond years of unsuccessful weight-loss attempts, deciding to undergo bariatric surgery was described as an emotionally challenging process. Many participants described the decision as a balance between hope for a different future and fears surrounding the operation itself. Rather than feeling certain, they often described reaching the decision while experiencing uncertainty, emotional conflict, and a strong desire for change.

For several participants, fear of surgery remained one of the greatest barriers to making the final decision:

> Ben anesteziden uyanamayacağımı düşündüğüm için çok öteledim zaten ameliyatı. Anesteziden korktum. Beni bayıltamazlar veya bayıltsalar da uyandıramazlar korkusu vardı sadece... *(P10)*
>
> I kept postponing the surgery because I thought I might never wake up from anesthesia. I was afraid of anesthesia. My only fear was that they either wouldn't be able to put me under or, if they did, they wouldn't be able to wake me up. *(P10)*

Another commonly reported experience involved feeling misunderstood during the decision-making process:

> Ben o yüzden bu kararı neden verdiğimin ve neden bu aşamaya geldiğimin anlaşılabilmesi, bana karşı empati kurulabilmesi açısından yalnız hissediyordum kendimi. Çok yakın sevdiğim arkadaşlarımla birçok konuda anlaşıldığımı hissettim de bu kilo konusunda hiç anlaşılmadığımı her zaman hissettim. Hâlâ da hissediyorum. *(P1)*
>
> That is why I felt alone, in terms of people understanding why I made this decision and why I had reached this point, and in terms of people empathizing with me. I have felt understood by my very close friends in many matters, but I have always felt that I was never understood about my weight. I still feel that way. *(P1)*

As one participant explained:

> Karar sürecinde annemle, eşimle ve çocuklarımla mücadele ettim. Hayatımda yeri olan insanların, en yakınlarımın; eşim, annem ve kızım bana en çok karşı çıkan bu üç kişi oldu. (...) Hani siz psikolojiyi soruyorsunuz ya, onun cevabını vermeye çalışıyorum. Öncelikle ailemle paylaştım. Ailem tabii ki hayır dedi. Annem aynı şekilde hayır dedi. Kızım çok karşı çıktı. Zorluklar yaşadık. *(P4)*
>
> During the decision-making process, I struggled with my mother, my spouse, and my children. Among the people who are closest to me in my life, my spouse, my mother, and my daughter were the three people who opposed me the most. (...) You know, you are asking about the psychological aspect. I am trying to answer that. First of all, I shared it with my family. Of course, my family said no. My mother also said no. My daughter strongly objected. We went through difficulties. *(P4)*

Some participants also entered surgery with very limited expectations, doubting whether they would be able to lose weight even after the operation. As one participant stated:

“Ben kilo vereceğime inanmıyordum. Ameliyat olsam bile kilo vereceğime inanmıyordum.” *(P10)*

“I didn't believe I would lose weight. Even if I had the surgery, I didn't believe I would lose weight.” *(P10)*

4.1.5. Reaching the Point of No Return

As participants reflected on their decision-making process, many described reaching a point at which bariatric surgery became unavoidable for themselves. Many participants expressed a strong desire to become *“normal”* as soon as possible, explaining that they felt they had already delayed surgery for too long.

The urgency of change. Many participants described a specific event that marked a psychological turning point in their decision-making process. Although surgery had often been considered for years, these moments created a sense of urgency and led participants to seek surgery without further delay. Feelings of urgency, psychological exhaustion, increasing body weight, and the realization that time was running out accelerated their decision.

> O kadar hızlı karar verdim ki doktora hemen "Tamam." dedim. Pazartesi görüştük, çarşamba günü ameliyat oldum... Dedim ki, "Yeter." Beni tetikleyen nokta oydu. Ondan önce o kadının söyledikleri hep aklımdaydı. Artık "Yeter. Ölmeden bir de ben zayıf olayım." dedim.*(P6)*
>
> I made the decision so quickly. I immediately told the doctor, "Okay." We met on Monday, and I had the surgery on Wednesday... I finally said, "Enough." That was the moment that triggered everything. I kept remembering what that woman had said. I thought, "Enough. Before I die, I want to know what it feels like to be thin. *(P6)*

Similarly, another participant described a particular life event as the turning point:

> Tatile gittiğimde terliyordum, yürüyemiyordum. Bacaklarım çok ağrıyordu, hastaneye gitmek zorunda kaldım. Doktor bana 'Bu bacaklar ne kadar ağırlık taşıyor haberin var mı? Yazık değil mi?' dedi. Dışardan birinden bunu duymak çok ağır geldi bana. Yeni bir hayata başlamam gerektiğini orada anladım. O tatilde yaşadığım olay benim için çok büyük bir etken oldu. *(P8)*
>
> When I went on holiday, I was constantly sweating and could barely walk. My legs hurt so much that I had to go to the hospital. The doctor said to me, 'Do you have any idea how much weight those legs are carrying? Isn't that a shame?' Hearing those words from someone else hit me really hard. That was when I realized I needed to start a new life. What happened during that holiday became a major turning point for me. *(P8)*

Although the circumstances differed, these accounts suggest that many participants eventually reached a psychological threshold beyond which delaying surgery no longer seemed possible:

“Marketten çıktım, eve geldim, arabayı park ettim. Market poşetleriyle eve çıkarken birden kalbim çok hızlı çarpmaya başladı. Dedim ki, "Bu iş kötüye gidiyor. Ameliyat ol." Tamamen böyle oldu.” *(P9)*

“I had just come back from the supermarket. As I was carrying the shopping bags upstairs, my heart suddenly started racing. I said to myself, "This is getting serious. Have the surgery." That's exactly how it happened.” *(P9)*

Accepting surgery as a last resort. Many described perceiving surgery as a last resort after weighing its risks and benefits, trusting healthcare professionals, and recognizing that previous weight-loss attempts had been unsuccessful.

“Tek çözümün o olduğunu düşünüyordum. O yüzden karar verdim. Ameliyat en son, çıkıştaki son kapı...” *(P5)*

“I thought it was the only solution. That's why I decided to have the surgery. Surgery was the very last door—the final way out.”*(P5)*

Similarly, another participant described surgery as:

“Başka çarem olmadığını düşündüm. (...) Yıllar alacağını gördüm. Bu benim sürdürebileceğim bir süreç değildi. Ameliyatın daha hızlı sonuç vereceğini düşünmem kararımı etkiledi.” *(P7)*

“I felt that I had no other choice. (…) It would take years to reach that weight. That wasn't a process I could sustain, so believing surgery would provide faster results influenced my decision.” *(P7)*

This decision was often presented as the final step after realizing that previous methods had not produced lasting results. One participant explained:

“Bu sporla, diyetle olacak iş değil... Son çare.” *(P9)*

“This wasn't something that could be solved with diet and exercise anymore... Surgery was the last resort.” *(P9)*

Expectations before surgery. After accepting bariatric surgery as the only remaining option, participants began to imagine how life might change following the operation. Although expectations varied in intensity, hope for a different future was evident across participants' accounts.

“Tabii ki geleceğe dair bir umudum vardı. Çünkü sonuçta bu ameliyata, vücut fonksiyonlarımın normale döneceğini umut ederek gidiyoruz. Beklentim bir an önce bu kilolardan kurtulup zayıflamaktı.” *(P9)*

“Of course I had hope for the future. After all, we undergo this surgery hoping that our bodies will function normally again. My expectation was simply to get rid of the excess weight and become thin as soon as possible.’’ (*P9*)

Another participant described as:

“Ameliyat öncesinde tabii ki başaracağım diyordum. Bunun bir sonu olmalı.’’ *(P4)*

“Before the surgery, of course, I kept saying, I will succeed. This has to come to an end’’ *(P4)*

This expectation reflected their desire to achieve a lasting solution after years of unsuccessful weight-loss attempts. One participant explained:

“Ameliyata girerken dedim ki, inşallah bu son olacak.’’ *(P6)*

“As I was going into surgery, I said, 'I hope this will be the end.’’ *(P6)*

However, not all participants approached surgery with idealized expectations. One of them consciously tried to remain realistic and prepared.

“Çok ütopik hayaller kurmamam gerektiğini düşündüm ve beklentimi çok yüksek tutmamaya çalıştım.’’ *(P1)*

“I thought that I should not have very utopian dreams, and I tried not to keep my expectations too high.’’ *(P1)*

Expectations about support. Beyond expectations regarding the operation itself, participants frequently emphasized the importance of receiving adequate preparation before surgery. Many were expecting clear information, psychological guidance, and ongoing professional support to help them prepare for both the surgery and the lifestyle changes that would follow.

“Bu konuda aldığım destek azdı. Doktorun birlikte çalıştığı ekipten daha yoğun bir destek alacağımı düşünmüştüm ama orası çok zayıftı. Sonrasında bariatrik cerrahi konusunda deneyimli başka biriyle imkânlarımla çalışmaya devam ettim.’’ *(P7)*

“The support I received in this area was limited. I expected much more support from the team working with my surgeon, but that part was quite weak. Afterwards, I continued working on my own with another who specialized in bariatric surgery.’’ *(P7)*

One participant explained:

“Bence öncesinde destek alınmalı. Kişiyi ameliyat olma kararına getiren süreç zaten zorlantının muhtemelen en büyük olduğu süreç.” *(P1)*

“I think support should be provided before surgery. The process of deciding to have surgery is probably the most psychologically difficult stage.” *(P1)*

Entering surgery: Emotional reactions. Immediately before surgery, participants relied on various coping strategies to manage uncertainty and anxiety, including self-reassurance, religious coping, and trust in their surgeons. Many relied on self-reassurance, prayer, religious coping strategies, and trust in their surgeons to manage anxiety and try to normalize the perceived risks associated with the operation.

For some participants, religious beliefs and spiritual practices became important sources of comfort during the preoperative period. participants described relying on prayer and placing their trust in God to cope with uncertainty and anxiety before surgery. Reflecting on this experience, one participant stated:

“Sabah ezan okunacak. Saat 7'de de bizden kan falan alacaklar. Öyle bilgi verdiler bize. Ayrıldım. Yani tabii saatler ilerledikçe daha bir heyecan vardı. Korku da bastırdı. Namaz kıldım. Dua ettim.” *(P3)*

“The morning call to prayer was about to be heard. They had told us they would take our blood at seven o'clock. I went back to my room. As the hours passed, I became more anxious, and the fear grew stronger. I prayed and performed my prayer.” *(P3)*

For many participants, surgery represented more than a medical procedure. It was described as a new beginning and a source of hope for a different future. One participant expressed this expectation as follows:

“Heyecanlıydım. Yeniden doğmuş gibi olacağımı düşünüyordum.” *(P5)*

“I was excited. I thought I was going to feel as if I had been born again.” *(P5)*

Taking together, these findings demonstrate that the decision to undergo bariatric surgery was neither impulsive nor solely medically driven. Rather, it is a prolonged psychosocial process in which years of unsuccessful weight-loss efforts, emotional struggles, social experiences, and evolving expectations gradually culminated in the decision to pursue surgery.

4.2. Theme 2. Early Postoperative Challenges

Following the decision to undergo bariatric surgery, participants entered the early postoperative period, where they encountered new physical, emotional, and psychological challenges. The second theme captures participants' experiences during the early postoperative period, a time characterized by profound physical, emotional, and psychological adjustment. Although bariatric surgery was generally viewed as the beginning of a new life, participants consistently described the weeks and months following surgery as considerably more demanding than they had anticipated. Rather than experiencing an immediate sense of relief or transformation, they found themselves adapting to unfamiliar bodily sensations, navigating emotional distress, reconstructing long-established eating habits, and coping with the psychological demands of sustaining change. The findings are organized into four interconnected subthemes: (1) *Facing an Unexpected Reality*, (2) *Learning to Live with a New Body*, (3) *Struggling to Rebuild Eating Behaviors*, and (4) *Carrying the Psychological Burden Alone*. The subthemes and categories are presented in Figure 4.3.

4.2.1. Facing an Unexpected Reality

According to the participants the early postoperative period as substantially different from what they had anticipated before surgery. Rather than experiencing immediate relief, many encountered unexpected physical discomfort, emotional challenges, and difficulties adapting to the profound changes imposed by surgery.

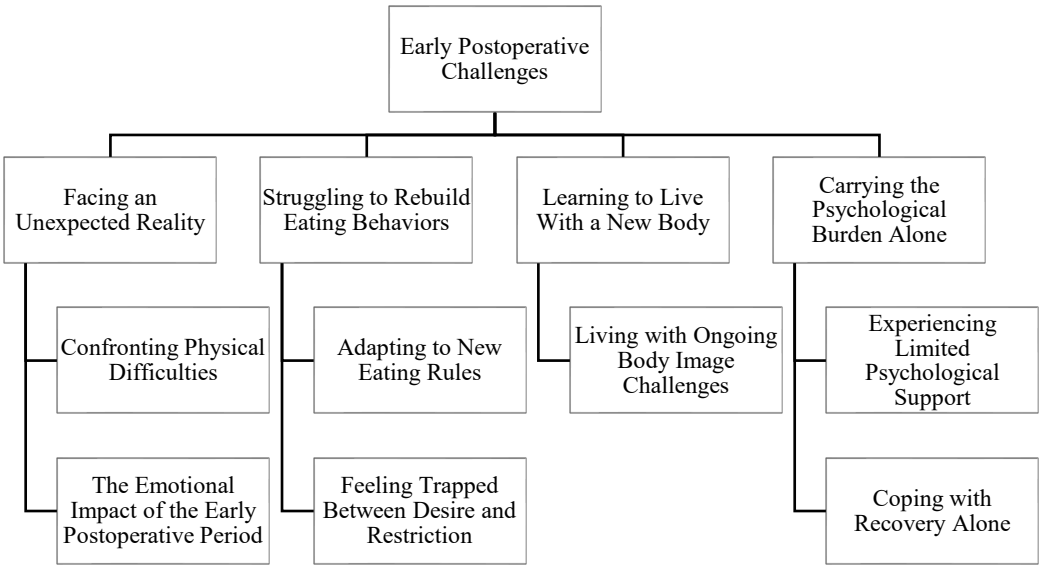

Figure 4.3. *Early Postoperative Challenges*

Confronting physical difficulties. The unexpected physical demands of the early postoperative period were one of the most salient findings. Rather than experiencing the immediate improvement they had anticipated, many participants described the first days and weeks after surgery as physically exhausting and, at times, overwhelming. Intense pain, postoperative complications, and the body's new physiological limitations often made even basic daily activities difficult, leaving participants feeling physically vulnerable while adapting to their altered bodies.

> Sürekli hastanedeydim çünkü bende beklenmeyen şeyler yaşandı. Ellerim, ayaklarım... Ayaklarım tutmuyordu, yürüyemiyordum. Tansiyonum sürekli düşüyordu. Sürekli hastane kapısındaydım. O günleri sanki hatırlamak bile istemiyorum. *(P3)*

> I was constantly in the hospital because unexpected things happened to me. My hands and feet were affected. My legs would not support me, and I could not walk. My blood pressure kept dropping. I was always at the hospital. Honestly, I do not even want to remember those days. *(P3)*

During the early postoperative period, participants often described physical pain as the most immediate and overwhelming experience. For some, the intensity of the pain was

so great that it left little room to attend to their emotional reactions during the first days after surgery. One participant explained:

> İlk başta dren çok rahatsız ediyordu. Ama asıl içeride büyük bir kesik ağrısı vardı. Hareketimi çok kısıtlıyordu. İlk hafta çok zor geçti. Fiziksel acı bu kadar yoğunken duygularıma odaklanacak hâlim bile yoktu. *(P1)*
>
> At first, the drain was uncomfortable. But the real pain came from the large incision inside. It severely restricted my movement. The first week was very difficult. The physical pain was so intense that I could hardly focus on my emotions. *(P1)*

The emotional impact of the early postoperative period. Alongside the physical demands of recovery, participants described the early postoperative period as emotionally overwhelming. Rather than feeling immediate relief, many experienced fear, uncertainty, loneliness, and emotional exhaustion while trying to adjust to their new bodies and routines.

Temporary regret was a common emotional response during the early postoperative period. Across interviews, several participants described questioning their decision shortly after surgery, particularly while coping with severe physical discomfort and the demands of recovery. One participant explained:

“Ameliyattan hemen sonra, 'Ne gerek vardı? Durduk yere boğazımı tutsaydım da burada yatmasaydım,' diye düşündüm.’’ *(P10)*

“Right after the surgery, I thought, 'What was the point? I wish I had just controlled myself instead of lying here.’’ *(P10)*

Alongside temporary regret, many participants also described the early postoperative period as frightening. One participant recalled:

“Kan kusuyorum. Yani midem kesildiği için kan kusuyorum. Yani bunu hiç unutamıyorum. Çok korkmuştum.’’ *(P4)*

“I was vomiting blood. I mean, I was vomiting blood because my stomach had been cut. I can never forget that. I was very scared.’’ *(P4)*

4.2.2. Struggling to Rebuild Eating Behaviors

Recovery following bariatric surgery required participants to fundamentally reconstruct their eating behaviors rather than simply eating less. Everyday activities such as deciding what to eat, when to eat, how much to eat, and how to respond to hunger became conscious and effortful processes. Many participants described this adjustment as one of the most demanding aspects of the postoperative period. Although surgery physically altered their eating capacity, many emphasized that adapting to new eating habits required continuous behavioral and psychological adjustment.

Adapting to new eating rules. One of the greatest challenges involved learning an entirely new way of eating. Participants described having to follow strict dietary rules regarding food choices, portion sizes, meal timing, fluid intake, and eating pace while simultaneously learning to distinguish physical hunger from psychological hunger. Ongoing appetite, uncertainty about which foods could be tolerated, concerns about harming their bodies, difficulties refusing food in social situations, and the continuous effort required to maintain weight-loss goals made this adaptation both physically and mentally demanding.

> Zorlanma konusu bir hafta sürdü. O gün neyin ne olduğunu anlayamadım, mantığını kavrayamadım. Eşime, 'Ben bu yemeği yerim, bana niye kahve fincanıyla çorba koyuyorsun? Bana yarım kase ver, hatta bir kase ver,' diyordum. Gözüm doymuyordu. Eşim ise, 'Yiyemezsin, öyle hissediyorsun ama yiyemezsin,' diyordu. Bir gün inat ettim. Bana bir kase çorba koydu ama söylediği gibi yalnızca bir fincanını içebildim. O an anladım ki midem artık eskisi gibi değildi. *(P10)*

> The difficult part lasted for a week. That day, I couldn't understand what was happening, and I couldn't grasp the logic of it. I kept saying to my spouse, 'I can eat this meal. Why are you serving me soup in a coffee cup? Give me half a bowl, or even a full bowl.' I never felt satisfied. My spouse kept saying, 'You can't eat it. That's how you feel, but you can't.' One day, I insisted. My spouse served me a bowl of soup, but just as they had said, I was only able to drink one cup of it. At that moment, I realized that my stomach was no longer the way it used to be. *(P10)*

Feeling trapped between desire and restriction. While participants gradually learned the practical rules of eating after surgery, many explained that their psychological relationship with food changed much more slowly. Across participants, one of the most report experiences was realizing that surgery had reduced the stomach’s capacity but

not eliminated appetite. This discrepancy between psychological desire and physical restriction is one of the most difficult challenges of the early postoperative period. Participants repeatedly emphasized that although their bodies could no longer tolerate food, the urge to eat often remained unchanged.

> Ama bana biri ameliyatı sorarsa şunu söylerim: İştahın azalmıyor. İştah aynı. Mide almıyor. İştahında hiçbir değişiklik olmuyor. Yemek istiyorsun ama yiyemiyorsun. Mide almıyor. İştahta bir değişim yok. Ameliyattan iki-üç gün sonra hâlâ sıvıyla besleniyordum ama baklavayı o kadar istiyordum ki... Kenarından köşesinden yedim. Arkadaşlarıma söylediğimde çok şaşırdılar. Evde çocuklarıma ve eşime yemek hazırlarken peynir kesiyor, yemek istiyordum. İştah gitmiyor. İştah aynı duruyor. Ama yiyemiyorsun. Miden kabul etmiyor. Bazen sadece küçücük bir parça alıp dilime değdiriyor, tadını almaya çalışıyordum. Aslında yememem gerekiyordu. *(P4)*
>
> But if someone asks me about the surgery, I say this: Your appetite doesn't decrease. Your appetite stays the same. Your stomach just can't take it. There is no change in your appetite at all. You want to eat, but you can't. Your stomach can't take it. There is no change in your appetite. Two or three days after the surgery, I was still on a liquid diet, but I wanted baklava so much... I ate a little piece from the edge of it. When I told my friends, they were very surprised. (…) While I was preparing food for my children and my spouse at home, I would cut some cheese and want to eat it. Your appetite doesn't go away. Your appetite stays the same. But you can't eat it. Your stomach doesn't accept it. Sometimes I would just take a tiny piece, touch it to my tongue, and try to taste it. Actually, I wasn't supposed to eat it. *(P4)*

A similar experience was expressed by another participant, who described the conflict between physical and psychological hunger:

“Böyle bir yerde miden yokmuş gibi hissediyorsun. Gözün doymuyor. Vücudum zayıf ama beynim hâlâ obez. Yemek söylüyorum, porsiyon geliyor ama içimden iki porsiyon yemek geçiyor.” *(P10)*

“At times like that, you feel as if you don't have a stomach. You have never felt satisfied. My body is thin, but my mind is still obese. I order food, one portion arrives, but inside I feel like eating two portions.” *(P10)*

Another participant summarized the conflict succinctly:

“Beyin istiyor. Mide istemiyor.” *(P8)*

“The mind wants it. The stomach doesn't.” *(P8)*

For many participants, this mismatch also resulted in intense emotional reactions. Some described grieving the loss of familiar eating experiences. One participant vividly described the emotional impact of realizing that eating would never be the same:

“İlk kez ameliyattan sonra tavuk yiyecektim. Çok heyecanlıydım. İnanılmaz acıkmıştım. Bir lokma aldım ve tıkandım. O masada bütün ameliyat sürecinin duygusal boşalmasını yaşadım. Hüngür hüngür ağlamaya başladım.’’ *(P2)*

“It was the first time I was going to eat chicken after the surgery. I was very excited. I was incredibly hungry. I took one bite, and it got stuck. At that table, I experienced the emotional release of the whole surgery process. I started crying my eyes out.’’ *(P2)*

Some participants described giving in to these urges despite their physical limitations. As one participant recalled:

“Pastayı çok seviyordum. Kendimi kaybetmiş gibi yedim. Midem almıyordu ama yine de yedim. Sonrasında inanılmaz bir ağrı yaşadım. Yerlerde süründüm resmen. Sonra kendime kızdım; 'Neden yaptın bunu?' dedim.’’ *(P4)*

“I loved cake very much. I ate it as if I had lost control of myself. My stomach couldn't take it, but I ate it anyway. Afterwards, I experienced incredible pain. I was literally writhing on the floor. Then I got angry with myself and said, 'Why did you do this?'’’ *(P4)*

4.2.3. Learning to Live with a New Body

Adjusting to life after bariatric surgery involved more than adapting to physical changes; it also required learning to live with a body that often did not fully meet participants' expectations. Weight loss did not automatically lead to body acceptance. Although substantial weight loss was generally viewed as a positive outcome, becoming familiar with a rapidly changing body was not always immediate. Across participants, adapting to their new appearance is an ongoing psychological process characterized by unfamiliarity, uncertainty, and the need to gradually reconcile physical changes with their sense of self.

Living with ongoing body image challenges. One of the most frequently reported challenges involved adapting to the rapid pace of bodily change. Although participants welcomed their weight loss, many explained that psychologically adjusting to their changing appearance took considerably longer. Rather than immediately recognizing or accepting their new bodies, they described feeling unfamiliar with them and needing time to develop a new bodily awareness.

Reflecting on this experience, one participant explained:

> Şöyle alışmakta zorlandım. Çünkü ben hiçbir zaman bedenime değdiğimde kemiğimi hissedemezdim. Birkaç kere oturduğumda leğen kemiklerimi bir şişlik zannettim. Sonra dokununca onun kemik olduğunu anladım. Omzumu kaşarken direkt kemiğe ulaşıyordum. Bir süre yabancılaştım. Kendi bedenimi yeniden tanımlamak zorunda kaldım.(…) Ve sonra çok hızlı beden değişikliğiyle işte 48'den 46'ya 46'dan birden bakıyorum 42 olmuşum. Alışveriş yaparken bedenimi tahmin edemiyordum. O kadar da alışma sürecinde bir bocalama yaşadım diyelim. *(P7)*
>
> This is what I had difficulty getting used to. Because I had never been able to feel my bones when I touched my body. A few times, when I sat down, I thought my pelvic bones were a swelling. Then, when I touched them, I realized they were my bones. When I scratched my shoulder, I could feel the bone directly. For a while, I felt unfamiliar with my own body. I had to redefine my body. (...) Then, with the very rapid body change, I went from size 48 to 46, and then suddenly I realized I was a size 42. When I was shopping, I couldn't estimate my own size. So, let's say I went through quite a period of struggling to get used to it. *(P7)*

One participant stated:

> Psikolojik olarak kendine sürekli soru soruyorsun. Bu kadar hızlı gidiyor ama bedenin bunu kabullenmiyor. Sonra bazen duygusallaşıyorsun. Ne yapacağını bilemiyorsun. Bence bedenin o an buna adapte olamadığı için böyle oluyor. *(P3)*
>
> Psychologically, you keep asking yourself questions. Everything is happening so fast, but your body doesn't accept it. Then sometimes you become emotional. You don't know what to do. I think it happens because your body can't adapt to it at that moment. (P3)

Beyond adapting to their changing bodies, some participants described weight loss as an emotionally complex experience. Although they were happy with the physical changes, they also experienced sadness and grief for their former selves. One participant explained:

> Her zaman mutluluk olmadı. Bir hüzün de eşlik etti. Aslında yas tutuyordum. Çok kilolu olduğum dönemlerdeki halime üzülüyordum. Bir mağazada kıyafet denerken aynada istediğim bedene yaklaştığımı görmek beni mutlu ediyordu ama aynı zamanda eski halime üzülüyordum. Kilo verdiğim her aşamada mutluluğun yanında hep bir hüzün de vardı. *(P1)*
>
> It wasn't always happiness. There was sadness as well. In fact, I was grieving. I was sad for the person I had been during the times when I was very overweight. When I tried on clothes in a store, seeing myself getting closer to the body I wanted made me happy, but at the same time I felt sad for my former self. At every stage of losing weight, happiness was always accompanied by sadness. *(P1)*

Some participants became concerned about visible skin sagging or wondered whether additional cosmetic surgery might eventually be necessary.

As one participant stated:

“Koltuk altındaki ve bacak bölgesindeki sarkmalar beni rahatsız ediyordu. Dar bir şey giydiğim zaman dışarıdan belli oluyordu. Bu sadece görsel olarak beni rahatsız ediyordu.” *(P9)*

“The sagging under my arms and around my legs was bothering me. When I wore something tight, it was visible from the outside. It was only the appearance of it that bothered me.” *(P9)*

Another participant stated:

> Eğer çok sarkma olsaydı bir operasyon daha gerekeceğini düşünüyordum. Sosyal medyada takip ettiğim birçok kişi estetik operasyon geçiriyordu ama ben bir kez daha ameliyat olmak istemiyordum. O yüzden bu beni kaygılandırıyordu. *(P7)*
>
> If there had been too much sagging, I thought I would need another operation. Many of the people I followed on social media were having cosmetic surgery, but I didn't want to undergo another surgery. That was why it made me anxious. *(P7)*

As one participant explained:

“Kilo verdikten sonra genital bölgede de sarkmalar olduğunu fark ettim. Bu da beni düşündüren konulardan biriydi.” *(P6)*

“After I lost weight, I noticed that there was sagging in the genital area as well. That was also one of the things that made me think.” *(P6)*

4.2.4. Carrying the Psychological Burden Alone

Findings showed that recovery extended far beyond physical healing. Participants often said that medical care focused mainly on surgery and weight loss, while their emotional and behavioral needs received little attention. As a result, many had to cope with psychological challenges on their own.

Experiencing limited psychological support. Participants repeatedly emphasized the need for ongoing psychological support, psychoeducation, behavioral guidance, and multidisciplinary follow-up throughout the postoperative period. Several participants explained that, in the absence of appropriate psychological care, they often sought emotional support from dietitians or surgeons despite recognizing that these concerns extended beyond nutritional or medical issues.

> Psikolojik bir şey kafamı kurcaladığında ilk diyetisyenime yazıyordum. Çünkü bu konuda aldığım bir destek yoktu. Aslında onun da alanı olmayan şeylerdi ama iki kere dedim ki keşke bu süreçte bir psikolojik danışmanımız olsaydı. Fazla yediğimi düşündüğümde, kusmalarımda ve oluşturduğum beslenme bozukluğunda kesinlikle bir destek isterdim. *(P2)*

> Whenever something psychological was bothering me, the first person I would message was my dietitian. Because I didn't have any support in that regard. Actually, those things weren't even in her area of expertise, but I said twice, 'I wish we had had a psychological counselor during this process.' When I thought I had eaten too much, during the times I vomited, and with the eating disorder I developed, I definitely would have wanted support. *(P2)*

Looking back, they questioned whether addressing the emotional factors underlying obesity at an earlier stage could have altered their treatment journey.

“Kilo verme sürecini ameliyat olmadan psikolojik destekle düzeltebilir miydim diye düşündüğüm zamanlar oldu. Önce duygularımı iyileştirip sonra kendi başıma kilo verebilir miydim diye sorguladım.” *(P3)*

“There were times when I wondered whether I could have improved my weight loss process with psychological support without having the surgery. I questioned whether I could have first healed my emotions and then lost weight on my own.” *(P3)*

Coping with recovery alone. Beyond the absence of professional support, many participants described carrying much of the emotional burden of recovery on their

own. Several explained that they deliberately limited what they shared with family members or friends because they did not want to worry others or felt that their experiences would not be fully understood. Others continued to cope independently with concerns about weight regain, ongoing social comparison, and negative comments about their changing appearance.

“Evet üç gün olmuştu ben ameliyat olalı. Çünkü kimsenin bilmesini istemiyordum. Böyle de bir psikolojik durumum vardı. İnsanlara söylemedim. Kimseyle paylaşmadım. Ailemin dışında kimse ameliyat olduğumu bilmiyordu.’’ *(P4)*

“It had been three days since I had the surgery. Because I didn't want anyone to know. I was in that kind of psychological state as well. I didn't tell people. I didn't share it with anyone. No one except my family knew that I had undergone the surgery.’’ *(P4)*

Another participant described as:

“Kimseye söylemedim. Hâlâ da bilmezler. Zaten Allah da bir nasip verdi, herkes safra kesesi ameliyatı olarak biliyor.’’ *(P6)*

“I didn't tell anyone. They still don't know. God made it possible somehow, and everyone thinks it was gallbladder surgery.’’ *(P6)*

Following substantial weight loss, some participants also reported encountering a different form of stigma. Rather than receiving only positive feedback, they described being told that they looked “too thin,” “unhealthy,” or “aged,” which created new appearance-related concerns during recovery.

“İnsanlar sürekli söylüyordu; ‘Ay çökmüşsün, kırışmışsın’, ‘göz altların morarmış’, ‘bir deri bir kemik kalmışsın.’ Ben de sarkma olmasın diye ameliyat döneminde çok fazla kolajen kullandım. Bu yorumlar insanı gerçekten etkiliyor.’’ *(P6)*

“People kept saying, 'Oh, you've collapsed,' 'You've become wrinkled,' 'You have dark circles under your eyes,' and 'You're nothing but skin and bones.' I also used a lot of collagen during the surgery period so that I wouldn't sag. Those comments really affect a person.’’ *(P6)*

Participants also remained sensitive to appearance-based comments from others. As one participant explained:

“Kiloluyken 'zayıfla' diyorlardı. Zayıflayınca bu sefer 'çok zayıf oldun', 'bir deri bir kemik kaldın' demeye başladılar. Hiç susmuyorlar.” *(P7)*

“When I was overweight, people used to say, 'Lose weight.' After I lost weight, this time they started saying, 'You've become too thin,' and 'You're nothing but skin and bones.' They never stop talking.” *(P7)*

These accounts illustrate that appearance-related stigma did not disappear after weight loss; instead, it often changed form, with participants becoming the target of new appearance-based evaluations.

4.3. Theme 3. The Need for Lasting Change

As participants gradually adapted to the early postoperative period, they also began to recognize that surgery alone was not enough for long-term success. This theme focuses on their growing realization that lasting change required continuous behavioral and psychological adjustment. This theme captures participants' growing realization that bariatric surgery alone was not sufficient to achieve long-term change. Although surgery was initially viewed as the primary solution to obesity, participants gradually came to understand that maintaining weight loss required continuous behavioral effort, psychological adaptation, and personal responsibility. Throughout their accounts, they reflected on the limitations of surgery itself, emphasizing that sustainable outcomes depended on developing new habits, changing daily routines, and addressing the psychological factors underlying obesity and weight management.

This theme consists of two subthemes: *(1) Recognizing the Limits of Surgery, (2) Rebuilding Behavior for Long-Term Change.* The subthemes, and categories are presented in Figure 4.4.

4.3.1. Recognizing the Limits of Surgery

Participants indicated that the things the surgery could change were limited and its effects were restricted. In addition, as participants reflected on their postoperative experiences, many described that surgery did not eliminate the psychological and behavioral challenges associated with obesity. Instead, they came to understand that

long-term success depended on changes extending far beyond the surgical procedure itself.

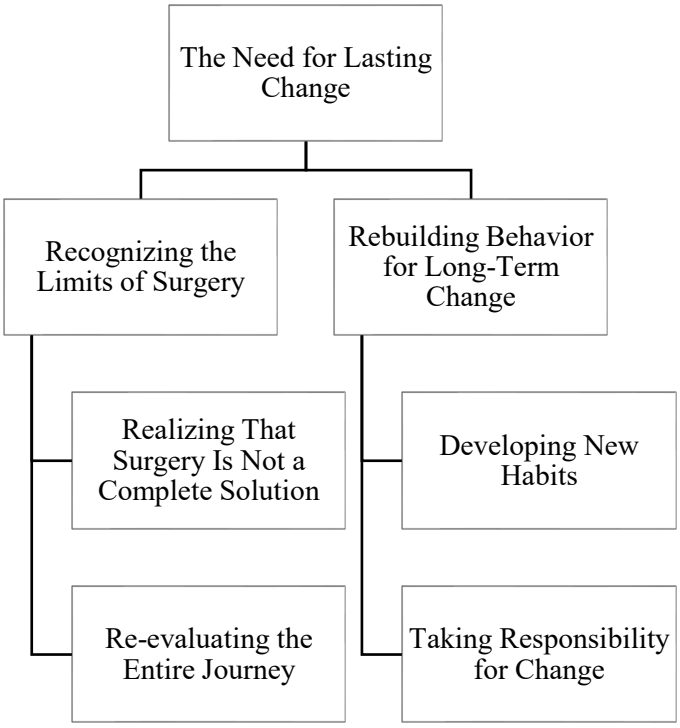

Figure 4.4. *The Need for Lasting Change*

Realizing that surgery is not a complete solution. One of the most frequently expressed perceptions was that bariatric surgery was not a complete solution to obesity. Although the operation facilitated weight loss, participants gradually came to understand that it neither eliminated emotional eating nor resolved long-standing habits or the psychological aspects of obesity. Instead, many described surgeries as the beginning of a much longer process requiring continuous self-awareness, behavioral change, and sustained personal effort.

Reflecting this shared realization, one participant stated:

“Ameliyat bir kurtuluş değil.” *(P3)*

“Surgery is not cure-all.” *(P3)*

Another participant explained:

“Ameliyat oldum, kurtuldum değil. Bir yaşam biçimini değiştirmen gerekiyor. Kiloda kalmak ve zayıf olarak hayata devam etmek istiyorsan bu yine senin elinde. Ameliyat sihirli değnek değildi benim için.’’ *(P6)*

“It's not, 'I had the surgery, and now I'm saved.' You have to change your way of living. If you want to maintain your weight and continue living as a thin person, that is still in your hands. For me, the surgery was not a magic wand.’’ *(P6)*

One participant stated:

> İnsanlar eğer ameliyat sonrasında bile bazı sorunlar çözemiyorsa psikolojik danışmanlar var. Bu çok normal, bu bir hastalık. Buna destek olabiliyorsa çok güzel o süreci atlatır diye düşünüyorum. Yoksa atlatamaz, yine aynı kiloya gelir. *(P8)*
>
> If people still can't solve some of their problems even after the surgery, there are psychological counselors. This is completely normal; this is an illness. If they can receive support, I think they will get through the process much better. Otherwise, they won't get through it, and they will end up at the same weight again. *(P8)*

Similarly, another participant emphasized that surgery represented only the first step of a much longer journey:

“Ameliyat bu işin başlangıcı sadece. Sonraki süreç çok önemli.’’ *(P8)*

“The surgery is only the beginning of this process. What comes afterward is very important.’’ *(P8)*

Several participants described experiencing anxiety about regaining weight as their appetite gradually returned after surgery.

“Mesela acıktığımı hissediyorum. Yemek yemeye ihtiyacım doğuyor. Kendi kendime, "Acaba yine kilo mu alacağım?" diye tırsıyorum. Onu da hemen eşime soruyorum. "Bak, ben acıkıyorum. Geçen sene acıkmıyordum.’’ *(P10)*

“For example, I feel hungry. I feel the need to eat. I get scared and ask myself, 'Am I going to gain weight again?' I immediately ask my spouse about it. I say, 'Look, I'm getting hungry. I wasn't getting hungry last year.*’’ (P10)*

Re-evaluating the entire journey. Looking back on their experiences, many participants critically re-evaluated their entire bariatric surgery journey. Rather than focusing solely on the operation itself, they reflected on the decisions they had made, the mistakes they believed they had made, and the behavioral changes they wished they had adopted earlier. Several emphasized that, if given another opportunity, they would approach the process differently and highlighted the importance of proper guidance, long-term support, and adherence to postoperative recommendations.
One participant explained:

“Bizim yaptığımız hataları yapmamaları lazım. Bu sağlıkla ilgili ciddi bir süreç. Doğru adımlarla ilerlemeleri ve destek almaları gerekiyor. Ben almadım ama alsam iyi olurdu.’’ *(P4)*

“They shouldn't make the mistakes that we made. This is a serious process related to health. They need to move forward by taking the right steps and receiving support. I didn't receive it, but it would have been better if I had.’’ *(P4)*

As one participant reflected:

“Katı-sıvı ayrımını ben çok ciddi anlamda yapamadım. Onun için de iyi kilo vermediğimi düşünüyorum. Bunu atlamamalılar.’’ *(P5)*

“I wasn't able to follow the separation of solids and liquids properly. Because of that, I don't think I lost as much weight as I could have. They shouldn't skip this.’’ *(P5)*

4.3.2. Rebuilding Behavior for Long-Term Change

Participants consistently emphasized that successful weight management extended far beyond the surgical procedure itself. Rather than relying solely on the physiological effects of surgery, they described long-term success as an ongoing process of reshaping everyday behaviors and adopting a healthier way of living. Across interviews, participants increasingly viewed sustainable weight loss as something that required continuous effort, personal commitment, and the gradual establishment of new routines.

Developing new habits. One of the most frequently discussed aspects of long-term success was the need to establish and maintain new habits. Participants explained that

surgery provided an opportunity to change, but preserving its benefits depended on consistently making healthier choices in everyday life. Participants frequently described postoperative recovery as a process of learning new behavioral patterns rather than simply following dietary recommendations.

“Sen zaten kilo veriyorsun ama sonraki hayatında dikkat ediyorsun. Mesela beyaz ekmek normal insan için de sıkıntılı. Bunları öğreniyorsun.’’ *(P6)*

“You already lose weight, but after that you have to be careful in your daily life. For example, white bread is a problem even for a normal person. You learn these things.’’ *(P6)*

Another participant described:

“Lokantaya gidiyoruz. Ben sadece etini yiyorum, yanında lavaşını ya da garnitürünü yemiyorum. Masaya oturduğum zaman da yararlı ne varsa onu seçiyorum’’ *(P10)*

“We go to a restaurant. I only eat meat; I don't eat the lavash or the side dishes. When I sit down for a meal, I have learned to choose whatever is beneficial.’’ *(P10)*

Taking responsibility for change. As participants reflected on their experiences, many emphasized that maintaining weight loss ultimately depended on their own choices rather than the surgery itself. They increasingly viewed long-term success as requiring self-discipline, personal responsibility, and continuous effort to prevent weight regain.

“Süreç tamamen kafada biten bir süreç. Kendinizi ona göre yönetmeniz gerekiyor. Eğer yönetemezseniz ameliyatın hiçbir faydası yok. Ameliyat sadece başlangıcı yapıyor, sonunu siz getiriyorsunuz.’’ *(P8)*

“The whole process is something that is completed in the mind. You have to manage yourself accordingly. If you can't manage yourself, the surgery is of no benefit. The surgery only starts the process; you are the one who brings it to the end.’’ *(P8)*

4.4. Theme 4. Transforming Life After Bariatric Surgery

Following the challenges of the early postoperative period, participants gradually described a broader transformation that extended far beyond weight loss. As they adapted to life after surgery, many reported meaningful changes in their relationships

with food, their bodies, themselves, and the world around them. These changes were not experienced solely as physical improvements; rather, participants increasingly described surgery as a turning point that reshaped their daily lives, social relationships, self-perceptions, and overall well-being.

This theme consisted of five subthemes: *(1) Developing a New Relationship with Food, (2) Reconstructing the Relationship with the Body, (3) Becoming Socially Visible Again, (4) Reconstructing the Self, and (5) Transforming Everyday Life.* The subthemes, and categories are presented in Figure 4.5.

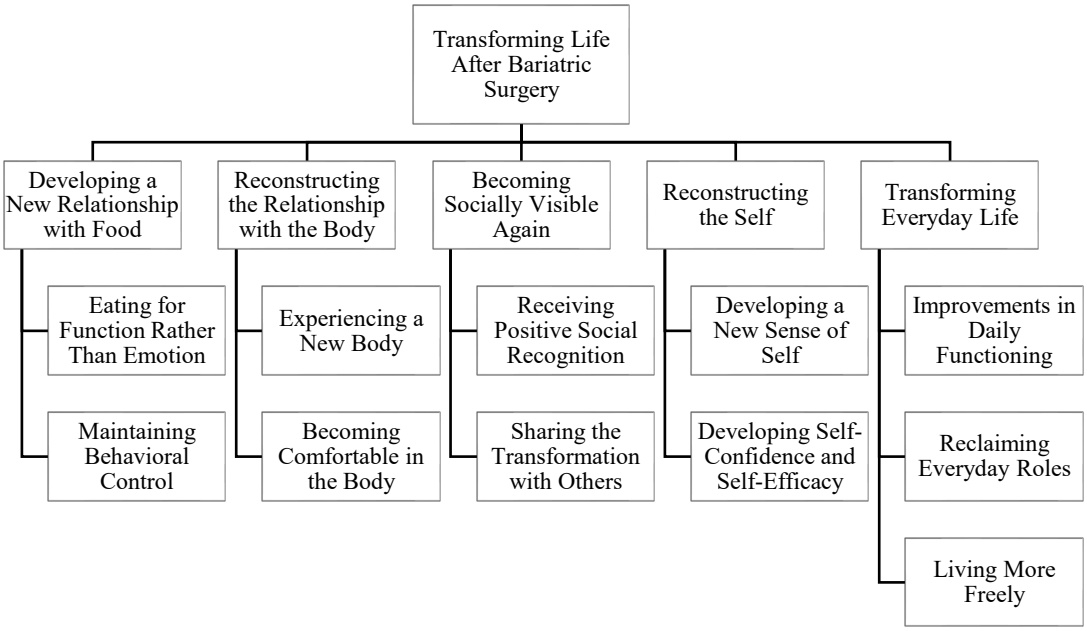

Figure 4.5. *Transforming Life after Bariatric Surgery*

4.4.1. Developing a New Relationship with Food

Following bariatric surgery, participants described fundamental changes in their relationships with food. Eating gradually shifted from being emotionally driven to serving a more functional role in daily life. Many participants explained that food was no longer the central focus of their lives, and they increasingly viewed eating as a means of maintaining health rather than coping with emotions or seeking pleasure.

Eating for function rather than emotion. Across interviews, participants frequently contrasted their current eating behaviors with their preoperative relationship with food, emphasizing greater control, reduced emotional attachment, and a more balanced approach to eating.

“Ameliyattan önce yemek için yaşayan bir insandım. Ameliyattan sonra yaşamak için yemeye başladım.’’ *(P5)*

“Before the surgery, I lived to eat. After the surgery, I started eating to live.’’ *(P5)*

Another participant explained:

“Yani ben ameliyat sonrasında yaşamak için yemem kadar gerektiğini yiyorum.” *(P6)*

“After the surgery, I eat only as much as I need in order to live.’’ *(P6)*

Maintaining behavioral control. Beyond changes in eating itself, participants emphasized developing greater control over their everyday behaviors. Rather than relying solely on the restrictive effects of surgery, many explained that maintaining weight loss depended on consciously regulating their eating habits and sustaining healthier routines over time.

“Ameliyattan önce ben ne suyu, hayatımı kolayla yaşadım derdim. Şimdi ise kola içmek istemiyorum. Bir faydası yok. Su içiyorum ve katı-sıvı ayrımına hâlâ çok dikkat ediyorum.‘’ *(P8)*

“Before surgery, I used to say, ‘Water? I lived on cola.’ Now I don't even want to drink cola. It has no benefit. I drink water, and I still pay close attention to separating food and fluids.’’ *(P8)*

This shift was also reflected in participants' everyday health-related choices.

“Yine istediğim şeyleri yiyorum ama daha küçük porsiyon. Yarısını saklıyorum. Bırakabilmeyi öğrendim. Hem yiyebileceğim kadar almayı hem de tabağımda kalırsa da kalsın demeyi öğrendim.” *(P7)*

“I still eat the foods I enjoy, but in smaller portions. I save half of it. I learned that I can leave food on my plate. I learned both to take only as much as I can eat and to accept that it's okay if some food is left over.’’ *(P7)*

Participants described becoming more intentional in their everyday food choices.

“Alışverişe gittiğimde artık ne kadar az abur cubur aldığımı fark ettim. ‘Ben onu yersem yemek yemeyeceğim’ diyordum. Sonuçta sağlık daha önemli.” *(P4)*

“When I went grocery shopping, I realized how much less junk food I was buying. I would tell myself, ‘If I eat that, I won't eat a proper meal.’ In the end, my health is more important.” *(P4)*

“Katı ve sıvıyı hiçbir zaman birlikte tüketmedim. Hâlâ bu kurala çok dikkat ederim.” *(P8)*

“I have never consumed solids and liquids together. I still follow this rule very carefully.” *(P8)*

4.4.2. Reconstructing the Relationship with the Body

Following substantial weight loss, participants described developing a new relationship with their bodies. Rather than focusing solely on weight loss itself, many explained that they gradually became more aware of their changing bodies and began experiencing greater comfort, confidence, and satisfaction with their physical appearance.

Experiencing a new body. Participants frequently described becoming increasingly aware of their physical transformation. Many compared their current bodies with their former bodies, noticing changes that had once seemed impossible. Rather than immediately taking these changes for granted, they described surprise, excitement, and a growing appreciation for their new bodies.

“Hayal ettiğim bir beden vardı ve ben o bedene indim.” *(P6)*

“I had always imagined a certain body, and I finally reached that body.” (P6)

Many participants also described a sense of surprise and excitement as they gradually recognized the extent of their physical transformation.

“Kendime sürekli şaşırarak aynada bakıyordum. Sabah uyandığımda 'Ben kilo vermişim, zayıflıyorum' diyordum. Hemen kalkıp yıllardır giymediğim kıyafetleri deniyordum. Bu benim için çok heyecan vericiydi.” *(P1)*

“I kept looking at myself in the mirror in amazement. Every morning I woke up thinking, 'I've lost weight. I'm getting thinner.' I would immediately get up and try on clothes I hadn't worn for years. It was incredibly exciting for me.’’ *(P1)*

Becoming comfortable in the body. As participants became more familiar with their changing bodies, many described feeling increasingly comfortable and satisfied with their appearance.They explained that the physical changes improved their self-perception and made their daily experiences with their bodies easier and more natural.
“Artık kendimi çok beğeniyorum.’’ *(P3)*

“I really like myself now.’’ *(P3)*

Greater comfort with their bodies was also reflected in everyday situations that had previously been associated with discomfort or embarrassment.

> Eskiden eşim bana kıyafet almakta çok zorlanırdı. Bana uygun beden bulmak zordu ve bu beni çok üzerdi. Şimdi ise bedenimle ilgili böyle bir kaygım kalmadı. Artık benim için rahatça alışveriş yapabiliyor ve birlikte sosyal etkinliklere katılırken herhangi bir çekincem olmuyor. *(P7)*
>
> My husband used to have a hard time buying clothes for me because it was difficult to find my size, and that really upset me. Now I no longer have that concern. He can easily shop for me, and I no longer feel hesitant about participating in social activities together. *(P7)*

Several participants also described rediscovering everyday bodily movements that had once been difficult or impossible.

“Ayakkabılarımı rahat bağlayabiliyorum. Arabaya rahat inip binebiliyorum. Bacak bacak üstüne atabilmek bile benim için büyük bir lüks ve keyif.’’ *(P9)*

“I can tie my shoes comfortably now. I can get in and out of the car easily. Even being able to cross my legs feels like a luxury and gives me great pleasure.’’ *(P9)*

4.4.3. Becoming Socially Visible Again

Changes in physical appearance were accompanied by noticeable changes in participants' social experiences. Many described feeling more visible, accepted, and confident in social settings following weight loss. Participants explained that these changes extended beyond appearance, influencing how they interacted with others and how they believed they were perceived.

Receiving positive social recognition. Participants frequently described receiving more positive reactions from family members, friends, colleagues, and even strangers following weight loss. Compliments about their appearance, increased attention from others, and feeling more valued in social interactions contributed to greater confidence and encouraged them to participate more actively in everyday social life.

> Mesela ben bunun için bile, ameliyat olduğum için çok şükrediyorum. Bu duyguyu hayatta yaşadım. Eskiden insanlar bana 'Artık yeme' derdi. Şimdi ise 'Bir lokma daha ye' diyorlar. Babamın bana 'Şunu da ye, bunu da ye' demesi benim için çok farklı ve çok güzel bir duyguydu. *(P6)*
>
> For example, even for this alone, I am very grateful that I had the surgery. I experienced this feeling in my life. People used to tell me, 'Stop eating.' Now they tell me, 'Have one more bite.' Hearing my father encourage me to eat was a completely different and very meaningful feeling for me. *(P6)*

Others described becoming noticeably more visible in their social environments and feeling that they attracted more positive attention than before surgery.

“İnsanlar kiloluyken sizin varlığınızdan bile haberdar değilken, zayıfladığınız zaman size ilgi göstermeye başlıyorlar. Bunlar yaşadığınız sıkıntıları bir nebze unutturuyor.’’ *(P8)*

“When you're overweight, people barely notice your existence. After losing weight, people start paying attention to you. That makes you forget at least some of the difficulties you've been through.’’ *(P8)*

Another participant stated that:

> Dersine girmediğim çocukların bile dikkatini çekmeye başladım. Çocuklar yanıma geliyor, benimle konuşmaya çalışıyorlar. Fikirlerimi daha çok merak ediyorlar. 'Öğretmenim, siz nasıl evli değilsiniz? Çok güzelsiniz, boylu poslu, başarılı birisiniz' diyorlar. Eskiden bunları hiç söylemezlerdi. Bunlar insanı gerçekten mutlu ediyor. (*P6)*
>
> Even students who weren't in my class started noticing me. They would come up and try to talk to me. They became much more interested in my opinions. They would say, 'Teacher, how are you not married? You're beautiful, tall, and successful.' Before, they never said things like that. When they learned my age, they would say, 'Teacher, aren't you only 30 or 31?' Those reactions genuinely made me happy. *(P6)*

Beyond receiving positive feedback, many participants described becoming more confident in social situations and engaging more comfortably in activities they had previously avoided.

“Eskiden kendimi beğenmediğim zaman dışarı çıkmak istemiyordum. Ama şimdi ilk defa gideceğim bir yere bile hiç çekinmeden girebiliyorum. Artık hayatın içinde daha fazla varım. Bu beni çok mutlu ediyor’’ (P7)

“When I didn't like myself, I didn't want to go out. Now I can walk into a place I've never been before without any hesitation. I'm much more involved in life now, and that makes me very happy.’’ (P7)

Sharing transformation with others. Many participants described openly sharing their postoperative experiences with others after witnessing the positive impact of surgery on their own lives. Several encouraged people struggling with obesity to consider bariatric surgery, while others explained that their own experiences enabled them to guide, support, or motivate individuals facing similar challenges.

“Her zaman bana danışanlara şunu söylüyorum: Doğru doktoru bulabilir ve bu disiplini hayat boyu sürdürebileceksen, ben herkese ameliyatı öneriyorum. Bir sürü kişiyi ameliyat olmaya gönderdim’’ *(P7)*

“I always tell people who ask me that if they can find the right surgeon and maintain this discipline for life, I would recommend the surgery to anyone. I sent many people to have the surgery.’’ *(P7)*

Another participant explained:

> Benim kilo vermemden sonra kilolu bir akrabam da aynı doktora gidip ameliyat oldu. O da çok güzel kilo verdi. Birkaç kişiye vesile olduğumu düşünüyorum. Hiç durma diyorum. Ben on sene önce ameliyat olsaydım keşke. 'Hemen ol, çok rahatlayacaksın. Nefes alışın değişecek, hayat konforun artacak' diye sürekli söylüyorum. *(P4)*
>
> After I lost weight, one of my relatives, who was also overweight, went to the same surgeon and had the operation. They also lost a lot of weight. I helped several people through my own experience. I always tell them, 'Don't wait. I wish I had had the surgery ten years earlier. Go ahead. You'll feel so much better, your breathing will change, and your quality of life will improve. *(P4)*

4.4.4. Reconstructing the Self

Beyond physical and social changes, participants described profound changes in how they understood themselves. Weight loss was frequently described as transforming participants' appearance, identity, self-perception, and confidence.

Developing a new sense of self. Participants described reconstructing their identities following bariatric surgery. Many reflected on the contrast between their former and current selves, explaining that weight loss allowed them to rediscover aspects of themselves that had long been overshadowed by obesity. Several described this experience as a psychological rebirth accompanied by greater self-acceptance and a renewed understanding of who they had become.

“Ameliyattan sonra kendimi daha kadın gibi hissetmeye başladım. Kendime bakmaya başladım. Fiziksel güzelliğimde eksik gördüğüm şeyleri karakterimle kapatmaya çalışıyordum. Artık beni isteyen beni olduğum gibi sevsin diye düşünüyorum.” *(P5)*

“After the surgery, I felt like a woman for the first time. I started taking better care of myself. Before, I tried to compensate for what I believed I lacked physically through my personality. Now I think that whoever wants me should accept me as I am.” *(P5)*

For some women, this transformation also involved redefining their sense of femininity and embracing aspects of themselves that they felt had previously been constrained by obesity.

> Ameliyattan sonra kendimi ilk defa daha kadın gibi hissetmeye başladım. Kendimi hiçbir zaman genç kız gibi hissetmemiştim. Hiç süsleneyim, takıp takıştırayım hissiyatı yoktu bende. Biraz fiziğimden kaynaklı olduğunu düşünüyorum. Sonrasında zayıfladım, güzelleştim, kendime bakmaya başladım. Kendimi daha kadın gibi hissettiğim bir döneme girdim. *(P2)*
>
> After the surgery, I felt like a woman for the first time. I had never really felt like a young woman before. I never had the desire to dress up or accessorize, and I think that was partly because of my body. After losing weight, I felt more attractive, started taking better care of myself, and entered a period in which I truly felt more feminine. *(P2)*

Others described broader changes in how they perceived themselves and interacted with the world.

“Eskiden daha mütevazıydım. Şimdi artık aynı insan olmadığımı düşünüyorum. Eskiden erkekler konusunda da seçici değildim. Şimdi ise ben ölümü göze aldım sizi mi takarım diyorum.’’ *(P6)*

“I used to be more modest. Now, I don't think I'm the same person anymore. I wasn't selective about men before, either. Now I say, 'I was willing to risk death—why would I care about you?’’ *(P6)*

Developing self-confidence and self-efficacy. Alongside changes in identity, participants described developing greater confidence in their ability to manage their health and maintain the changes achieved through surgery. Rather than attributing their success solely to the operation itself, many emphasized their own determination, self-discipline, and capacity to regulate their behaviors. Successfully sustaining weight loss strengthened their belief that long-term change depended on their own efforts and reinforced a growing sense of personal competence.

> Şu anda herkes bana şaşırıyor. Eski fotoğraflarımı gördüklerinde 'Bu sen değilsin' diyorlar. Bu bir azim ve başarı öyküsü. Ameliyat bu işin başlangıcıydı ama asıl önemli olan devam etmekti. Bir buçuk yıl sonra aldığınız her kilo üzerinizde kalabilir ama ben almadım. Çünkü dikkat ettim. *(P8)*
>
> People are amazed when they see my old photos. They say, 'That can't be you.' This is a story of determination and success. Surgery was only the beginning; what really mattered was continuing. Every kilogram you gain after the first year and a half can stay with you, but I didn't regain it because I stayed disciplined. *(P8)*

This growing sense of competence was also reflected in participants' confidence in regulating their own behaviors and preventing weight regain.

> Şu anda da ameliyat olduğum halim gibi değil, midenin genişlediğini düşünüyorum. Ve kendimi kontrol altına almış durumdayım. Kendi kontrolümü kendim yapmaya çalışıyorum eski kiloma geri dönmemek için. O konuda da başarılı olduğumu düşünüyorum. *(P5)*
>
> Right now, my stomach is not the same as it was right after the surgery; I think it has expanded. And I have myself under control. I try to control myself so that I don't go back to my previous weight. I think I have been successful in that as well. *(P5)*

One participant, who had previously described struggling with eating control and self-regulation, reflected on her postoperative experience as follows:

> Yani diyorum ki ben süreci çok düzgün yönettiğime inanıyorum. Ben kendime güveniyorum. Hâlâ kurallara dikkat ediyorum. 2023 Temmuzundan beri ilk defa yanlışlıkla arkadaşımın kolasını ağzıma aldım. Tadı gelir gelmez hemen peçete bulup yutmadan ağzımdan çıkardım. *(P6)*
>
> I believe I have managed this process very well. I trust myself I still follow the rules carefully. For the first time since July 2023, I accidentally took a sip from my friend's cola instead of my coffee. As soon as I tasted it, I immediately found a tissue and spat it out without swallowing it. *(P6)*

4.4.5 Transforming Life Everyday

Participants consistently described that the benefits of bariatric surgery extended far beyond weight loss, influencing multiple aspects of their everyday lives. Improvements in physical functioning, family and occupational roles, and overall quality of life enabled many to participate more actively in daily activities and experience a greater sense of freedom.

Improvements in daily functioning. Participants described substantial improvements in physical functioning that made everyday activities easier and more enjoyable. Many reported increased mobility, greater energy, reduced physical discomfort, and the ability to move more freely without the limitations they had previously experienced.
“53 yaşındayım ama merdivenlerden 9–10 yaşındaki bir kız çocuğu gibi sekerek iniyorum. Çünkü eskiden o merdivenleri nefes nefese çıkıyordum.” *(P4)*

“I'm 53 years old, but now I go down the stairs skipping like a 9- or 10-year-old girl. Before, I used to climb those same stairs completely out of breath.” *(P4)*

Participants also described feeling physically unrestricted during ordinary daily activities that had once caused discomfort or anxiety. One participant explained:

“Eskiden küçük sandalyelere otururken hep kaygılanırdım. Şimdi böyle bir kaygım kalmadı. Koşabiliyorum, merdiven çıkabiliyorum ve nefesimin ne kadar rahatladığını hissediyorum.” (P7)

“I used to worry whenever I had to sit on small chairs. Now I don't have that concern anymore. I can run, climb stairs, and I can really feel how much easier it is to breathe.” (P7)

Reclaiming everyday roles. Participants explained that improvements in physical and psychological well-being positively influenced their family, parental, romantic, and occupational roles. Many described becoming more active in caring for their children, participating more fully in family life, and feeling more capable in their professional responsibilities.

“Şimdi daha aktif biriyim. Çocuklarımla yere oturup oyun oynayabiliyorum. Rahatça alışverişe gidebiliyorum..’’ *(P10)*

“Now I'm much more active. I can sit on the floor and play with my children.’’ *(P10)*

Another participant reflected on how these changes strengthened her relationship with her child.

“Ameliyattan önce kızımla salıncakta sallanamazdım çünkü sığmıyordum. Şimdi yan yana salıncakta sallanabiliyoruz. Onun ayakkabılarını giydirirken bile çok daha rahat hareket edebiliyorum.’’ *(P7)*

“Before surgery, I couldn't swing next to my daughter because I didn't fit. Now we can swing side by side, and even helping her put on her shoes has become much easier.’’ *(P7)*

Living more freely. Beyond physical improvements, participants described gaining a broader sense of freedom that influenced how they engaged with everyday life. Many explained that they no longer avoided activities because of their bodies, felt less restricted by shame or anxiety, and became more willing to participate in social and professional settings.

“Eski kilomda olsaydım bu işi yaparken kendime yeterince saygı duyulduğunu hissetmezdim. Şimdi insanların karşısına çok daha rahat çıkabiliyorum. Kendimi daha özgürleşmiş hissediyorum.’’ *(P1)*

“If I had still been at my previous weight, I don't think I would have felt respected in this job. Now I feel much more comfortable standing in front of people. I feel freer’’ *(P1)*

Others described feeling more accepted within society after losing weight.

“Normal vücut ölçülerine yaklaştıkça toplum tarafından daha kabul edilebilir olduğumu hissetmeye başladım.’’ *(P9)*

“As my body became closer to what is considered a normal size, I began to feel more accepted by society.’’ *(P9)*

4.5. Theme 5. Gendered Experiences of Bariatric Surgery

Unlike the previous themes, which describe different stages of the bariatric surgery journey, this theme represents a cross-cutting pattern identified throughout the dataset. Rather than reflecting a distinct phase of the surgical process, gender consistently shaped how participants understood obesity, decided to undergo surgery, experienced interpersonal relationships, interpreted social expectations, and made sense of their lives following surgery.

This theme consisted of three subthemes: *(1) Gendered Pathways to Surgery, (2) Gendered Relationships and Social Expectations, and (3) Gendered Identity, Stigma, and Agency. The subthemes, and categories are presented in Figure 4.6.*

4.5.1. Gendered Pathways to Surgery

Participants' accounts described that the motivations leading to bariatric surgery were often shaped by gender. Although both women and men described obesity as burdensome, women more frequently associated surgery with appearance, body dissatisfaction, femininity, and social expectations. In contrast, men generally framed their decisions in terms of health, physical functioning, and quality of life.

Women's body-related motivations. Women's narratives frequently linked the decision to undergo surgery with dissatisfaction with their appearance and the social meanings attached to the female body. Rather than describing weight solely as a health concern, many participants discussed feeling that their bodies did not align with culturally valued ideals of femininity, attractiveness, and womanhood. Several also reflected on experiences of comparison, appearance-based evaluation, and family expectations that reinforced these concerns.

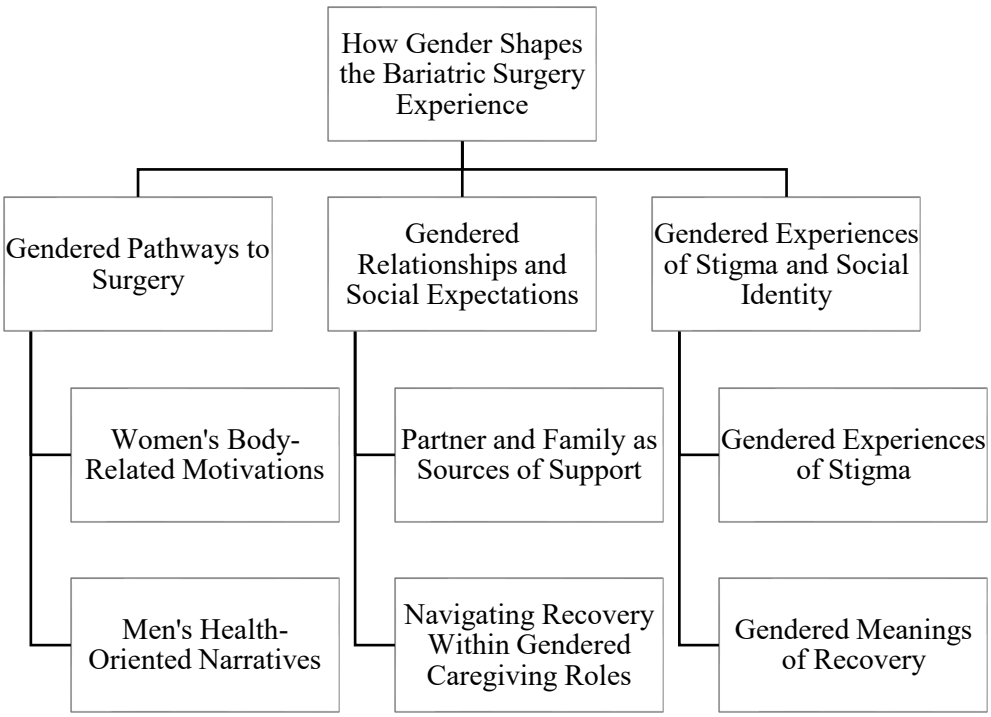

Figure 4.6. *How Gender Shapes the Bariatric Surgery Experience*

“Başarılı, etkili, hoş bir kadın görünümüne kilo vermeden erişemeyeceğimi düşünüyordum. Yaşadığım mutsuzluğu gidermenin en temel yollarından birinin kilo vermek olduğunu düşünüyordum.” *(P1)*

“I believed I could not become a successful, influential, and attractive woman unless I lost weight. I thought that losing weight was one of the main ways to overcome the unhappiness I was experiencing.” *(P1)*

For some women, these expectations originated within close family relationships and were closely tied to culturally valued forms of femininity.

“Annem hep benim de onun gibi süslenmemi, daha feminen olmamı isterdi. Kilo verdikten sonra annemin bu isteğinin yerine geldiğini hissettim." *(P2)*

“My mother always wanted me to dress up like her and be more feminine. After I lost weight, I felt that her wish had finally come true.” *(P2)*

Others described that, during childhood and adolescence, appearance influenced their social acceptance and shaped how they attempted to establish their identities.

“Sınıfta diğer kızlar seçilirken ben hep sonlarda kalırdım. Güzel görünemediğim için kendimi derslerimle ya da başka yönlerimle göstermeye çalışıyordum.’’ (P7)

“While the other girls in my class were chosen first, I was always among the last. Because I couldn't stand out through my appearance, I tried to prove myself through my academic success or other qualities.’’ (P7)

Men's health-oriented narratives. In contrast, male participants generally framed their decisions to undergo bariatric surgery in terms of health, physical functioning, and the practical limitations imposed by obesity rather than appearance. Across their accounts, surgery was more often described as a means of regaining mobility, reducing physical discomfort, and improving everyday functioning.

“Ben vücudumun görseli için olmadım. Bana artık rahatsızlık veriyordu. Ayakkabımı bağlayamıyordum.’’ (P8)

“I didn't have the surgery because of how my body looked. My body had become uncomfortable to live with. I couldn't even tie my shoes anymore.’’ *(P8)*

Another participant also described:

“Benim vücudumdan bir memnuniyetsizliğim olmadı. Görünüşüm için de ameliyat olmadım.’’ *(P8)*

“I wasn't dissatisfied with my body. I certainly didn't have surgery because of my appearance.’’ *(P8)*

4.5.2. Gendered Relationships and Social Expectations

Participants' experiences of support and interpersonal relationships were also shaped by gender. While many emphasized the importance of partners and family members throughout the surgical journey, the availability, meaning, and expectations of support differed according to gender roles and social expectations.

Partner and family as sources of support. Male participants frequently described their partners and family members as central sources of emotional and practical support throughout the surgical journey. They explained that spouses encouraged the decision to undergo surgery, assisted with postoperative care, and helped them adhere to dietary

recommendations and lifestyle changes. This continuous support was often described as facilitating successful recovery and long-term adaptation.

Several male participants also acknowledged that their partners played an active role in helping them maintain postoperative routines and behavioral changes.

“Kesinlikle yalnız olunmamalı. Saati saatine dikkat edilmesi gereken şeyler var. Yanınızda size destek olacak birinin olması gerekiyor; hem ameliyat sonrasında hem de uzun süre boyunca." *(P9)*

“You definitely shouldn't go through this alone. There are things you have to pay attention to at specific times. You need someone by your side to support you—not only immediately after surgery but for a long time afterward.” *(P9)*

Some participants also attributed part of their success to the continuous support they received from their spouses and family members.

> Süreç de zaten onun sayesinde oldu. Kendimi tamamen ona teslim ettim. Tabiri caizse beni güdüyordu. Yemek saatim geldiğinde yemeğimi getiriyordu, su içmem gerektiğinde suyumu getiriyordu. Beni hiç yalnız bırakmadı. "Eşim bana her şeyi ölçüsünde hazırlıyordu; ayranımı, proteinimi, mamamı... Hastanede mamayı suyla verince içemedim. Eşim doktorla konuştu, nasıl hazırlanması gerektiğini öğrendi. Hep bana baktı. Ben hiç zorlanmadım. *(P10)*
>
> I made it through the whole process because of her. I completely entrusted myself to her. She brought my meals when it was time to eat, reminded me to drink water, and never left me alone. My wife prepared everything for me in the right portions—my ayran, protein supplements, and meal replacements. When the hospital prepared one of them with water and I couldn't drink it, she contacted the doctor and found out how it should actually be prepared. She took care of everything. I never really struggled. *(P10)*

Navigating recovery within gendered caregiving roles. Although family relationships were important for both women and men, women more frequently described recovering within the context of ongoing caregiving responsibilities. Rather than being able to focus solely on their own recovery, several participants explained that they quickly resumed childcare, meal preparation, and household duties despite experiencing pain, fatigue, and physical limitations. These accounts suggest that gendered expectations surrounding caregiving often limited the support women received during the postoperative period and contributed to feelings of being insufficiently cared for.

> Doktor bana, 'Eve gidersen çocuğuna bakmaya başlayacaksın. Yeni ameliyatlısın, biraz daha burada kal,' dedi. Gerçektende eve döndüğümde ameliyatlı halimle hem çocuğuma baktım hem de ev işleriyle ilgilenmek zorunda kaldım. Beklediğim bakımı ailemden alamadım. Bana en büyük desteği arkadaşlarım verdi. Evde çocuklar vardı... o halsizlikle bir sürü şey hazırlamam gerekirken çocuk bakımını da üstlenmek durumunda kaldım. *(P7)*
>
> The doctor told me, 'If you go home, you'll start taking care of your child. You've just had surgery, so stay here a little longer.' And indeed, when I returned home, I had to take care of both my child and the household chores while I was still recovering from the surgery. I didn't receive the care I had expected from my family. My greatest support came from my friends. There were children at home... Even with all that weakness, I had to prepare many things and also take on the responsibility of caring for my child. *(P7)*

Another participant similarly described continuing to perform domestic responsibilities despite her own recovery needs.

"Yıllık iznimde ameliyat oldum ama evde üç erkeğe yemek hazırlıyordum. Ben tamamen mutfakla yaşıyordum." *(P4)*

"I had my surgery during my annual leave, yet I was still preparing meals for the three men at home. My life continued to revolve around the kitchen." *(P4)*

4.5.3. Gendered Identity, Stigma, and Agency

Gender also influenced how participants interpreted the meaning of bariatric surgery and positioned themselves within broader social expectations. Although both women and men described positive changes following surgery, they differed in how they understood stigma, identity, and successful recovery. While women more frequently discussed appearance-related judgments, femininity, and social acceptance, men generally emphasized health, autonomy, and personal responsibility. These findings suggest that gender shaped participants' experiences of obesity as well as the meanings they attached to postoperative change.

Gendered experiences of stigma. Women more frequently described weight stigma as extending beyond body size to broader expectations surrounding femininity, attractiveness, and social value. Their accounts reflected concerns about being evaluated on culturally valued ideals of appearance. They described that body weight

influenced how they believed they were perceived in both social and professional contexts.

“Başarılı, etkili, hoş bir kadın görünümüne kilo vermeden erişemeyeceğimi düşünüyordum.” *(P1)*

“I believed I could not become a successful, influential, and attractive woman unless I lost weight.” *(P1)*

Participant further reflected that appearance had become an unavoidable part of social life, despite personally disagreeing with these expectations.

> Toplumun görüntüye göre karar verdiğini fark ettim. Özellikle iş ortamlarında insanların sizi nasıl gördüğü birçok şeyi etkiliyor. Bu oyunun kuralını doğru bulmuyorum ama bu kurala göre oynamak zorunda olduğumu hissediyorum. Toplumda ki bu sisteme ve kurallara uyamadıkça üzülüyorum. *(P1)*
>
> I realized that society makes many decisions based on appearance. Especially in professional settings, how people see you affects many aspects of your life. I do not agree with these rules, but I feel that I have to play by them. *(P1)*

Women also described how these expectations were reproduced within family relationships from an early age.

“Annem hep daha süslü, daha feminen bir kız olmamı isterdi. Kilo verdikten sonra onun bu isteğinin gerçekleştiğini hissettim.” *(P2)*

“My mother always wanted me to be a more feminine and stylish girl. After I lost weight, I felt that her wish had finally come true.” *(P2)*

In contrast, male participants generally minimized the role of appearance in their decision to undergo surgery and rarely described comparable appearance-based pressures.

> “Hocam, bakın, normalde ben zaten vücudu orantısız olan bir insanım. Yani alt taraf, üst taraf, evet, çok takılmadım. Dolayısıyla benim amacım sadece kilo vermekti. Öyle olduğu için ben bu bahsetmiş olduğunuz ideal beden psikolojisine hiç girmedim.” *(P5)*
>
> “Look, normally I have always been a person with a disproportionate body. I mean, my lower body, my upper body... yes, I didn't pay much attention to that. Therefore, my only goal was to lose weight. Because of that, I never got into the ideal body psychology that you mentioned.” *(P5)*

Gendered meanings of recovery. Although both women and men described surgery as life-changing, they attached different meanings to their recovery. Women more frequently interpreted weight loss in relation to femininity, attractiveness, intimate relationships, and being viewed differently by others. In contrast, men were more likely to describe successful recovery as an achievement resulting from determination, discipline, and personal responsibility.

One participant explained:

"Partnerimin yanında kendimi daha yakışır hissetmek bana çok iyi geldi." *(P7)*

"Feeling that I suited my partner better made me feel much better about myself." *(P7)*

For male participants, however, successful recovery was more often framed as evidence of perseverance and individual commitment.

"Bu bir azim ve başarı öyküsü. Ameliyat bu işin başlangıcıydı ama devam etmek benim elimdeydi. Karar verdim ve başardım.' *(P8)*

"This is a story of determination and success. The surgery was the beginning of the process, but continuing it was in my hands. I made the decision, and I succeeded." *(P8)*

4.6. Summary of the Results

Based on the data analysis, five main themes were identified and named as 1) *The Journey Toward Bariatric Surgery*, (2) *Early Postoperative Challenges*, (3) *The Need for Lasting Change,* (4) *Transforming Life After Bariatric Surgery*, and (5) *How Gender Shapes the Bariatric Surgery Experience*. Overall, the findings demonstrate that the bariatric surgery process is a complex psychological, behavioral, social, and gendered experience that extends far beyond the surgical procedure itself.

First theme the findings indicate that the decision to undergo bariatric surgery is influenced by factors such as increased physical and psychological burden, the impact on an individual's ability to perform daily life roles, long-term experiences with obesity, and repeated unsuccessful weight loss attempts. Experiences of weight-related stigma and discrimination also contributed to participants' decision-making processes.

In addition, many participants described long-term difficulties regulating their relationship with food, which is a prominent factor in the decision-making process. Participants further reported that their social environment, emotional state, and expectations shaped their preoperative experiences and the way they approached the decision-making process.

The *second* theme focused on participants' early postoperative experiences. The immediate postoperative period was characterized by intensive physical and emotional adjustment as participants learned to adapt to new eating patterns, bodily changes, and the realities of recovery. During this period, many also experienced difficulties adopting new eating behaviors, regulating their food intake, and adhering to postoperative dietary guidelines. Participants often described feeling trapped between their desire to eat and their physical limitations. As recovery progressed, many continued to struggle with body dissatisfaction, feelings of bodily alienation, and appearance-related concerns. Finally, participants frequently reported receiving insufficient psychological support and described navigating the recovery process largely on their own, which further complicated their adjustment.

The *third* theme illustrated how participants gradually reconstructed their behaviors. As recovery progressed, participants increasingly recognized that bariatric surgery alone was insufficient for long-term success. Rather than viewing surgery as a permanent solution, they emphasized the importance of behavioral change, personal responsibility, psychological adaptation, and the development of sustainable habits to maintain weight loss.

The *fourth* theme showed the broader life transformations that followed bariatric surgery. Beyond challenges, participants also described improvements in various areas of their lives. They reported a transformation in the meaning they attributed to food, emphasizing that eating gradually shifted from an emotionally driven behavior to a more functional part of daily life. They also described greater self-regulation and increased control over their eating behaviors. Additionally, participants positively described the changes in their bodies, becoming more comfortable with their physical appearance and, for many, achieving the body they had long desired. They described feeling more comfortable and freer in their bodies following this transformation. They

also reported becoming more socially visible after the surgery as their appearance changed. They stated that they began receiving positive feedback from their environment, became more involved in life, and felt more socially accepted. These experiences were accompanied by increased self-confidence, self-efficacy, and self-esteem. Participants explained that these physical and psychological changes affected their daily lives. They enjoyed being more active, performing their daily roles more easily, tried new activities, and achieved goals they had previously thought were out of reach.

The *fifth* theme identified gender as a cross-cutting dimension shaping the entire bariatric surgery process. Women more frequently described appearance-related pressures, body image concerns, and gendered social expectations, whereas men generally emphasized health, physical functioning, and personal responsibility. In addition, women more often reported feeling lonely and unsupported throughout both the preoperative and postoperative periods, while men frequently described receiving substantial emotional and practical support from their partners. Female participants also described that traditional caregiving responsibilities continued after surgery, requiring them to prioritize family needs despite their own recovery. These findings showed that gender influenced motivations for surgery, postoperative experiences, and interpretations of recovery.

Overall, when the findings were considered together, bariatric surgery emerged as a dynamic and multidimensional process that extended beyond the surgical intervention itself. The analysis showed that participants' experiences and needs changed across different stages of this process. The difficulties that shaped the decision to undergo surgery were followed by new challenges related to rapid physical change, eating, body image, and psychological adjustment. Over time, participants also became more aware of their own role in maintaining long-term change, while changes in their bodies were closely connected with changes in their daily lives, relationships, and sense of self. These experiences were shaped throughout the process by interpersonal relationships, social expectations, and gender. The inductive analysis allowed these interconnected patterns to emerge from participants' accounts rather than from predetermined theoretical categories. The theoretical perspectives guiding the study

then helped to interpret these patterns from different but complementary perspectives. Basic Psychological Needs Theory helped explain changes in participants' experiences of autonomy, competence, and relatedness across the process. Social Comparison Theory provided a framework for understanding how participants evaluated themselves in relation to others and to their past, changing, and expected selves. The feminist perspective helped interpret how gendered expectations shaped experiences of the body, caregiving, support, and recovery.

CHAPTER 5

DISCUSSION

This section first discusses the main findings of the research. The themes, their sub-themes, and categories are addressed considering relevant theories and previous research findings. Secondly, implications for theory, research, and practice are presented. Finally, suggestions for future research are included.

5.1. Discussion of the Findings

5.1.1. The Journey Toward Bariatric Surgery

The findings of this study indicate that deciding to undergo bariatric surgery is not a sudden medical decision. Participants' descriptions of bariatric surgery as a "last resort" align with previous research. Earlier studies have similarly shown that individuals may consider surgery as a final option after repeated attempts to lose weight (Keyte et al., 2024; Murtha et al., 2022; Ölmez & Adak, 2026; Roberson et al., 2016). However, the present findings suggest that unsuccessful weight loss attempts alone do not fully explain how this decision develops. For the participants, the journey toward surgery was shaped by the interaction of physical limitations, difficulties with eating behaviors, emotional distress, disruptions in daily roles, body dissatisfaction, and weight stigma over time. The present study extends the "last resort" perspective described in the literature (Ölmez & Adak, 2026; Wysoker, 2005) by illustrating how this perception may gradually develop. Viewing bariatric surgery as a "last resort" may

reflect a broader psychosocial process in which difficulties across different areas of life accumulate over time.

Understanding this cumulative process only through individual experiences may overlook broader social discourses surrounding weight management. People living in larger bodies are often stigmatized as lacking willpower, discipline, or personal responsibility (Cowan, 1998; Greenberg, 2003). Such views frame weight management largely as a matter of individual control and responsibility. In contrast, participants' experiences in this study indicate that the decision to undergo surgery developed within a broader context of repeated weight loss efforts, physical limitations, emotional experiences, social judgments, and relational influences. Previous research has also shown that weight stigma can negatively affect psychological well-being and social relationships. Bariatric surgery itself may also become a new source of stigma (Trainer & Benjamin, 2017; Wolff & Maydell, 2024). The perception of surgery as a "last resort" may therefore develop within a social environment in which individuals are expected to manage a complex weight-related condition through personal effort and may be blamed when these efforts are unsuccessful.

The findings also suggest that family relationships and family involvement may play an important role in the decision to undergo bariatric surgery. The present study cannot determine whether this pattern is specific to Türkiye. However, the prominent role of family relationships in participants' decision-making is noteworthy within the sociocultural context of the study. Research conducted in other cultural contexts where family relationships play an important role has similarly shown that family members can influence decisions about bariatric surgery (Lee et al., 2019).

From the perspective of Basic Psychological Needs Theory (Ryan & Deci, 2000), the needs for competence, autonomy, and relatedness provide a useful framework for understanding participants' preoperative experiences. Research on weight management has shown that autonomous motivation and perceived competence in behavior change are important for long-term weight management (Teixeira et al., 2012). Repeated weight loss attempts and difficulties maintaining these changes over time may have led some participants to question their ability to create lasting change.

This experience is particularly relevant to the need for competence. Increasing limitations in daily life may also have challenged participants' sense of control over their lives and bodies. From this perspective, surgery may have represented a way for some participants to regain a sense of control over their lives.

The need for relatedness also appears relevant to this process. Weight stigma and social exclusion can negatively affect social relationships and individuals' sense of belonging (Karakitsiou et al., 2024; Matacin & Simone, 2019). In the present study, experiences of feeling misunderstood, being judged, and withdrawing socially formed part of the psychosocial burden preceding surgery. Previous research has also shown that relationships with family members, partners, and healthcare professionals can play an important role in the decision-making process (Lee et al., 2019). These findings suggest that the decision to undergo bariatric surgery should not be understood as an entirely individual process. Participants attempted to make their own decisions while also navigating support, opposition, and guidance from people close to them. Autonomy in this context may therefore develop within social relationships rather than independently from them.

Social Comparison Theory (Festinger, 1954) also provides a useful perspective for understanding participants' preoperative body experiences. Participants evaluated themselves in relation to their current and former bodies, as well as culturally idealized standards of beauty. Previous research has shown that social comparison and idealized body standards are associated with body dissatisfaction (Betz et al., 2019; Doğan et al., 2024). The pursuit of bariatric surgery may therefore represent an attempt to reduce the perceived gap between one's actual self and socially valued ideals. An important contribution of the present study is its indication that this perceived gap may extend beyond physical appearance. Participants' accounts also connected bodily change with the desire to improve psychological well-being and regain a more valued social position.

Overall, previous studies have identified unsuccessful weight loss attempts, physical and psychological difficulties, body dissatisfaction, and weight stigma as important experiences surrounding bariatric surgery (Grogan, 2022; Keyte et al., 2024; Murtha et al., 2022; Trainer & Benjamin, 2017; Wolff & Maydell, 2024). The present study

extends this literature by showing how these experiences may accumulate and reinforce one another over time. The journey toward bariatric surgery can therefore be understood as a cumulative psychosocial process in which individuals gradually perceive their available options as narrowing until surgery becomes the most viable remaining option.

5.1.2. Early Postoperative Challenges

The second theme of this study shows that the early period after bariatric surgery involves physical recovery as well as significant psychological and behavioral adjustment. Previous research has also shown that individuals may experience emotional distress, body image concerns, and various psychosocial difficulties after bariatric surgery (Groven et al., 2015; Keyte et al., 2024; Sarwer et al., 2008). However, the present findings suggest that one source of these difficulties may be the mismatch between rapid physical changes and slower psychological adjustment. Participants' bodies had to adapt to new physical limits within a short period, while their expectations, eating desires, and body perceptions did not change at the same pace. This mismatch may help explain why a medically successful surgery can still be psychologically challenging during early recovery.

This mismatch was particularly visible in the gap between participants' expectations and their actual recovery experiences. Previous studies have shown that unrealistic expectations about rapid recovery or complete life transformation can make psychological adjustment after bariatric surgery more difficult (Cowan, 1998; Kubik et al., 2013). In the present study, temporary regret and uncertainty appeared especially during the early period when participants faced unexpected difficulties. These feelings may have reflected the gap between their expectations and postoperative experiences rather than regret about the decision to undergo surgery.

One of the most striking findings concerned participants' changing relationship with food. Participants often felt caught between what they wanted to eat and what their bodies could physically tolerate. This finding supports previous research showing that bariatric surgery requires major and lasting changes in eating behavior (Keyte et al., 2024; Snyder, 2009). Postoperative adjustment therefore involves learning to build a

new relationship between desires, physical limits, and eating behaviors. Participants who had previously used food to cope with their emotions could no longer eat in the same way after surgery. This loss of a familiar coping strategy may help explain the feelings of loss, grief, and anxiety described by some participants.

This adjustment process also had a cultural dimension. Some participants found it difficult to maintain their new eating patterns in social settings where food and hospitality played an important role. A previous study with women who had undergone bariatric surgery in Türkiye showed that cultural expectations around offering food, accepting food, and finishing what is served can influence postoperative eating behaviors (Güney & Göbel, 2025). The present findings similarly suggest that adapting to new eating patterns involves more than changing individual habits. Participants also had to protect their new physical limits within social environments shaped by established food and hospitality practices. In the Turkish context, these social practices may create an additional challenge during postoperative adjustment.

A similar difficulty was seen in participants' relationships with their rapidly changing bodies. Previous studies have shown that body dissatisfaction may continue after bariatric surgery due to excess skin, weight regain, and differences between physical appearance and internalized body image (Doğan et al., 2024; Ivezaj & Grilo, 2018; Kubik et al., 2013; Varns et al., 2018). The present findings suggest that postoperative body-related difficulties may extend beyond dissatisfaction with appearance. Participants described feeling unfamiliar with their bodies, experiencing a sense of loss related to their former selves, and having difficulty recognizing their changing bodies. One possible explanation is that physical changes occur faster than changes in how individuals mentally perceive and experience their bodies.

Previous research has emphasized the importance of psychological assessment, multidisciplinary care, and social support throughout the bariatric surgery process (Fabricatore et al., 2006; Ogden et al., 2019; Ogle et al., 2016). However, participants in the present study often tried to discuss their emotional difficulties with surgeons or dietitians, even when they knew that these concerns were psychological rather than medical or nutritional. This suggests that the absence of professional psychological support does not remove individuals' psychological needs. Instead, patients may turn

to other healthcare professionals who are available to them. The findings therefore point to a gap between postoperative services that mainly focus on medical care and patients' need for psychosocial support during adjustment.

Participants' experiences also suggest that weight-related stigma may continue even after substantial weight loss. Previous research has documented both weight stigma and the stigma surrounding bariatric surgery as an "easy way" to lose weight (Greenberg, 2003; Trainer & Benjamin, 2017; Wolff & Maydell, 2024). The present study extends this understanding by showing that social judgments may continue even as individuals move closer to socially valued thin body standards. Participants were told that they looked "too thin," "unhealthy," or "old." These comments suggest that the target of social judgment may change while appearance-based evaluation continues. This finding challenges the assumption that having a thinner body automatically protects individuals from appearance-based stigma.

Another aspect of stigma was that some participants hid their bariatric surgery from others or disclosed it only to selected people. This finding is consistent with experiences of nondisclosure and selective disclosure described in previous research. Sutton et al. (2009) reported that individuals may hide their decision to undergo bariatric surgery when they expect negative reactions from others. A more recent review also identified nondisclosure and selective disclosure as common responses to anticipated bariatric surgery stigma (Garcia et al., 2024). The presence of this behavior among several participants in the present study suggests that postoperative stigma is not limited to direct negative comments. Individuals may anticipate negative reactions and choose to hide their surgery before such reactions occur.

This process can also be understood through the concepts of competence and autonomy within Basic Psychological Needs Theory (Ryan & Deci, 2000). The sudden introduction of new physical limits may temporarily reduce individuals' sense of control over familiar behaviors, especially when their usual eating patterns are no longer physically possible. Developing new eating behaviors can therefore be understood as a process of rebuilding a sense of competence rather than simply following postoperative dietary rules.

Participants' feelings of being psychologically misunderstood and facing some parts of recovery alone are also relevant to the need for relatedness. These findings suggest that social support may play an important role in postoperative adjustment. Feeling understood and supported by close others may make this challenging adjustment process easier.

Social Comparison Theory (Festinger, 1954) also helps explain part of this adjustment process. Participants compared their new bodies with their previous appearance and with the bodies they had expected to have after surgery. Previous research has shown that differences between physical changes and internalized body image can make psychological adjustment after bariatric surgery more difficult (Doğan et al., 2024). Research has also found that comparing one's surgical outcomes with those of others may be related to postoperative satisfaction (Gaudrat et al., 2021). The present findings suggest that rapid weight loss may create several points of comparison at the same time: the former body, the changing body, and the expected or ideal body. These multiple comparisons may help explain why body satisfaction and a stable sense of self do not always develop immediately, even after substantial weight loss.

Overall, these findings show that the early postoperative period is a challenging psychosocial adjustment process in which individuals try to adapt to rapid physical changes and develop new relationships with food, their bodies, and their social environments.

5.1.3. The Need for Lasting Change

The third theme of this study shows that participants gradually realized that bariatric surgery alone was not enough to achieve lasting weight control. Previous research has emphasized that maintaining weight loss after bariatric surgery depends on lasting behavioral changes, adherence to dietary recommendations, and long-term lifestyle changes. Weight regain also remains an important concern over time (Choban et al., 2002; Keyte et al., 2024; Kushner & Sorensen, 2015; Snyder, 2009). The present findings extend this understanding by showing that recognizing these behavioral demands was part of the postoperative adjustment process. Participants may initially have expected the physical effects of surgery to create change. However, as they faced

the ongoing psychological and behavioral demands of weight management, they became increasingly aware of the limits of surgery.

This awareness led participants to reconsider their past behaviors and decisions. Previous research has also emphasized that bariatric surgery does not remove the behavioral and psychological factors involved in long-term weight management and that postoperative adjustment requires ongoing self-management (Cowan, 1998; Ogden et al., 2019). The present study contributes to this literature by showing that participants became increasingly aware of their own role in maintaining change.

This shift can also be understood through the concepts of autonomy and competence within Basic Psychological Needs Theory (Ryan & Deci, 2000). During the early postoperative period, physical restrictions required participants to change their eating behaviors. Over time, however, maintaining these changes became increasingly dependent on their own choices and self-regulation skills. As participants learned to manage their eating behaviors, build new routines, and recognize their own role in maintaining change, they may also have developed a stronger sense of competence in managing their daily lives.

An important contribution of this study is the distinction between surgery creating change and surgery creating an opportunity for change. Previous research has established the importance of behavioral adjustment and lifestyle changes after bariatric surgery (Choban et al., 2002; Keyte et al., 2024; Snyder, 2009). The present study extends this literature by showing how participants' understanding of surgery changed over time. Surgery was initially viewed mainly as a physical intervention. As the postoperative process continued, participants began to understand it as one part of a longer process involving learning, self-regulation, psychological adjustment, and the rebuilding of daily habits. Recognizing the limits of surgery does not necessarily mean being dissatisfied with the surgery. Instead, it may indicate that participants developed a more realistic understanding of how lasting change can be achieved.

Overall, these findings show that participants gradually came to view bariatric surgery as part of a longer process that requires lasting behavioral change and self-regulation, rather than as a solution that can create lasting change on its own.

5.1.4. Transforming Life After Bariatric Surgery

The fourth theme of this study shows that bariatric surgery involves a broad transformation that extends across many areas of life. Previous research has reported improvements in quality of life, physical functioning, self-esteem, body image, psychological well-being, physical activity, and social functioning after bariatric surgery (Cherick et al., 2019; Choban et al., 2002; Murtha et al., 2022). However, these positive outcomes are not experienced in the same way by everyone and may decrease over time for some individuals (Keyte et al., 2024). The literature also suggests that rapid bodily changes can challenge established identities and require individuals to reconcile their former and current selves (Perdue et al., 2020). Body image concerns and internalized anti-fat attitudes may also continue despite substantial weight loss (Sicilia et al., 2026; Wolff & Maydell, 2024). Taken together, these studies suggest that physical change does not automatically lead to the same level of psychosocial improvement for everyone.

The present study shows that postoperative changes were not experienced as separate outcomes. Instead, they appeared to be connected parts of a broader transformation. The present study extends previous literature by showing how these changes were connected within participants' experiences. Changes in participants' relationships with food and their bodies developed alongside changes in self-confidence, social participation, interpersonal relationships, and daily life. Postoperative transformation can therefore be understood as a broader psychosocial process in which changes across different areas of life are closely connected.

From the perspective of Basic Psychological Needs Theory (Ryan & Deci, 2000), the findings suggest that participants' psychological needs may have been supported in interconnected ways after surgery. Becoming more physically active and maintaining new routines may have strengthened their sense of competence. Having greater choice in eating, movement, and daily life can be understood in terms of autonomy. Returning to social life and experiencing changes in relationships may also be related to the need for relatedness. Postoperative transformation may therefore be connected to participants' ability to re-engage with areas of life that were personally meaningful to them.

Previous research has shown that appearance-based social comparisons are related to body dissatisfaction and internalized body ideals (Doğan et al., 2024; Sicilia et al., 2026). The present findings suggest that the standards used for comparison may change throughout the bariatric surgery process. Social Comparison Theory (Festinger, 1954) helps explain this process. Before surgery, participants often compared themselves with culturally idealized bodies and withdrew from social life. After surgery, they increasingly compared themselves with their former selves and recognized their physical progress. This may have contributed to greater body acceptance, self-confidence, and satisfaction with their appearance. However, appearance-based evaluations from others continued after weight loss. This suggests that surgery may change individuals' position within social comparison processes without completely removing these comparisons.

An important contribution of this study is that it presents postoperative changes as connected parts of a broader psychosocial transformation rather than as separate outcomes. In this sense, the meaning of bariatric surgery extended beyond weight loss and included changes in how participants related to themselves, their bodies, and their everyday lives.

5.1.5. How Gender Shapes the Bariatric Surgery Experience

The fifth theme of this study shows that gender was an important factor shaping participants' experiences throughout the bariatric surgery journey. Previous studies have shown that women report greater body dissatisfaction and more appearance-related concerns than men (Colosimo et al., 2025; Groven et al., 2015; Kochkodan et al., 2018; Mahony, 2008). The fact that most individuals undergoing bariatric surgery are women also suggests that the decision to seek surgery may be related to social body norms and appearance expectations alongside health concerns (Colosimo et al., 2025; Gregory et al., 2013). The findings of the present study show that women and men gave different meanings to some aspects of the surgical process. Gender also appeared to be related to how participants evaluated their bodies, made decisions about surgery, received support, and understood postoperative changes.

From a Feminist Theory perspective, the experiences of female participants suggest that body weight was connected with femininity, attractiveness, and social value. Previous studies showing that women face stronger social pressure to achieve a thin body support this interpretation (Lin & Kulik, 2002; Seekis & Barker, 2022). Similarly, research in the context of bariatric surgery has shown that women may associate obesity with a loss of femininity and weight loss with feeling feminine again (Paul et al., 2023). In the present study, female participants connected weight with youth, attractiveness, and femininity. These findings suggest that body dissatisfaction cannot be understood as a matter of individual appearance preferences alone. These experiences may be shaped by the social evaluation of women's bodies and cultural standards of femininity.

However, the influence of gender was not limited to appearance pressures experienced by women. Male participants placed greater emphasis on health, physical functioning, independence, and personal control. This may reflect different social expectations surrounding men and their bodies. Previous research has shown that men may view their bodies as less central to their sense of self and may be less likely to seek help even when experiencing health problems (Kochkodan et al., 2018). The differences between women and men should therefore not be interpreted as meaning that women are affected by their bodies while men are not. Instead, gender may shape how body-related concerns are expressed and which aspects of the body are considered important.

This interpretation may also be extended by considering how feminist scholarship conceptualizes masculinity as a socially constructed and gendered position rather than treating gender as relevant only to women. Rather than suggesting that men were less psychologically affected by obesity or bariatric surgery, these findings indicate that they expressed their experiences through different gendered expectations regarding what it means to have a healthy and capable body. Similar interpretations have been reported in qualitative research showing that men often frame bariatric surgery in terms of restoring physical functioning, strength, and social value within culturally valued masculine ideals (Groven & Braithwaite, 2015).

Gender differences were also visible in participants' experiences of postoperative support. Female participants continued to carry caregiving and household

responsibilities during recovery. This placed some women in a position where they needed care while still being expected to care for others. Etuk et al. (2025) found that caregiving burden among bariatric surgery candidates may be associated with depression, anxiety, and maladaptive eating behaviors. The present findings extend this understanding by suggesting that gender roles may shape the conditions available for recovery as well as individuals' reasons for undergoing surgery. Differences in support between female and male participants may therefore be related to the gendered distribution of caregiving and care-receiving roles within families.

From the perspective of Social Comparison Theory (Festinger, 1954), the findings suggest that gender may shape both the intensity of social comparison and the standards used for comparison. Socially idealized bodies, attractiveness, and femininity were more visible in female participants' evaluations. Physical ability, health, and functioning were more prominent among male participants. The findings should therefore not be interpreted as suggesting that men are unaffected by social comparison. Instead, women and men may evaluate themselves according to different social standards. This suggests that social comparison processes may operate differently depending on gender.

An important contribution of this study is that gender emerged as a context that can shape the entire bariatric surgery experience rather than as a separate aspect of the process. Previous studies have mainly focused on differences between women and men in surgery rates, health conditions, body satisfaction, and motivations for surgery (Colosimo et al., 2025; Kochkodan et al., 2018; Mahony, 2008). The present study brings these areas together by showing how gender appeared across decision-making, meanings attached to the body, access to support, caregiving responsibilities, and interpretations of postoperative change. Gender can therefore be understood as a cross-cutting dimension that shaped how participants experienced the processes discussed across the previous four themes. However, given the limited number of female and male participants in this study, these differences should be understood as gender-related patterns within this sample rather than fixed characteristics that can be generalized to all women and men.

Taken together, these findings suggest that bariatric surgery should not be understood as an easy or straightforward solution. Participants described physical, psychological, emotional, and social challenges throughout the bariatric surgery process. At the same time, nearly all participants stated that, despite these challenges, they would choose to undergo bariatric surgery again and would recommend it to others. These findings suggest that participants generally viewed the long-term benefits as outweighing the difficulties they experienced. This highlights the importance of helping individuals make informed decisions by understanding both the potential benefits and the psychosocial challenges associated with bariatric surgery.

5.2. Implications for Theory, Policy and Practice

There are several implications of this study. The findings suggest that psychological support should continue after surgery rather than being limited to preoperative assessment. The main counseling needs identified throughout the process include preparation for surgery and expectation management, emotion regulation, rebuilding the relationship with food, adjustment to body image and identity changes, coping with stigma, and strengthening social support.

First, preoperative psychological counseling should focus on preparing individuals for the postoperative process as well as assessing their readiness for surgery. Previous studies have shown that unrealistic expectations can make psychological adjustment after surgery more difficult. The expectation that surgery will solve all problems in life may also create risks for long-term psychological well-being (Cowan, 1998; Kubik et al., 2013). Preoperative psychological counseling can provide a space for individuals to discuss what they expect from surgery, how these expectations have developed, and what surgery can and cannot change.

Previous studies have shown that structured preoperative cognitive behavioral interventions can improve postoperative adjustment, reduce stress during the early postoperative period, and help patients develop realistic expectations about weight loss and life changes (Geller et al., 2019). Psychological counselors can also address individuals' experiences of weight stigma and repeated unsuccessful weight loss attempts during counseling. They can help individuals examine unrealistic

expectations about how surgery may change their lives and develop more realistic expectations about the postoperative process.

Preoperative counseling should prepare patients for the emotional, physical, and behavioral realities of the early postoperative period in addition to providing nutritional education. An important practical implication of this study is that psychological support should remain available after surgery. Previous studies have emphasized the importance of psychological assessment, social support, and multidisciplinary care throughout the bariatric surgery process (Fabricatore et al., 2006; Ogden et al., 2019). In the present study, some participants who did not have access to psychological support tried to discuss their emotional difficulties with their surgeons or dietitians. This suggests that existing follow-up services may not fully meet individuals' psychological needs after surgery. Psychological counselors should be an accessible part of the bariatric care team, and psychological support should not be seen as a service used only when serious mental health problems arise. During the early postoperative period, individuals may need a counseling space where they can discuss uncertainty, temporary regret, feelings of loss, and psychological difficulties. Psychological counselors can help individuals understand these difficulties as part of the postoperative adjustment process rather than as personal failure.

Although bariatric surgery can physically limit the amount of food individuals can eat, it may not automatically change the emotional meanings attached to food or previously developed coping strategies. Previous studies have emphasized that long-term outcomes after bariatric surgery depend on lasting behavioral change, adherence to dietary recommendations, and ongoing self-management (Choban et al., 2002; Keyte et al., 2024; Snyder, 2009). Psychological counseling can help individuals understand the emotional functions of their eating behaviors, develop alternative coping strategies, and maintain new behaviors over time. Psychological interventions that focus on emotion regulation and eating behaviors may also be useful. Approaches such as Acceptance and Commitment Therapy (ACT) and Mindfulness-Based Eating Awareness Training (MB-EAT) have shown positive outcomes for eating behaviors and psychological processes (Kristeller & Wolever, 2014; Weineland et al., 2012).

This support should continue beyond the early postoperative period. Weight regain remains an important concern in long-term bariatric care (Keyte et al., 2024; Kushner & Sorensen, 2015). Psychological counselors can address long-term processes such as self-regulation, maintaining motivation, and making healthy habits part of daily life. Long-term success and weight regain should not be understood only in terms of individual willpower and discipline. Considering individual, psychological, and environmental factors together may also help address feelings of self-blame and failure when weight regain occurs.

The cultural context in which individuals live should also be considered. For example, a study with women who had undergone bariatric surgery in Türkiye showed that cultural expectations such as pressure to eat, difficulty refusing offered food, and expectations to finish what is served may affect postoperative eating habits (Güney & Göbel, 2025). Psychological support should therefore address how individuals can maintain their new eating patterns during family meals, social visits, and other social situations. This approach may help place behavioral change within the individual's broader social and cultural environment.

Another important area for psychological counseling is adjustment to changes in body image and identity. Previous studies have shown that body dissatisfaction, difficulties related to excess skin, and differences between the physical body and internalized body image may continue despite substantial weight loss (Doğan et al., 2024; Ivezaj & Grilo, 2018; Varns et al., 2018). Individuals may also have difficulty connecting their former and current selves. The effects of living in a larger body for many years may continue to shape their identity after weight loss (Perdue et al., 2020; Sicilia et al., 2026; Wolff & Maydell, 2024).

Counselors can support individuals in adjusting to their changing bodies and sense of self. Body acceptance, excess skin, social visibility, and changes in interpersonal relationships can be addressed during counseling. Work on self-compassion and body acceptance may also help individuals develop a more accepting relationship with their bodies and changing sense of self. Compassion-focused approaches may be useful for addressing difficulties related to self-criticism and shame (Gilbert, 2014). Research in the bariatric surgery context also suggests that self-compassion may be a useful target

for addressing internalized weight bias, shame, and related emotional difficulties (Braun et al., 2021).

Psychological counselors should also consider that weight stigma may continue after surgery. Previous studies have shown that individuals who undergo bariatric surgery may be judged for choosing what others see as an “easy way” to lose weight (Trainer & Benjamin, 2017; Wolff & Maydell, 2024). Individuals may also hide their surgery or disclose it only to selected people because they expect negative reactions or stigma (Garcia et al., 2024; Sutton et al., 2009). In the present study, some participants also hid their surgery from people in their social environment. This suggests that anticipated stigma may influence decisions about disclosing bariatric surgery. Counseling can therefore address internalized weight stigma, shame, self-blame, and concerns about whether to disclose or hide the surgery from others.

The findings show that psychological adjustment is not an individual process alone. Family members and partners can play an important role in decision-making before surgery, postoperative care, behavioral changes, and emotional adjustment. Previous studies have also shown the importance of social support from family members and close others throughout the bariatric surgery process (Lee et al., 2019; Ogle et al., 2016). Involving close others in the process may therefore be helpful when this is in line with the individual’s preferences and needs. However, their involvement should respect the individual’s autonomy and help them better understand the individual’s postoperative needs and provide more effective support.

Connecting with others who have had similar experiences may also help patients feel understood and less alone. The bariatric surgery literature has highlighted the potential role of peer support and support groups in postoperative adjustment (Keyte et al., 2024). In addition to individual psychological counseling, peer support groups or structured group-based support programs may be included in bariatric care when appropriate.

Gender should also be considered an important context that may shape psychological needs throughout the bariatric surgery process. Previous research has shown differences between women and men in patterns of seeking bariatric surgery, body

image, and healthcare-seeking behaviors (Colosimo et al., 2025; Kochkodan et al., 2018). A gender-sensitive counseling approach should avoid assuming that women are concerned only with body image or that men undergo surgery only for physical health reasons. Counselors should explore how each individual is affected by social expectations based on their own experiences. For women, counseling may address appearance pressures and the psychological effects of caregiving responsibilities. For men, counseling can provide a safe space to discuss emotional difficulties that may otherwise remain unexpressed. This may help prevent psychological needs from being overlooked because of traditional expectations about masculinity.

The findings of this study clearly show that the role of psychological counselors in bariatric care should extend beyond preoperative assessment or a "gatekeeping" role. The integration of multidisciplinary care and psychological services is important for long-term outcomes after bariatric surgery (Fabricatore et al., 2006; Nieves-Khouw et al., 2009; Ogden et al., 2019). Collaboration among surgeons, dietitians, nurses, and mental health professionals should continue from preoperative preparation through long-term follow-up. Within such an integrated care model, bariatric team members can be trained to recognize early signs of psychological distress, emotional eating, and difficulties with postoperative adjustment. Mental health support should be considered a regular part of bariatric care rather than an optional service provided only when serious psychological problems arise. Bariatric clinics may also include routine and structured psychological screening in follow-up appointments. Previous research suggests that collaborative and integrated care models involving mental health professionals can support continued engagement in treatment, long-term weight management, and timely referral to mental health services (Sarwer et al., 2019).

This study shows that Basic Psychological Needs Theory (Ryan & Deci, 2000) may provide a useful framework for understanding psychosocial experiences across different stages of the bariatric surgery process. The findings suggest that successful adjustment after surgery is related to individuals' psychological needs as well as their ability to follow dietary recommendations. The needs for autonomy, competence, and relatedness may also become more important at different stages of the process. Before surgery, autonomy may be especially important when individuals make decisions

about surgery and their own health. After surgery, competence may become more important as individuals learn to manage new physical limits and behaviors. Relatedness may also become important as individuals seek understanding and support from their families and others around them. As patients begin to make more self-directed choices for their health, rather than following dietary rules mainly because of fear or external pressure, they may experience better psychological adjustment. This interpretation is consistent with research showing the importance of autonomous motivation in long-term weight management (Teixeira et al., 2015). The current findings extend this theoretical framework by showing how these psychological needs may change in importance across different stages of the bariatric surgery process.

The findings also suggest a possible extension of Social Comparison Theory (Festinger, 1954) in the context of bariatric surgery. Participants did not compare themselves only with idealized bodies or other people. They also compared themselves with their previous bodies, their changing bodies, the bodies they expected to achieve, and their previous levels of functioning. Social comparison in the context of bariatric surgery may therefore include comparisons between different versions of the self across time, alongside comparisons with other people and social body ideals.

The findings also suggest that a feminist perspective can offer a broader understanding of the bariatric surgery experience beyond women's appearance-related concerns. Previous studies have shown that women may experience stronger pressure related to thin body ideals (Grogan, 2022) and greater caregiving responsibilities (Etuk et al., 2025), while men may place greater emphasis on health and physical functioning in relation to surgery (Colosimo et al., 2025). The current study extends this literature by showing that gender may shape several parts of the bariatric surgery process, including decision-making, social support, caregiving responsibilities, stigma, recovery, and the meaning given to successful outcomes. A feminist perspective may therefore help explain how women and men experience the surgical process within different social expectations and gender roles.

5.3. Recommendations for Further Research

Research on bariatric surgery has increased significantly in recent years. However, studies have primarily focused on medical outcomes such as weight loss, surgical complications, and quality of life, whereas psychosocial processes have received comparatively less attention (Keyte et al., 2024; Ogden et al., 2019). In the Turkish context, studies examining the psychosocial experiences of individuals throughout the bariatric surgery process are relatively few. This study showed the need for more qualitative and quantitative research exploring the emotional, behavioral, interpersonal, and identity aspects of bariatric surgery.

Participants in the present study varied in terms of age, gender, time since surgery, and postoperative experiences. Although this diversity improved the findings, it also made it difficult to determine which psychosocial experiences were associated with specific participant characteristics. Future qualitative studies could focus on more homogeneous samples, such as individuals at similar postoperative stages, those who have undergone the same surgical procedure, or participants with comparable demographic characteristics. This may provide a clearer picture of the psychosocial needs that arise at different stages of the bariatric surgery process.

Future studies could also include larger and more gender-balanced samples to examine gender-related patterns in greater depth. This may help clarify how gender shapes body image, social support, caregiving responsibilities, and psychological adjustment throughout the bariatric surgery process.

The findings also showed that psychosocial experiences change over time. Individuals preparing for surgery, those in the early postoperative period, and those several years after surgery are likely to face different emotional, behavioral, and interpersonal challenges. Longitudinal studies following the same participants across these stages may clarify how psychological adjustment, identity reconstruction, body image, and social relationships evolve over time. Repeated interviews may also capture experiences and reflections that participants do not express during a single interview.

Another important finding was the central role of interpersonal relationships. Participants frequently described the influence of family members, partners, healthcare

professionals, and their wider social environment on their adjustment before and after surgery. However, this study examined these experiences only from the perspectives of individuals who had undergone bariatric surgery. Future research could also include family members, partners, surgeons, dietitians, psychologists, psychiatrists, nurses, and other healthcare professionals. Examining these perspectives together may provide a more complete understanding of the psychosocial processes and help to guide more person- and family-centered models of care.

The findings also point to the need for stronger evidence on psychological support in bariatric care. Future studies may focus on the effectiveness of preoperative psychoeducation, long-term psychological counseling, peer-support groups, family-based interventions, and programs targeting body image or emotion regulation. Such research could guide the development of evidence-based psychosocial services for routine bariatric care.

Future studies could also examine the psychological processes underlying bariatric surgery from different theoretical perspectives. Quantitative and mixed-methods research may investigate the roles of social comparison, basic psychological need satisfaction, body image, identity reconstruction, self-compassion, emotional regulation, and weight stigma in postoperative adjustment.

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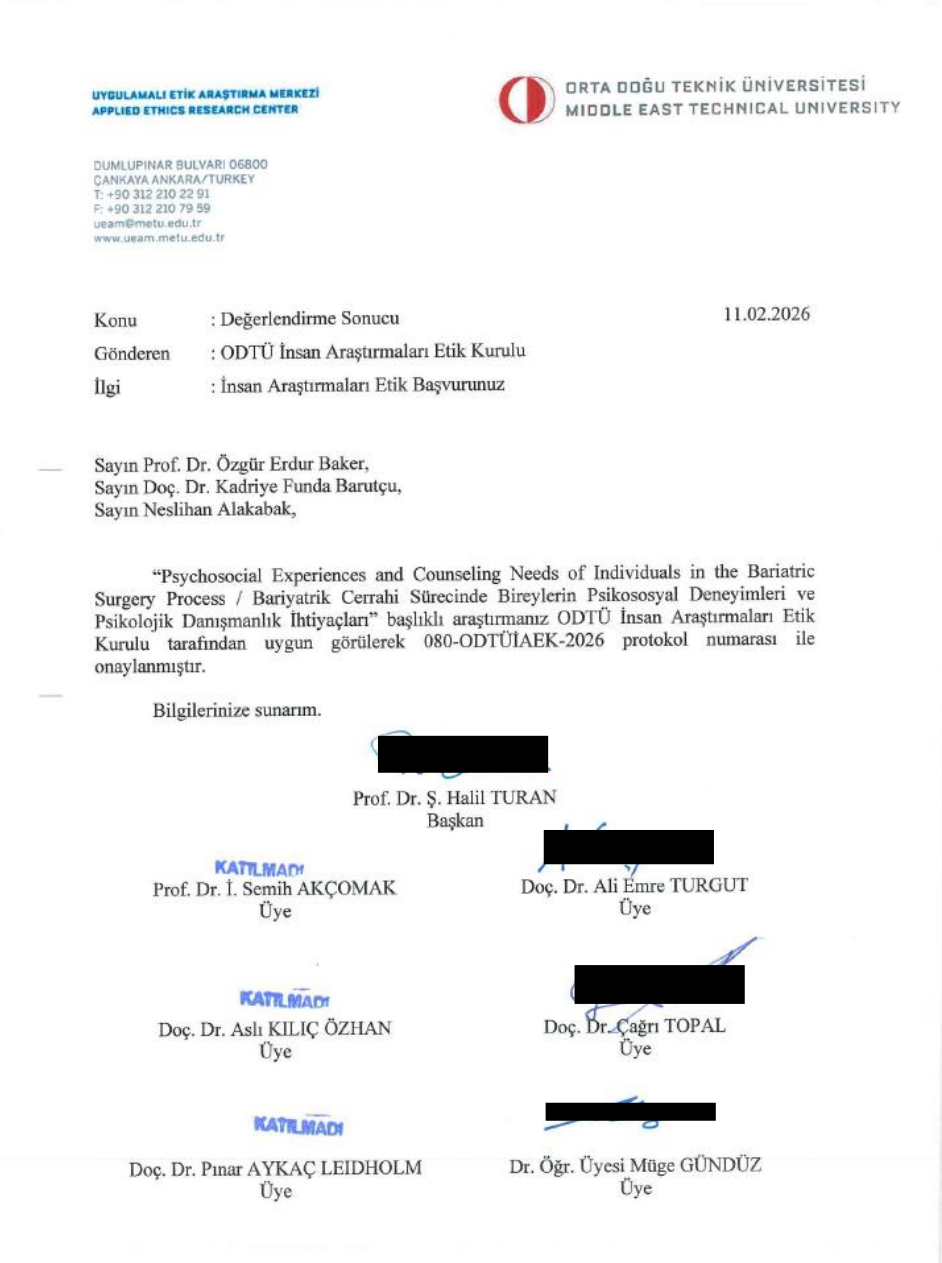
APPENDICES

A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE



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Konu : Değerlendirme Sonucu 11.02.2026
Gönderen : ODTÜ İnsan Araştırmaları Etik Kurulu
İlgi : İnsan Araştırmaları Etik Başvurunuz

Sayın Prof. Dr. Özgür Erdur Baker,
Sayın Doç. Dr. Kadriye Funda Barutçu,
Sayın Neslihan Alakabak,

"Psychosocial Experiences and Counseling Needs of Individuals in the Bariatric Surgery Process / Bariyatrik Cerrahi Sürecinde Bireylerin Psikososyal Deneyimleri ve Psikolojik Danışmanlık İhtiyaçları" başlıklı araştırmanız ODTÜ İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek 080-ODTÜİAEK-2026 protokol numarası ile onaylanmıştır.

Bilgilerinize sunarım.

[redacted]
Prof. Dr. Ş. Halil TURAN
Başkan

KATILMADI
Prof. Dr. İ. Semih AKÇOMAK
Üye

[redacted]
Doç. Dr. Ali Emre TURGUT
Üye

KATILMADI
Doç. Dr. Aslı KILIÇ ÖZHAN
Üye

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Doç. Dr. Çağrı TOPAL
Üye

KATILMADI
Doç. Dr. Pınar AYKAÇ LEIDHOLM
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Dr. Öğr. Üyesi Müge GÜNDÜZ
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B. ANNOUNCEMENT

Katılımcı Davet Metni

Herkese Merhaba;

Ben Orta Doğu Teknik Üniversitesi Psikolojik Danışma ve Rehberlik Anabilim Dalı'nda yüksek lisans öğrencisi Neslihan Alakabak. Bu araştırma, yüksek lisans tez çalışmam kapsamında ve Doç. Dr. Kadriye Funda Barutçu Yıldırım ile Prof. Dr. Özgür Erdur Baker danışmanlığında yürütülmektedir. Araştırmamın amacı, bariyatrik cerrahi geçirmiş bireylerin ameliyat öncesi ve sonrası yaşadıkları psikososyal deneyimleri, bu süreçte ortaya çıkan duygusal, sosyal ve danışmanlık ihtiyaçlarını derinlemesine anlamaktır. Bu doğrultuda bariyatrik cerrahi olmuş yetişkin bireyleri araştırmaya katılmaya davet ediyorum.

Araştırmaya Kimler Katılabilir?

- 18 yaş ve üzeri olmak
- Bariyatrik cerrahiyi **en az 3 ay önce** geçirmiş olmak

Araştırma Nasıl Yapılacak?

- Katılım tamamen gönüllülük esasına dayanmaktadır.
- Görüşmeler çevrimiçi (Zoom/Teams) veya yüz yüze yapılabilir.
- Görüşme yaklaşık 60–90 dakika sürecektir.
- Katılımcı izni doğrultusunda ses kaydı alınacaktır.
- Paylaşılan tüm bilgiler gizli tutulacak ve yalnızca bilimsel amaçlarla kullanılacaktır.

Neden Katılmalısınız?

Katkınız, bariyatrik cerrahi sürecini yaşayan bireylerin psikolojik danışmanlık ihtiyaçlarının daha iyi anlaşılmasına ve bu alanda daha etkili hizmetler geliştirilmesine ışık tutacaktır.
Sizin deneyiminiz, bu alanda yapılacak çalışmalar için çok değerli. Görüşmeye katılmak veya daha fazla bilgi almak için benimle iletişime geçebilirsiniz:

Katkınız ve desteğiniz için şimdiden çok teşekkür ederim.

Saygılarımla,

Neslihan Alakabak
ODTÜ – PDR Yüksek Lisans Öğrencisi

C. PARTICIPANT CONSENT FORM

GÖNÜLLÜ KATILIMCI ONAY FORMU

Araştırma Başlığı: *Bariyatrik Cerrahi Sürecinde Bireylerin Psikososyal Deneyimleri ve Psikolojik Danışmanlık İhtiyaçları: Nitel Araştırma*

Bu araştırma, Orta Doğu Teknik Üniversitesi Psikolojik Danışma ve Rehberlik Anabilim Dalı yüksek lisans öğrencisi *Neslihan Alakabak* tarafından*, Doç. Dr. Kadriye Funda Barutçu Yıldırım ve Prof. Dr. Özgür Erdur Baker* danışmanlığında yürütülmektedir. Bu form, araştırmaya katılmadan önce sizi çalışma hakkında bilgilendirmek amacıyla hazırlanmıştır.

Araştırmanın Amacı Nedir?

Bu çalışmanın amacı, bariyatrik cerrahi geçirmiş bireylerin ameliyat öncesi ve sonrası psikososyal deneyimlerini, beden algısı ve kimlik değişimi süreçlerini, yemekle ilişki ve duygu düzenleme deneyimlerini ve psikolojik danışmanlık ihtiyaçlarını anlamaktır.

Benden Ne Bekleniyor?

Araştırmaya katılmayı kabul etmeniz durumunda, sizin için uygun bir zaman diliminde yaklaşık 60–90 dakikalık yarı yapılandırılmış bir görüşme yapılacaktır. Görüşme yüz yüze veya çevrim içi (Zoom/Teams) gerçekleştirilebilir.

Görüşmede size aşağıdaki içeriklerde sorular yöneltilecektir:

- Ameliyat öncesi motivasyonlar, duygular ve beklentiler
- Ameliyat günü ve erken dönem deneyimleri
- Beden algısı, kimlik ve benlik süreçleri
- Sosyal ve kültürel deneyimler
- Yemekle ilişki ve duygu düzenleme
- Psikolojik danışmanlık ihtiyaçları

Sizden beklenen, soruları içten ve rahatça yanıtlamanızdır.

Katılımınızla İlgili Bilmeniz Gerekenler

- Çalışmaya katılım tamamen gönüllüdür.
- İstediğiniz zaman hiçbir gerekçe göstermeden çalışmadan ayrılabilirsiniz.
- Görüşmenin sağlıklı şekilde çözümlenebilmesi için ses kaydı alınacaktır.
- Elde edilen tüm bilgiler gizli tutulacaktır ve kimliğiniz ile ilişkilendirilmeyecektir.
- Veriler, "Katılımcı 1, Katılımcı 2…" şeklinde kodlanacaktır.
- Kayıtlar ve görüşme dökümleri yalnızca araştırmacı tarafından erişilebilir olup, araştırma tamamlandıktan sonra güvenli şekilde imha edilecektir.
- Elde edilen veriler yalnızca bilimsel araştırma, raporlama ve akademik yayın süreçlerinde kullanılacaktır.
- Görüşme sırasında herhangi bir soru sizi rahatsız ederse yanıtlamadan geçebilir veya görüşmeyi sonlandırabilirsiniz.

Çalışmaya katkınız bilimsel araştırmalar için büyük önem taşımaktadır. Katılımınız için şimdiden teşekkür ederiz.

Araştırmacı:

Neslihan Alakabak

Danışmanlar:

Dr. Öğr. Üyesi Funda Barutçu Yıldırım

Prof. Dr. Özgür Erdur Baker

Yukarıdaki bilgileri okudum; araştırmanın amacı, süreci, gönüllülük esasları ve gizlilik ilkeleri hakkında bilgilendirildim.

Gönüllü olarak araştırmaya katılmayı ***kabul ediyorum****.*

Ad – Soyad: **Tarih:** __ / __ / 20__

İmza: _____

D. INTERVIEW PROTOCOL

Bariyatrik Cerrahi Sürecinde Psikososyal Deneyimler ve Psikolojik Danışmanlık İhtiyaçları- Nitel Görüşme Formu

1. BÖLÜM- DEMOGRAFİK BİLGİLER

- Doğum Yılı:
- Eğitim düzeyi:
- Meslek:
- Medeni durum/ilişki durumu:
- Bariyatrik cerrahi geçirdiğiniz ay ve yıl/ameliyatınızın üzerinden geçen süre?
- Kaç Kilo Kaybı Oldu:
- Hedef Kilo Neydi?

2. BÖLÜM – AMELİYAT ÖNCESİ SÜREÇ, MOTİVASYONLAR ve BEKLENTİLER

Giriş:

1. Bana kendinizden ve bu ameliyata uzanan sürecinizden kısaca bahseder misiniz?

2. Ameliyat öncesi baskın duygu ve düşünceleriniz nelerdi?

Karar verme:

3. Bu ameliyatı olmaya nasıl karar verdiniz?

- Kararınızı etkileyen psikolojik, sosyal veya kültürel faktörler nelerdi?

4. Medyadaki ve toplumdaki "ideal beden" algısı karar sürecinizi nasıl etkiledi?

Beklentiler:

5. Gerçekleşen veya gerçekleşmeyen beklentileriniz oldu mu?

3. BÖLÜM – AMELİYAT GÜNÜ ve ERKEN DÖNEM DENEYİMLERİ

Ameliyat Günü:

6. Ameliyat günü ve hastanedeki ilk dönem sizin için nasıl geçti? (Fiziksel ve duygusal açıdan)

İlk Zamanlar:

7. Ameliyat sonrası ilk haftalar/aylarda fiziksel ve psikolojik olarak zorlandığınız noktalar nelerdi?

- Bu süreçte "İyi ki yaptırdım" veya "Keşke yaptırmasaydım" dediğiniz anlar oldu mu? Neden?

Sosyal Destek:

8. Aile, arkadaşlar ve sağlık ekibinden aldığınız destek sizin için nasıl bir etki yarattı?

9. Bu dönemde yalnız hissettiğiniz anlar oldu mu? Olduysa nasıldı?

BÖLÜM 4 – BEDEN ALGISI, KİMLİK ve BENLİK DENEYİMİ

Psikolojik Etkiler:

10. Ameliyatın sizin üzerinizdeki genel psikolojik etkileri neler oldu?

11. Bedeninizdeki değişimlere uyum sağlarken zorlandığınız dönemler oldu mu?

- Fazla deri, sarkmalar, yara izleri veya vücut şeklinizdeki değişiklikler sizi nasıl etkiliyor?

Yaşam Kalitesi:

12. Yaşam kalitenizde iyileşen ya da beklediğiniz kadar iyileşmeyen alanlar var mı?

Sosyal ve İlişkisel Değişimler:

13. Ameliyat sonrası sosyal yaşamınızda veya yakın ilişkilerinizde ne gibi değişiklikler oldu?

- İş, aile ve günlük yaşam aktiviteleriniz nasıl etkilendi?
- Sosyal ortamlarda davranışlarınızda değişiklik oldu mu?
- Kendinizi toplumsal rollerde (kadın/erkek, partner, ebeveyn, çalışan vb.) farklı hissetmeye başladınız mı?

BÖLÜM 5 – SOSYAL, TOPLUMSAL ve KÜLTÜREL DENEYİMLER

14. Türkiye'de kilolu bireylerin toplum tarafından nasıl algılandığını düşünüyorsunuz?

15. Kilonuz azaldıktan insanların size davranışlarında ne gibi değişiklikler gözlemlediniz?

- Kilo kaybınızdan sonra duyduğunuz ve aklınızda en çok yer eden cümle neydi?

16. Ameliyat sonrası toplumun "ideal beden" algısına bakışınız değişti mi?

BÖLÜM 6 – YEMEKLE İLİŞKİ, DUYGU DÜZENLEME ve KOPMALAR

17. Ameliyat öncesi yemek sizin için ne ifade ediyordu? (Yakıt, kaçış, ödül, teselli vb.)

18. Ameliyat sonrası yemekle ilişkiniz nasıl değişti?

- Yemekle ilgili yas, özlem, kayıp ya da suçluluk hissettiğiniz dönemler oldu mu?
- Yeme davranışında aşırı kontrol, 'yemeği özleme', kontrol kaybı gibi duygular yaşadınız mı?

19. Ameliyattan sonra başka alanlarda (alışveriş, spor, sosyal medya, ilişki arayışı vb.) aşırılıklara kaydığınız dönemler oldu mu?

BÖLÜM 7 – PSİKOLOJİK DANIŞMANLIK İHTİYAÇLARI

20. Ameliyat öncesinde psikolojik destek aldınız mı? Aldıysanız hangi konularda ve faydalı oldu mu? Almadıysanız hangi dönemde psikolojik desteğe en çok ihtiyaç duyduğunuzu hissettiniz?

21. Bu süreci yaşayan kişilere psikolojik destek almalarını önerir misiniz neden?

22. Psikolojik olarak en zorlandığınız konular nelerdi?

- Bu zorlandığınız dönemlerde aklınızda en çok dönen düşünce veya cümle neydi?

23. Bariyatrik cerrahiye özel hazırlanmış bir psikolojik destek programında hangi konular mutlaka yer almalı?

- Psikolojik danışmana ''Lütfen şu konuyu atlama'' diyeceğiniz önemli bir alan var mı?

BÖLÜM 8 – KAPANIŞ

24. Aynı süreci yaşayacak birine hangi önerileri vermek isterdiniz?

Geriye Bakış:

25. Sürecin başına dönseniz aynı kararı tekrar verir miydiniz? Neden?

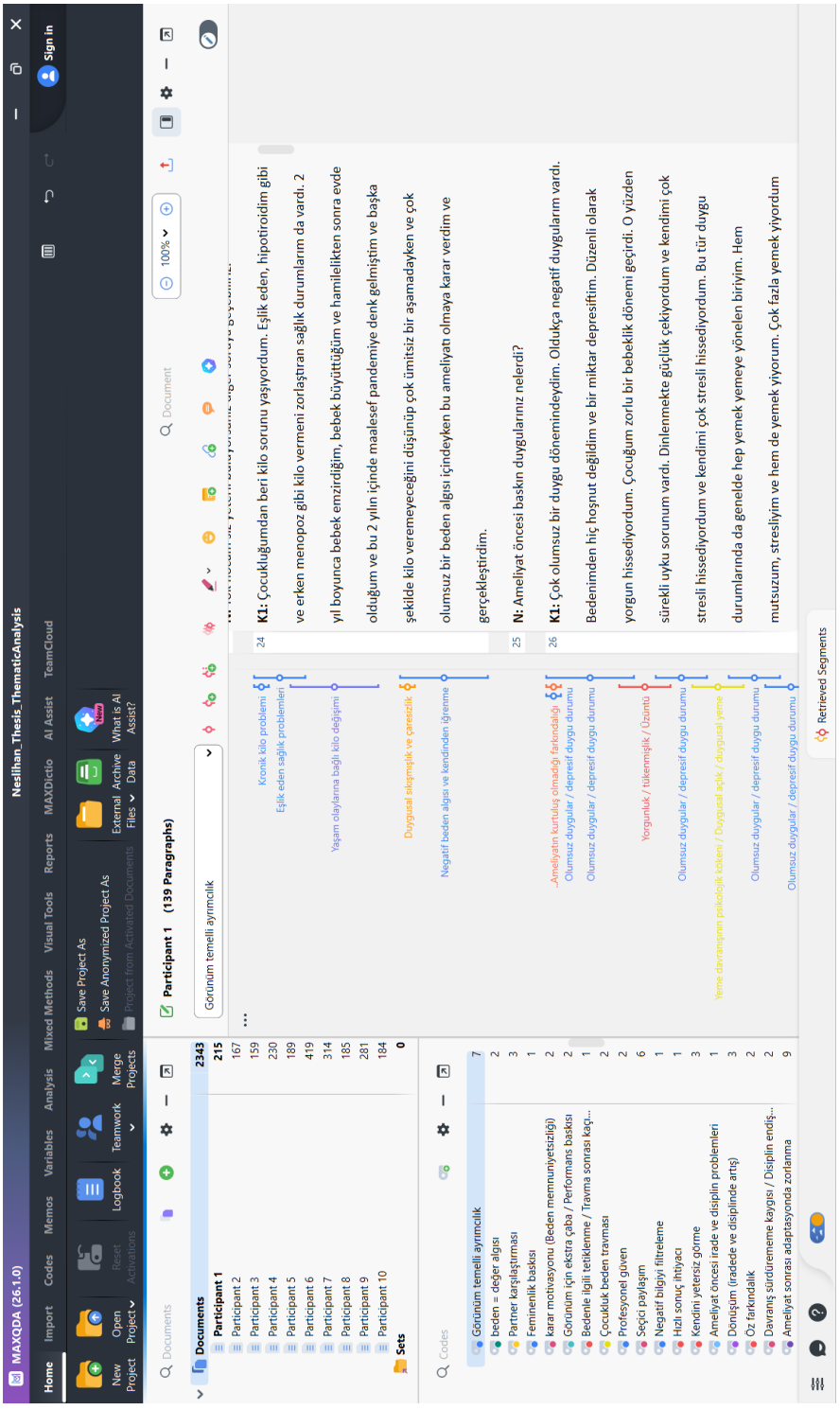
26. Geriye dönüp baktığınızda neleri farklı yapmak isterdiniz?

Özet:

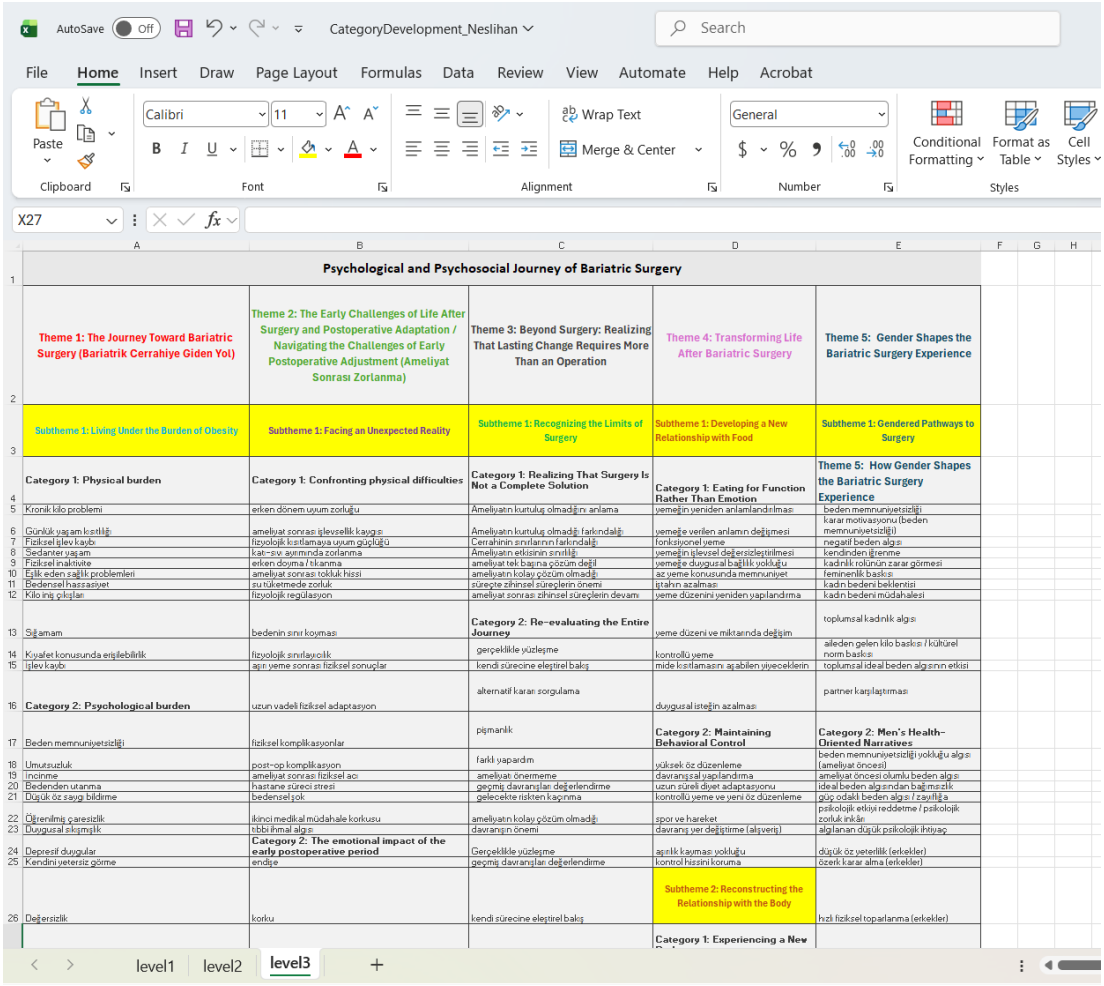
27. Bu yolculuğu tek kelimeyle özetlemeniz gerekse hangi kelimeyi seçerdiniz? Neden?

28. Paylaşmak istediğiniz başka bir şey var mı?

E. MAXQDA CODING SCREENSHOT



F. EXAMPLE OF CATEGORY DEVELOPMENT PROCESS



AutoSave Off | CategoryDevelopment_Neslihan | Search

File Home Insert Draw Page Layout Formulas Data Review View Automate Help Acrobat

Paste | Calibri 11 | Wrap Text | Merge & Center | General | Conditional Formatting | Format as Table | Cell Styles

Clipboard | Font | Alignment | Number | Styles

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	A	B	C	D	E
1	**Psychological and Psychosocial Journey of Bariatric Surgery**				
2	**Theme 1: The Journey Toward Bariatric Surgery (Bariatrik Cerrahiye Giden Yol)**	**Theme 2: The Early Challenges of Life After Surgery and Postoperative Adaptation / Navigating the Challenges of Early Postoperative Adjustment (Ameliyat Sonrası Zorlanma)**	**Theme 3: Beyond Surgery: Realizing That Lasting Change Requires More Than an Operation**	**Theme 4: Transforming Life After Bariatric Surgery**	**Theme 5: Gender Shapes the Bariatric Surgery Experience**
3	**Subtheme 1: Living Under the Burden of Obesity**	**Subtheme 1: Facing an Unexpected Reality**	**Subtheme 1: Recognizing the Limits of Surgery**	**Subtheme 1: Developing a New Relationship with Food**	**Subtheme 1: Gendered Pathways to Surgery**
4	**Category 1: Physical burden**	**Category 1: Confronting physical difficulties**	**Category 1: Realizing That Surgery Is Not a Complete Solution**	**Category 1: Eating for Function Rather Than Emotion**	**Theme 5: How Gender Shapes the Bariatric Surgery Experience**
5	Kronik kilo problemi	erken dönem uyum zorluğu	Ameliyatın kurtuluş olmadığını anlama	yemeğin yeniden anlamlandırılması	beden memnuniyetsizliği
6	Günlük yaşam kısıtlığı	ameliyat sonrası işlevsellik kaygısı	Ameliyatın kurtuluş olmadığı farkındalığı	yemeğe verilen anlamın değişmesi	karar motivasyonu (beden memnuniyetsizliği)
7	Fiziksel işlev kaybı	fizyolojik kısıtlamaya uyum güçlüğü	Cerrahinin sınırlarının farkındalığı	fonksiyonel yeme	negatif beden algısı
8	Sedanter yaşam	kat–sıvı ayrımında zorlanma	Ameliyatın etkisinin sınırlılığı	yemeğin işlevsel değersizleştirilmesi	kendinden iğrenme
9	Fiziksel inaktivite	erken doyma / tıkanma	ameliyat tek başına çözüm değil	yemeğe duygusal bağlılık yokluğu	kadınlık rolünün zarar görmesi
10	Eşlik eden sağlık problemleri	ameliyat sonrası tokluk hissi	ameliyatın kolay çözüm olmadığı	az yeme konusunda memnuniyet	feminenlik baskısı
11	Bedensel hassasiyet	su tüketmede zorluk	süreçte zihinsel süreçlerin önemi	iştahın azalması	kadın bedeni beklentisi
12	Kilo iniş çıkışları	fizyolojik regülasyon	ameliyat sonrası zihinsel süreçlerin devamı	yeme düzenini yeniden yapılandırma	kadın bedeni müdahalesi
13	Sığamam	bedenin sınır koyması	**Category 2: Re-evaluating the Entire Journey**	yeme düzeni ve miktarında değişim	toplumsal kadınlık algısı
14	Kıyafet konusunda erişilebilirlik	fizyolojik sınırlayıcılık	gerçeklikle yüzleşme	kontrollü yeme	aileden gelen kilo baskısı / kültürel norm baskısı
15	İşlev kaybı	aşırı yeme sonrası fiziksel sonuçlar	kendi sürecine eleştirel bakış	mide kısıtlamasını aşabilen yiyeceklerin	toplumsal ideal beden algısının etkisi
16	**Category 2: Psychological burden**	uzun vadeli fiziksel adaptasyon	alternatif kararı sorgulama	duygusal isteğin azalması	partner karşılaştırması
17	Beden memnuniyetsizliği	fiziksel komplikasyonlar	pişmanlık	**Category 2: Maintaining Behavioral Control**	**Category 2: Men's Health–Oriented Narratives**
18	Umutsuzluk	post–op komplikasyon	farklı yapardım	yüksek öz düzenleme	beden memnuniyetsizliği yokluğu algısı (ameliyat öncesi)
19	İncinme	ameliyat sonrası fiziksel acı	ameliyat önermeme	davranışsal yapılandırma	ameliyat öncesi olumlu beden algısı
20	Bedenden utanma	hastane süreci stresi	geçmiş davranışları değerlendirme	uzun süreli diyet adaptasyonu	ideal beden algısından bağımsızlık
21	Düşük öz saygı bildirme	bedensel şok	gelecekte riskten kaçınma	kontrollü yeme ve yeni öz düzenleme	güç odaklı beden algısı / zayıflığa
22	Öğrenilmiş çaresizlik	ikinci medikal müdahale korkusu	ameliyatın kolay çözüm olmadığı	spor ve hareket	psikolojik etkiyi reddetme / psikolojik zorluk inkârı
23	Duygusal sıkışmışlık	tıbbi ihmal algısı	davranışın önemi	davranış yer değiştirme (alışveriş)	algılanan düşük psikolojik ihtiyaç
24	Depresif duygular	**Category 2: The emotional impact of the early postoperative period**	Gerçeklikle yüzleşme	aşırılık kaygısı yokluğu	düşük öz yeterlilik (erkekler)
25	Kendini yetersiz görme	endişe	geçmiş davranışları değerlendirme	kontrol hissini koruma	özerk karar alma (erkekler)
26	Değersizlik	korku	kendi sürecine eleştirel bakış	**Subtheme 2: Reconstructing the Relationship with the Body**	hızlı fiziksel toparlanma (erkekler)
				Category 1: Experiencing a New	

level1 level2 level3 +

G. TURKISH SUMMARY / TÜRKÇE ÖZET

GİRİŞ

1.1. Çalışmanın Arka Planı

Bariatrik cerrahi, özellikle cerrahi dışı yöntemlerle yeterli ve kalıcı kilo kaybı sağlanamayan ağır obezitesi olan bireylerde giderek daha sık tercih edilen etkili bir tedavi yöntemidir (Nieves-Khouw vd., 2009; Sarwer vd., 2008). Cerrahinin yaygınlaşması, geleneksel kilo yönetimi yöntemlerinin bazı bireylerde uzun dönemde etkili olmamasıyla ilişkilendirilmektedir (Groven vd., 2015; Panteliou & Miras, 2017).

Obezite, genetik, fizyolojik, davranışsal, çevresel ve sosyal etmenlerin etkileşimi sonucunda gelişen çok boyutlu bir hastalıktır (Ranzenhofer vd., 2019). Obezite, kronik sağlık sorunları, psikolojik sıkıntılar, beden algısı sorunları, kilo damgalaması, ayrımcılık ve yaşam kalitesinde azalma ile ilişkilidir (Gregory vd., 2013; Sørensen vd., 2022; Tuthill vd., 2006;). Bu deneyimler bireylerin cerrahi kararı ile sağlık, görünüm, hareketlilik ve sosyal yaşama ilişkin beklentilerini etkileyebilmektedir.

Bariatrik cerrahi temel olarak ağır obezite ve obeziteye eşlik eden hastalıkların tedavisinde uygulanmaktadır. Bununla birlikte, bireyler cerrahiyi yalnızca fiziksel sağlıklarını iyileştirmek için değil görünüm, beden algısı, özgüven, yaşam kalitesi ve sosyal kabul gibi nedenlerle de tercih edebilmektedir (Keyte vd., 2024; Rajeev vd., 2023). Ancak yalnızca kilo vermek veya fiziksel görünümü iyileştirmek istemek cerrahi için yeterli değildir. Cerrahiye uygunluk, rehberler doğrultusunda yapılan kapsamlı klinik değerlendirme ile belirlenmektedir (Eisenberg vd., 2022).

Bariatrik cerrahi yalnızca kilo kaybı sağlayan bir tedavi değildir. Bariatrik cerrahi, bireylerin yeme davranışları, bedensel değişimler, beden algısı, kişilerarası ilişkiler ve benlik algısı gibi birçok alanda uyum sağlamalarını gerektiren fiziksel, davranışsal, psikolojik ve sosyal bir süreçtir (Greenberg, 2003). Ameliyat sonrasında sağlıkta ve

günlük işlevsellikte iyileşmeler görülürken, duygusal güçlükler, beden algısı sorunları ve aile ile sosyal ilişkilerde değişimler de yaşanabilmektedir (van Hout vd., 2009). Bu nedenle cerrahinin başarısı yalnızca kilo kaybı veya Beden Kitle İndeksi (BKİ) değişimi ile değerlendirilmemelidir.

Bu yaklaşım, tedavi sürecinin her aşamasında psikolojik değerlendirme ve psikososyal desteğin önemini ortaya koymaktadır. Psikolojik değerlendirme, bireylerin beklentilerini, davranış değişikliğine hazır oluşlarını, baş etme kaynaklarını, yeme ile ilişkili güçlüklerini, sosyal desteklerini ve ameliyat sonrası uyumu etkileyebilecek riskleri belirlemeye yardımcı olmaktadır (Glinski vd., 2001). Ayrıca tedavinin planlanmasına, bilinçli karar verilmesine ve bakımın sürekliliğinin sağlanmasına katkı sunmaktadır. Bu nedenle ameliyat sonrası deneyimlerin anlaşılması, yalnızca fiziksel sonuçların değil, psikolojik iyi oluşun, kimliğin, ilişkilerin ve günlük yaşama uyumun desteklenmesi açısından da önemlidir.

Araştırmalar, bariatrik cerrahinin yaşam kalitesini artırdığını; sağlık sorunları, hareket kabiliyeti, öz bakım, günlük yaşam aktiviteleri, ağrı, anksiyete ve depresyon belirtilerinde iyileşme sağlayabildiğini göstermektedir (Price vd., 2014). Bununla birlikte bariatrik cerrahi, bireylerin duygusal, sosyal ve davranışsal uyum sağlamasını gerektiren önemli bir psikolojik değişim sürecidir (Greenberg, 2003) ve fiziksel sağlık ile günlük yaşam üzerinde olumlu etkiler oluşturabilmektedir (van Hout vd., 2009).

Araştırmalar, bariatrik cerrahinin kilo kaybı, fiziksel sağlık ve yaşam süresi açısından en etkili tedavi yöntemlerinden biri olduğunu göstermektedir (Morton, 2013). Cerrahi sonrasında bireylerin fiziksel sağlıklarında ve psikososyal iyi oluşlarında iyileşmeler görülmekte; yeme bozukluğu belirtileri, depresyon düzeyi azalabilmekte, öz güven, benlik saygısı ve kontrol duygusu artabilmektedir (Hardman & Christiansen, 2018; Price vd., 2014).

Bariatrik cerrahi her bireyde aynı olumlu sonuçları sağlamamaktadır (Sarwer vd., 2008). Fazla deri oluşumu, malnütrisyon ve bağırsak problemleri gibi fiziksel komplikasyonların yanı sıra psikososyal güçlükler de görülebilmektedir (Groven vd., 2015; Sarwer vd., 2008). Bazı bireyler ameliyat sonrasında fiziksel ve psikolojik işlevsellikte olumsuz deneyimler yaşamakta, duygusal baş etme yöntemi olarak yeme

davranışını sürdürmeye devam edebilmektedir. Bu durum, cerrahinin altta yatan psikolojik sorunları tek başına çözmekte yetersiz kalabildiğini ve ruh sağlığını destekleyici ek müdahalelere ihtiyaç duyulduğunu göstermektedir (Coulman vd., 2017; Keyte vd., 2024; Morton, 2013).

Ayrıca bariatrik cerrahi geçiren bireylerde intihar, kendine zarar verme, alkol kullanımını ve yeme bozukluğu riskinin artabileceği bildirilmektedir (Hardman & Christiansen, 2018; Neovius, 2018). Buna karşın mevcut çalışmalar büyük ölçüde cerrahinin fiziksel sonuçlarına odaklanmış olup, ameliyat öncesi ve sonrası psikososyal sürecin anlaşılması uzun dönemli uyum açısından önem taşımaktadır (Glinski vd., 2001; Keyte vd., 2024). Ağır psikiyatrik belirtiler gösteren bireylerde ise cerrahi tamamen reddedilmemekte, psikolojik durum düzelene kadar ertelenebilmektedir (Glinski vd., 2001).

Obeziteye bağlı psikolojik sorunlar bariatrik cerrahi sonrasında azalabilse de, cerrahi bazı bireylerde altta yatan psikolojik sorunları tamamen ortadan kaldırmamaktadır. Bazı hastalarda düşük özgüven devam edebilmektedir (Hardman & Christiansen, 2018). Kilo kaybı ile beden algısı arasındaki ilişkiye ilişkin bulgular ise sınırlı ve tutarsızdır (De Panfilis vd., 2007; Ivezaj & Grilo, 2018; Leombruni vd., 2007). Ayrıca, sistematik derlemeler bariatrik cerrahinin uzun dönem psikolojik ve sosyal iyilik halini tek başına sürdüremediğini, bu nedenle psikolojik müdahalelerin ve uzun dönem izlemininin gerekli olduğunu göstermektedir (Al-Kadi & Al-Sulaim, 2024).

Bariatrik cerrahi adaylarında en sık görülen ruh sağlığı sorunları depresyon ve tıkınırcasına yeme bozukluğu olup, duygudurum bozuklukları, anksiyete bozuklukları, madde kullanım bozuklukları ve kişilik bozuklukları da yaygın olarak görülmektedir (Keyte vd., 2024; Sarwer vd., 2008). Bu psikolojik sorunlar cerrahi sürecini ve ameliyat sonrası iyileşmeyi etkileyebildiğinden, bazı bireylerde ameliyat öncesinde bireysel psikoterapi gerekebilmektedir (Glinski vd., 2001).

Bariatrik cerrahi, bireyin kimliğini, ruhsal durumunu, benlik algısını, kişilerarası ilişkilerini ve sosyal yaşama katılımını etkileyen dönüştürücü bir süreçtir. Bu nedenle ameliyat öncesi psikolojik değerlendirme, gerçekçi hedeflerin belirlenmesi ve uzun dönem psikososyal izlemin sağlanması başarılı uyum açısından önemlidir (Kubik vd.,

2013). Ameliyat sonrası sunulan psikososyal hizmetler bireylerin sürece uyumunu kolaylaştırmakta ve sosyal destek sağlamaktadır (Glinski vd., 2001). Ayrıca beklentilerin gerçekçi biçimde yönetilmesi ve işlevsel olmayan düşüncelerin ele alınması psikososyal desteğin temel bileşenleri arasında yer almaktadır (Cowan, 1998).

Bariatrik cerrahiye başvuran bireyler genellikle fazla kiloya bağlı sağlık sorunlarının tamamen ortadan kalkmasını, normal kiloya ulaşmayı ve yaşamlarının kısa sürede önemli ölçüde değişmesini beklemektedir (Cowan, 1998). Bu olumlu beklentilere rağmen inkâr, duygu ve dürtü düzenleme güçlükleri, somatizasyon, siyah-beyaz düşünme ve düşük benlik saygısı gibi psikolojik özellikler cerrahi sürecini zorlaştırabilmektedir (Glinski vd., 2001). Toplumsal damgalama, önceki başarısız kilo verme girişimleri, yaşam boyu vitamin desteği gereksinimi ve ameliyat sonrasındaki katı beslenme düzeni de bu süreci psikolojik açıdan zorlaştırmaktadır (Cowan, 1998; Greenberg, 2003; Groven vd., 2015). Bu nedenle bariatrik cerrahi sürecinde psikolojik hazırlık ve psikolojik danışma desteği büyük önem taşımaktadır (Glinski vd., 2001).

Bariatrik cerrahi, uzun dönemli davranış değişikliği gerektiren kısıtlayıcı bir tedavi yöntemidir (Snyder, 2009). Bu yüzden cerrahi öncesinde bireylerin kapsamlı psikolojik değerlendirmeden geçirilmesi, ameliyat öncesi ve sonrası psikososyal destek planlarının oluşturulması önem taşımaktadır (Glinski vd., 2001; Keyte vd., 2024). Ancak bariatrik cerrahi adaylarının psikososyal değerlendirilmesine ilişkin standart bir rehber bulunmamakta ve mevcut öneriler kesin bir çerçeve sunmamaktadır (Fabricatore vd., 2006).

Araştırmalar, ameliyat öncesi ve sonrası psikolojik destek gruplarının psikolojik iyi oluşu desteklediğini, kaygıyı azalttığını ve tedaviye uyumu artırdığını göstermektedir (Keyte vd., 2024). Bariatrik cerrahide sunulan psikolojik destek, bireylerin yaşadığı toplumsal damgalanma ve kültürel beden ideallerini de dikkate almalıdır.

Büyük bedenli bireyler sıklıkla kilo damgalaması, ideal beden normları ve toplumsal görünüş beklentileriyle karşılaşmaktadır. Bu deneyimler içselleştirilmiş utanç, düşük benlik saygısı ve ruh sağlığı sorunlarına yol açabilmektedir (Cowan, 1998; Feister, 2012). Ayrıca bariatrik cerrahi toplumda zaman zaman "kolay çözüm" veya "irade

eksikliğinin göstergesi" olarak değerlendirilebilmekte, bu damgalayıcı söylemler bireylerin beklentilerini ve ameliyat sonrasındaki psikososyal deneyimlerini etkileyebilmektedir (Cowan, 1998; Feister, 2012).

Bu araştırmada bariatrik cerrahi sürecindeki psikososyal deneyimleri açıklayabilmek amacıyla Feminist Kuram, Sosyal Karşılaştırma Kuramı ve Temel Psikolojik İhtiyaçlar Kuramı kuramsal çerçeve olarak kullanılmıştır. Bu kuramlar, beden algısı, kimliğin yeniden yapılandırılması ve psikolojik uyumun daha kapsamlı biçimde anlaşılmasına katkı sağlamaktadır (Deci & Ryan, 2000; Festinger, 1954; Groven vd., 2015).

Bariatrik cerrahinin fiziksel sonuçları yaygın olarak araştırılmış olmasına rağmen, ameliyat sonrası yaşanan deneyimler ve uzun dönem psikolojik etkiler sınırlı sayıda çalışmada ele alınmıştır. Bu nedenle özellikle kadın ve erkeklerin ameliyat sonrası deneyimlerini inceleyen nitel araştırmalara ihtiyaç duyulmaktadır (Groven vd., 2015). Türkiye'de de bariatrik cerrahinin duygusal ve sosyal etkilerini bireylerin deneyimleri üzerinden inceleyen nitel çalışmalar sınırlıdır. Bu araştırma, bariatrik cerrahi geçiren bireylerin psikolojik danışma gereksinimlerini, duygularını, baş etme süreçlerini, sosyal uyumlarını ve psikolojik deneyimlerini bütüncül ve kültürel açıdan duyarlı bir bakış açısıyla incelemeyi; ayrıca bariatrik cerrahi sürecinde psikolojik değerlendirme ve bakım uygulamalarının geliştirilmesine katkı sağlamayı amaçlamaktadır.

1.2. Araştımanın Amacı

Bu araştırmanın amacı, bariatrik cerrahi sürecinden geçen bireylerin psikolojik danışma gereksinimlerini ve psikososyal deneyimlerini incelemektir. Araştırmada, katılımcıların ameliyat öncesi ve sonrası süreçte yaşadıkları duygusal, psikolojik, kimlik ve sosyal değişimlerin nasıl ortaya çıktığı ve yaşamlarını nasıl etkilediği ele alınmaktadır. Ayrıca bariatrik cerrahinin yalnızca fiziksel sonuçlarına değil, psikolojik, sosyal ve toplumsal boyutlarına da odaklanılarak obezite, beden algısı, beden memnuniyetsizliği ve sağlık hizmetlerine ilişkin daha bütüncül bir bakış açısı sunulması amaçlanmaktadır.

Bariatrik cerrahi sürecinde multidisipliner bakım ve psikolojik değerlendirmenin önemi uzun süredir vurgulanmasına rağmen (Choban vd., 2002; Sarwer vd., 2008), psikolojik değerlendirmenin içeriğine ilişkin standart ve açık rehberler henüz

bulunmamaktadır (Snyder, 2009). Bu nedenle araştırma, bireylerin bariatrik cerrahi sürecindeki yaşantılarını anlamaya ve psikolojik danışma gereksinimlerini belirlemeye odaklanmaktadır.

Türkiye'de bariatrik cerrahi geçiren bireylerin psikososyal deneyimlerini inceleyen çalışmalar sınırlıdır. Son yıllarda yapılan bazı araştırmalar ameliyat sonrası deneyimlere odaklanmış olsa da (Usta vd., 2025), ameliyat öncesi ve sonrası süreci birlikte ele alan psikososyal deneyimler ve psikolojik danışma gereksinimleri yeterince araştırılmamıştır. Bu doğrultuda araştırmanın, Türkiye'nin kültürel ve sağlık hizmetleri bağlamında bariatrik cerrahi sürecindeki psikososyal deneyimlere ve psikolojik danışma gereksinimlerine ilişkin alanyazına katkı sağlaması amaçlanmaktadır.

1.3. Araştırma Soruları

Bu araştırmada aşağıdaki sorulara yanıt aranmıştır:

1. Kadınlar ve erkekler bariatrik cerrahi öncesi ve sonrası deneyimlerini nasıl tanımlamaktadır?
2. Katılımcılar bu süreçte hangi psikolojik, sosyal, duygusal ve bedensel değişimleri yaşamaktadır?
3. Katılımcılar bariatrik cerrahi öncesi ve sonrasında hangi psikolojik danışma gereksinimlerini tanımlamaktadır?

1.4. Çalışmanın Önemi

Bu araştırma, bariatrik cerrahinin yalnızca tıbbi bir girişim değil, aynı zamanda önemli bir psikolojik ve sosyal değişim süreci olduğunu ortaya koyması bakımından önem taşımaktadır. Bariatrik cerrahiye ilişkin mevcut çalışmalar büyük ölçüde fiziksel ve tıbbi sonuçlara odaklanırken, bireylerin ameliyat öncesi ve sonrası yaşadıkları duygusal, kimlik, kişilerarası ilişki ve psikososyal değişimler daha sınırlı düzeyde incelenmiştir (Keyte vd., 2024; Kubik vd., 2013). Özellikle Türkiye'de bu sürece ilişkin psikososyal deneyimleri ele alan çalışmaların yetersiz olması nedeniyle araştırmanın alanyazındaki bu boşluğa katkı sağlaması amaçlanmaktadır.

Bariatrik cerrahiye hazırlanan bireylerin psikososyal ve psikolojik danışma gereksinimlerinin belirlenmesi önemlidir. Cerrahiye uyum yalnızca ameliyatın tıbbi başarısına değil, bireylerin beklentilerini, motivasyonlarını, beden algılarını, yeme davranışlarını, baş etme kaynaklarını ve sosyal desteklerini değerlendirebilmelerine de bağlıdır. Bu gereksinimlerin belirlenmesi, gerçekçi beklentilerin geliştirilmesine, tedaviye aktif katılımın desteklenmesine ve uzun dönem psikososyal uyumun güçlendirilmesine katkı sağlayabilir.

Araştırma ayrıca ameliyat sonrasında bireylerin kimlik yeniden yapılanması, bedensel değişim, değişen yeme davranışları ve sosyal uyum süreçlerine ilişkin deneyimlerini katılımcıların bakış açısından ortaya koymaktadır (Keyte vd., 2024). Bu yönüyle ameliyat öncesi ve sonrası sunulacak psikolojik destek hizmetlerinin geliştirilmesine katkı sağlaması ve Türkiye'de bariatrik cerrahi alanındaki psikolojik danışma alanyazınını güçlendirmesi beklenmektedir.

Bunun yanında kilo damgalaması, ayrımcılık ve toplumsal cinsiyete dayalı beden beklentileri, bireylerin bariatrik cerrahi deneyimlerini önemli ölçüde etkilemektedir (Cowan, 1998; Greenberg, 2003 Toplumsal yargılar, kilo damgalaması ve kültürel beden idealleri, bireylerin beden algısını, benlik saygısını ve psikolojik uyumunu etkileyebilmektedir (Cash, 2004; Groven vd., 2015; Grogan, 2022). Bu etmenlerin anlaşılması, ameliyat öncesi ve sonrası yaşanan güçlüklerin daha doğru değerlendirilmesine ve daha kapsayıcı psikolojik müdahalelerin geliştirilmesine katkı sağlayacaktır.

Son olarak, araştırma bariatrik cerrahi sürecindeki psikososyal deneyimleri ve psikolojik danışma gereksinimlerini kültürel açıdan duyarlı ve birey merkezli bir bakış açısıyla ele almaktadır. Elde edilen bulguların ameliyat öncesi psikososyal değerlendirmelerin, ameliyat sonrası psikolojik danışma ve psikoeğitim uygulamalarının geliştirilmesine katkı sağlaması; ayrıca multidisipliner bariatrik bakım ekiplerine bireylerin psikolojik gereksinimleri konusunda yol göstererek daha kapsamlı ve hasta merkezli bakımın desteklenmesine katkıda bulunması beklenmektedir.

2. YÖNTEM

2.1. Araştırma Tasarımı

Bu araştırma, bariatrik cerrahi sürecinden geçen bireylerin ameliyat öncesi ve sonrası psikososyal deneyimlerini ve psikolojik danışma gereksinimlerini incelemek amacıyla nitel betimsel araştırma desenine göre yürütülmüştür (Sandelowski, 2000). Araştırmada katılımcıların ameliyat öncesi ve sonrası deneyimleri ile süreçte yaşadıkları psikolojik, duygusal, sosyal ve bedensel değişimler incelenmiştir.

Katılımcıların deneyimlerini kendi bakış açılarından ortaya koyabilmek amacıyla tümevarımsal nitel içerik analizi kullanılmıştır (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). Kodlar, kategoriler ve temalar görüşme verilerinden türetilmiş, kuramsal çerçeveler ise yalnızca bulguların yorumlanması aşamasında kullanılmıştır.

2.2. Katılımcılar

Araştırmaya bariatrik cerrahi geçirmiş 10 birey katılmıştır. Katılımcılar amaçlı ölçüt örnekleme ve kartopu örnekleme yöntemleriyle belirlenmiştir (Palinkas vd., 2015). Araştırmaya görüşmeden 1 ila 8 yıl önce bariatrik cerrahi geçirmiş bireyler dahil edilerek ameliyat sonrası farklı dönemlerde yaşanan psikososyal deneyimler ve psikolojik danışma gereksinimleri incelenmiştir (Palinkas vd., 2015; Sarwer vd., 2008).

Araştırmaya dahil edilme ölçütleri aşağıdaki şekilde belirlenmiştir:

1. 18 yaşından büyük olmak.
2. Görüşmeden 1 ila 8 yıl önce bariatrik cerrahi geçirmiş olmak.
3. Psikolojik, duygusal ve bedensel deneyimlerini paylaşmaya gönüllü olmak.

Araştırmaya dahil edilmeme ölçütleri aşağıdaki şekilde belirlenmiştir:

1. 18 yaşın altında olmak.
2. Görüşmeden 1 yıldan daha kısa süre önce veya 8 yıldan daha uzun süre önce bariatrik cerrahi geçirmiş olmak.

3. Görüşmeye katılmak veya bariatrik cerrahi sürecine ilişkin kişisel deneyimlerini paylaşmak istememek ya da bunu yapamayacak durumda olmak.

Veriler, katılımcılarla gerçekleştirilen yarı yapılandırılmış yüz yüze ve çevrim içi görüşmeler yoluyla toplanmış, ses kayıtları yazıya aktarıldıktan sonra tümevarımsal nitel içerik analizi ile analiz edilmiştir (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). Katılımcıların gizliliğini koruyabilecek bilgiler bulgulardan çıkarılmış ve yalnızca genel özelliklerine yer verilmiştir.

2.3. Veri Toplama Aracı

Veriler, araştırmacı tarafından geliştirilen "Bariatrik Cerrahi Sürecinde Psikososyal Deneyimler ve Psikolojik Danışma İhtiyaçları" başlıklı yarı yapılandırılmış görüşme formu aracılığıyla toplanmıştır. Görüşme soruları alanyazın doğrultusunda hazırlanmış; uzman görüşü, pilot görüşme ve bilişsel görüşmeler doğrultusunda düzenlenmiştir (Kallio vd., 2016; Willis & Artino, 2013). Son görüşme formu; demografik bilgiler, ameliyat öncesi ve sonrası deneyimler, beden algısı ve kimlik, sosyal ilişkiler, yeme davranışları, psikolojik danışma gereksinimleri ve değerlendirme olmak üzere sekiz bölümden oluşmaktadır.

Görüşmeler yarı yapılandırılmış olarak yürütülmüş, gerektiğinde derinleştirici sorular yöneltilmiştir. Tüm görüşmeler Türkçe gerçekleştirilmiş, katılımcılardan sözlü onam alınmış ve araştırma etik kurul onayı doğrultusunda yürütülmüştür.

2.4. Veri Toplama Süreci

Veri toplama süreci öncesinde Orta Doğu Teknik Üniversitesi İnsan Araştırmaları Etik Kurulundan (080-ODTÜİAEK-2026) etik onay alınmıştır. Katılımcılar bariatrik cerrahi klinikleri, hastaneler ve sosyal medya platformları aracılığıyla araştırmaya davet edilmiş, araştırmanın amacı ve süreci hakkında bilgilendirilmiş ve gönüllü onam formu alınmıştır. Görüşmeler katılımcıların tercihleri doğrultusunda çevrim içi görüntülü görüşmeyle gerçekleştirilmiş ve ses kayıtları yazıya aktarılmıştır. Toplam görüşme süresi 538 dakika olup görüşmeler ortalama 50 dakika sürmüş; en kısa görüşme 36 dakika, en uzun görüşme ise 86 dakika olarak gerçekleşmiştir. Veri toplama süreci, araştırma amaçlarını karşılayacak yeterli veri elde edilinceye kadar

sürdürülmüş ve veri yeterliliği süreç boyunca değerlendirilmiştir (Saunders vd., 2018). Katılımcı gizliliğini korumak amacıyla tüm veriler anonimleştirilmiş ve katılımcılar P1, P2 gibi kodlarla raporlanmıştır.

2.5. Veri Analizi

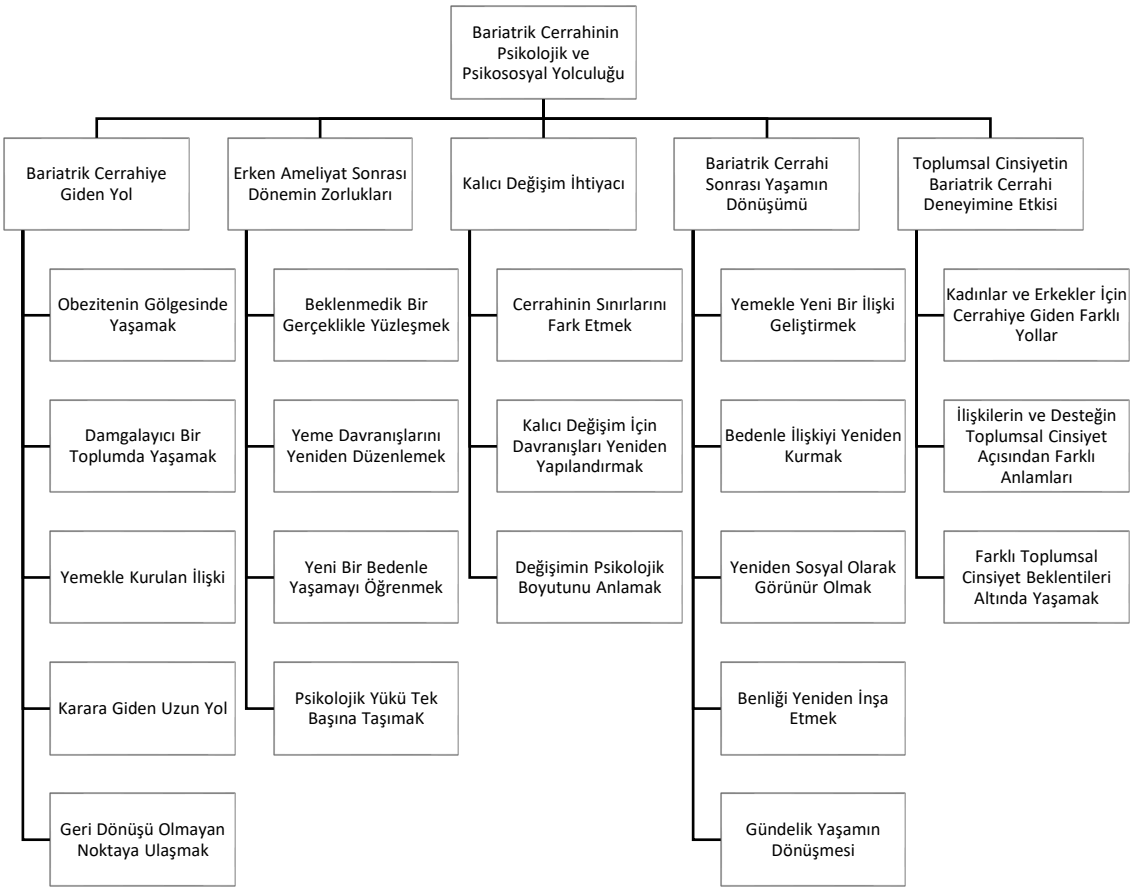
Veriler, katılımcı deneyimlerine dayalı kod, kategori ve temaların sistematik biçimde ortaya çıkarılmasını sağlayan tümevarımsal nitel içerik analizi yöntemiyle analiz edilmiştir (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Analiz sürecinde görüşmeler yazıya aktarıldıktan sonra tekrar tekrar okunarak açık kodlama yapılmış ve kodlar MAXQDA 2022 programı kullanılarak oluşturulmuştur. Benzer kodlar alt kategoriler ve kategoriler altında bir araya getirilmiş, ardından soyutlama yoluyla temalar oluşturulmuştur (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). Analiz süreci boyunca kodlar, kategoriler ve temalar özgün görüşme kayıtlarıyla karşılaştırılarak gözden geçirilmiş; elde edilen bulgular tez danışmanlarıyla düzenli olarak değerlendirilmiş ve gerekli düzenlemeler yapılmıştır. Bulgular, katılımcı ifadelerinden seçilen doğrudan alıntılarla desteklenerek sunulmuştur.

2.6. Araştırmanın Sınırlılıkları

Bu araştırmanın bazı sınırlılıkları bulunmaktadır. Araştırmanın ele aldığı obezite, kilo damgalanması ve ayrımcılık gibi hassas konular nedeniyle bazı bireyler araştırmaya katılmak istememiş veya katılmaya çekinmiş olabilir. Ayrıca, görüşmeye katılan bazı bireyler de kişisel deneyimlerini aktarırken sosyal olarak kabul gören yanıtlar vermeyi tercih etmiş ya da bazı deneyimlerini paylaşmaktan kaçınmış olabilir. Ayrıca, örneklemde yaş, cinsiyet, sosyoekonomik durum, eğitim düzeyi ve ameliyat sonrası deneyimler açısından çeşitlilik sağlanmaya çalışılmış olsa da bazı bakış açıları yeterince temsil edilememiş olabilir. Katılımcıların ameliyat sonrası farklı dönemlerde görüşülmesi, sürece ilişkin farklı deneyimlerin incelenmesini sağlamış olmakla birlikte, kesitsel araştırma deseni aynı bireylerde zaman içerisindeki değişimin izlenmesine olanak vermemiştir. Son olarak, analiz sürecinde araştırmacının olası etkisini azaltmak amacıyla kodlar ve temalar tez danışmanlarıyla düzenli olarak değerlendirilmiş olsa da bulguların yorumlanmasında araştırmacının bakış açısının etkisi tamamen ortadan kaldırılamamıştır.

4. BULGULAR

Verilerin tümevarımsal nitel içerik analizi sonucunda; *(1) Bariatrik Cerrahiye Giden Yol, (2) Erken Ameliyat Sonrası Dönemin Zorlukları, (3) Kalıcı Değişim Gerekliliği, (4) Bariatrik Cerrahi Sonrası Yaşamın Dönüşümü ve (5) Bariatrik Cerrahi Deneyiminde Toplumsal Cinsiyetin Rolü* olmak üzere beş ana tema belirlenmiştir. Bu temalar altında katılımcıların ortak deneyimlerini yansıtan alt temalar ve kategoriler oluşturulmuştur. Bulgular, katılımcıların doğrudan alıntılarıyla desteklenerek sunulmuştur. Araştırmada elde edilen tematik yapının genel görünümü Şekil 4.1'de gösterilmektedir.



Şekil 4.1. **Bulguların akış şeması: temalar ve alt temalar**

4.1. Tema 1. Bariatrik Cerrahiye Giden Yol

Katılımcılar bariatrik cerrahiye karar verme sürecini tek bir olaydan ziyade, yıllar içinde şekillenen uzun ve çok boyutlu bir yolculuk olarak tanımlamışlardır. Bu süreç, obezitenin fiziksel ve psikolojik yükü, toplumsal damgalama, yemekle kurulan ilişki, tekrarlayan başarısız kilo verme girişimleri ve çevresel etkenlerin bir araya gelmesiyle şekillenmiştir.

4.1.1. Obezitenin Gölgesinde Yaşamak

Katılımcılar, obezitenin yalnızca fazla kilo anlamına gelmediğini; fiziksel, psikolojik ve sosyal yaşamlarını uzun yıllar boyunca etkileyen çok yönlü bir yük olduğunu belirtmişlerdir. Fiziksel hareket kısıtlılığı, kronik sağlık sorunları, olumsuz beden algısı ve günlük yaşam rollerini yerine getirmede yaşanan güçlükler, cerrahi kararını etkileyen temel nedenler arasında yer almıştır. Katılımcılar, bu yükün çocukluk yıllarından itibaren birikerek yaşamlarının birçok alanını etkilediğini ifade etmişlerdir.

> Hem psikolojik danışman olarak hem de yetişkin bir kadın olarak düşündüğümde, beden algım hep olumsuzdu ve temelleri çoğunlukla çocukluğumdaki tecrübelerime de dayanıyordu diye düşünüyorum. Çünkü ben bebekliğimde dâhil, çocukluğumda, ergenliğimde, genç kızlığımda ve yetişkinliğimde her zaman normal kilonun üstünde bir kişiydim. Yani hiçbir zaman ideal bir kiloda değildim. Bu konuyla barışık olduğum bir dönem hayatımda hiç olmadı. Her zaman o kiloyu vermem gerektiği, ancak ondan sonra normal bir insan olabileceğime dair bir düşüncem vardı. O yüzden de bu ameliyata karar verdiğimde, çok yüksek kiloya ulaştığım dönemin öncesinde de hep o düşünceler vardı. Arka alanımda çocukluğumdan beri gelen böyle bir düşünce ve onun beraberinde getirdiği olumsuz beden algısına dair olumsuz duygular vardı. Çünkü kendimi aynada beğenmiyordum. *(P1)*

4.1.2. Damgalayıcı Bir Toplumda Yaşamak

Katılımcılar, obezite nedeniyle aile, iş ve sosyal yaşamda damgalanma, yargılanma ve dışlanma yaşadıklarını ifade etmişlerdir. Zamanla bu tutumları içselleştirdiklerini; zayıflığı güzellik, başarı ve kabul görmeyle, fazla kiloyu ise başarısızlık ve

mutsuzlukla özdeşleştirdiklerini belirtmişlerdir. Bu süreç, benlik algılarını olumsuz etkileyerek cerrahi kararını güçlendiren önemli etkenlerden biri olmuştur.

> Mesela bir veli geliyor diyelim ki sizin sıra dışı bir saç renginiz yoksa, adımı da bilmiyorsa ne diyecek? "Şişman olan öğretmen." Bu şekilde tanımlıyor. Yani şimdi ya adımı gerçekten öğrenmeyi önemsiyor ya da başka türlü adlandırıyor. Ama "şişman öğretmen" sınıfından çıkmış olmayı önemli buluyorum. İş görüşmelerinde de aynı şekilde; dış görünüşte genç görünmek, daha dinamik görünmek, daha güzel görünmek önemli. *(P7)*

4.1.3. Yemekle Kurulan İlişki

Katılımcılar, yemeğin yalnızca fiziksel açlığı gidermek için değil; duygularını düzenlemek, rahatlamak, kendilerini ödüllendirmek ve yaşadıkları duygusal boşlukla baş etmek için de kullandıklarını ifade etmişlerdir. Cerrahi öncesinde birçok katılımcı, yeme davranışlarının altında psikolojik nedenlerin bulunduğunu fark ettiklerini ve obezitenin yalnızca beslenmeyle açıklanamayacağını belirtmiştir.

> Benimki beslenmek değildi. Benimki başka bir şeydi. Yediklerimi düşündüğümde... Bu başka bir şeydi. Gerçekten bir boşluğun kapanması için. Benim kilomun ya da kilo verememin, yani kilolu hâlimin devam etmesinin sebebi kesinlikle oydu. Artık yemekten ne umuyorsam ya da yemek bana ne hissettiriyorsa, o yüzden olmuş. *(P7)*

4.1.4. Karara Giden Uzun Yol

Katılımcılar, bariatrik cerrahi kararının ani değil, yıllar süren başarısız kilo verme girişimleri, fiziksel ve psikolojik yıpranma ile şekillenen uzun bir süreç sonunda alındığını ifade etmişlerdir. Diyet, egzersiz, beslenme danışmanlığı ve farklı kilo verme yöntemlerine rağmen kalıcı sonuç elde edememeleri umutsuzluk duygularını artırmıştır. Ayrıca aile üyeleri, sağlık profesyonelleri ve çevrenin etkisi karar sürecini şekillendirirken, birçok katılımcı ameliyat öncesinde korku, kararsızlık ve anlaşılmama duyguları yaşadığını belirtmiştir.

“Ben hayatım boyunca kilo vermeye çalışmışım ama verememiş ve artık bunu kabul edip bununla yaşayan bir çocuktum.’’ *(P2)*

4.1.5. Geri Dönüşü Olmayan Noktaya Ulaşmak

Katılımcılar, zamanla cerrahiyi son çare olarak görmeye başladıklarını ve bazı dönüm noktalarının ameliyat kararını hızlandırdığını ifade etmişlerdir. Ameliyat öncesinde daha sağlıklı bir yaşam sürme ve kilo verme umudu taşırken, aynı zamanda psikolojik destek ve süreç hakkında daha fazla bilgilendirilmeye ihtiyaç duyduklarını belirtmişlerdir. Cerrahiye giriş sürecinde ise korku, umut ve heyecan gibi farklı duyguları bir arada yaşadıklarını dile getirmişlerdir.

"Tek çözümün o olduğunu düşünüyordum. O yüzden karar verdim. Ameliyat en son, çıkıştaki son kapı..." *(P5)*

4.2. Tema 2. Erken Ameliyat Sonrası Dönemin Zorlukları

Katılımcılar, ameliyat sonrası ilk dönemi beklediklerinden daha zor geçen, fiziksel, duygusal ve psikolojik uyum gerektiren bir süreç olarak tanımlamışlardır. Bu tema; beklenmedik bir gerçeklikle yüzleşme, yeni bedene uyum sağlama, yeme davranışlarını yeniden düzenleme ve psikolojik güçlüklerle baş etme deneyimlerini kapsamaktadır.

4.2.1. Beklenmedik Bir Gerçeklikle Yüzleşmek

Katılımcılar, ameliyat sonrası ilk dönemin beklediklerinden çok daha zor geçtiğini ifade etmişlerdir. Bu süreçte yoğun fiziksel ağrı, yorgunluk, komplikasyonlar ve yeni bedene uyum sağlama güçlüğünün yanı sıra korku, pişmanlık, belirsizlik ve yalnızlık gibi duygular yaşadıklarını belirtmişlerdir.

"Ameliyattan hemen sonra, 'Ne gerek vardı? Durduk yere boğazımı tutsaydım da burada yatmasaydım,' diye düşündüm." *(P10)*

4.2.2. Yeme Davranışlarını Yeniden Düzenlemek

Katılımcılar yeme davranışlarını tamamen yeniden düzenlemek zorunda kaldıklarını ifade etmişlerdir. Yeni beslenme kurallarına uyum sağlamanın zorlayıcı olduğunu, fiziksel olarak daha az yiyebilmelerine rağmen iştahlarının ve yeme isteğinin devam ettiğini belirtmişlerdir.

“Böyle bir yerde miden yokmuş gibi hissediyorsun. Gözün doymuyor. Vücudum zayıf ama beynim hâlâ obez. Yemek söylüyorum, porsiyon geliyor ama içimden iki porsiyon yemek geçiyor.” *(P10)*

4.2.3. Yeni Bir Bedenle Yaşamayı Öğrenmek

Katılımcılar, kilo vermelerine rağmen yeni bedenlerine ve değişen görünümlerine uyum sağlamanın zaman aldığını ifade etmişlerdir. Bazıları bedenlerine yabancılaştıklarını, bazıları ise deri sarkmaları ve beden algısıyla ilgili kaygılar yaşadıklarını belirtmiştir. Birçok katılımcı için fiziksel değişime psikolojik uyum, kilo kaybından daha uzun süren bir süreç olmuştur.

> Psikolojik olarak kendine sürekli soru soruyorsun. Bu kadar hızlı gidiyor ama bedenin bunu kabullenmiyor. Sonra bazen duygusallaşıyorsun. Ne yapacağını bilemiyorsun. Bence bedenin o an buna adapte olamadığı için böyle oluyor. *(P3)*

4.2.4. Psikolojik Yükü Tek Başına Taşımak

Katılımcılar, ameliyat sonrasında psikolojik destek, psikoeğitim ve uzun dönemli takip hizmetlerinin yetersiz olduğunu ifade etmişlerdir. Bu nedenle birçok katılımcı, yaşadığı psikolojik güçlüklerle tek başına baş etmeye çalıştığını, bazı duygularını çevresiyle paylaşamadığını ve ameliyat sonrasında da görünüşlerine yönelik yorumlarla karşılaşmaya devam ettiklerini belirtmiştir.

> Psikolojik bir şey kafamı kurcaladığında ilk diyetisyenime yazıyordum. Çünkü bu konuda aldığım bir destek yoktu. Aslında onun da alanı olmayan şeylerdi ama iki kere dedim ki keşke bu süreçte bir psikolojik danışmanımız olsaydı. Fazla yediğimi düşündüğümde, kusmalarımda ve oluşturduğum beslenme bozukluğunda kesinlikle bir destek isterdim. *(P2)*

4.3. Tema 3. Kalıcı Değişim İhtiyacı

Katılımcılar, zamanla bariatrik cerrahinin tek başına kalıcı kilo kaybı sağlamaya yetmediğini fark ettiklerini ifade etmişlerdir. Kalıcı değişimin sürdürülebilmesi için davranışların değiştirilmesi, yeni alışkanlıklar geliştirilmesi ve obezitenin psikolojik boyutunun ele alınması gerektiğini vurgulamışlardır.

4.3.1. Cerrahinin Sınırlarını Fark Etmek

Katılımcılar, zamanla bariatrik cerrahinin obeziteyi tek başına çözen bir yöntem olmadığını fark ettiklerini ifade etmişlerdir. Ayrıca birçok katılımcı, süreçlerini geriye dönüp değerlendirdiklerinde daha fazla destek alsalardı bazı hataları yapmayacaklarını belirtmiştir.

"Ameliyat oldum, kurtuldum değil. Bir yaşam biçimini değiştirmen gerekiyor. Kiloda kalmak ve zayıf olarak hayata devam etmek istiyorsan bu yine senin elinde. Ameliyat sihirli değnek değildi benim için." *(P6)*

4.3.2. Kalıcı Değişim İçin Davranışları Yeniden Yapılandırmak

Katılımcılar, kalıcı kilo kontrolünün yeni alışkanlıklar geliştirmeyi, sağlıklı yaşam davranışlarını sürdürmeyi ve değişim sürecinin sorumluluğunu üstlenmeyi gerektirdiğini ifade etmişlerdir. Uzun dönem başarının ameliyattan çok bireyin kendi çabasına bağlı olduğunu vurgulamışlardır.

"Süreç tamamen kafada biten bir süreç. Kendinizi ona göre yönetmeniz gerekiyor. Eğer yönetemezseniz ameliyatın hiçbir faydası yok. Ameliyat sadece başlangıcı yapıyor, sonunu siz getiriyorsunuz." *(P8)*

4.4. Tema 4. Bariatrik Cerrahi Sonrası Yaşamın Dönüşümü

Katılımcılar ameliyat sonrasında yaşadıkları değişimin yalnızca kilo kaybıyla sınırlı olmadığını; yemekle ilişkilerinden beden algılarına, sosyal yaşamlarından benlik algılarına kadar birçok alanda dönüşüm yaşadıklarını ifade etmişlerdir.

4.4.1. Yemekle Yeni Bir İlişki Geliştirmek

Katılımcılar ameliyat sonrasında yemekle kurdukları ilişkinin değiştiğini ve yemeğin artık duygusal bir ihtiyaçtan çok sağlıklı yaşamın bir parçası hâline geldiğini ifade etmişlerdir. Aynı zamanda daha bilinçli beslenme alışkanlıkları geliştirdiklerini belirtmişlerdir.

"Ameliyattan önce yemek için yaşayan bir insandım. Ameliyattan sonra yaşamak için yemeye başladım." *(P5)*

4.4.2. Bedenle İlişkiyi Yeniden Kurmak

Katılımcılar, kilo kaybıyla birlikte bedenlerini yeniden tanımaya başladıklarını ve bedenlerinden daha fazla memnuniyet duyduklarını ifade etmişlerdir. Fiziksel hareketlerdeki kolaylık ve bedenlerine yönelik olumlu algı, günlük yaşamlarını da olumlu yönde etkilemiştir.

“Hayal ettiğim bir beden vardı ve ben o bedene indim.” *(P6)*

4.4.3. Yeniden Sosyal Olarak Görünür Olmak

Katılımcılar kilo verdikten sonra çevrelerinden daha olumlu geri bildirimler aldıklarını, sosyal ortamlarda daha görünür hissettiklerini ve daha aktif bir sosyal yaşama katıldıklarını ifade etmişlerdir. Bazıları ise kendi deneyimlerinden yola çıkarak benzer süreçte olan kişilere destek olduklarını belirtmiştir.

“Eskiden kendimi beğenmediğim zaman dışarı çıkmak istemiyordum. Ama şimdi ilk defa gideceğim bir yere bile hiç çekinmeden girebiliyorum. Artık hayatın içinde daha fazla varım. Bu beni çok mutlu ediyor’’ (P7)

4.4.4. Benliği Yeniden İnşa Etmek

Katılımcılar kilo verdikten sonra çevrelerinden daha olumlu geri bildirimler aldıklarını, sosyal ortamlarda daha görünür hissettiklerini ve daha aktif bir sosyal yaşama katıldıklarını ifade etmişlerdir. Bazıları ise kendi deneyimlerinden yola çıkarak benzer süreçte olan kişilere destek olduklarını belirtmiştir.

“Ameliyattan sonra kendimi daha kadın gibi hissetmeye başladım. Kendime bakmaya başladım. Fiziksel güzelliğimde eksik gördüğüm şeyleri karakterimle kapatmaya çalışıyordum. Artık beni isteyen beni olduğum gibi sevsin diye düşünüyorum.’’ *(P5)*

4.4.5. Gündelik Yaşamın Dönüşmesi

Katılımcılar ameliyat sonrasında günlük yaşam aktivitelerini daha rahat yerine getirebildiklerini, aile ve iş yaşamında daha aktif rol alabildiklerini ve kendilerini daha özgür hissettiklerini ifade etmişlerdir. Fiziksel iyilik hâlindeki artışın yaşam kalitelerini belirgin biçimde yükselttiğini belirtmişlerdir.

“Eskiden küçük sandalyelere otururken hep kaygılanırdım. Şimdi böyle bir kaygım kalmadı. Koşabiliyorum, merdiven çıkabiliyorum ve nefesimin ne kadar rahatladığını hissediyorum.’’ (P7)

4.5. Tema 5. Toplumsal Cinsiyetin Bariatrik Cerrahi Deneyimine Etkisi

Katılımcıların paylaşımları, toplumsal cinsiyetin bariatrik cerrahi sürecinin tüm aşamalarını etkilediğini göstermiştir. Kadın ve erkek katılımcılar; ameliyat kararı, sosyal ilişkiler, destek mekanizmaları ve ameliyat sonrasındaki deneyimlerini farklı şekillerde anlamlandırmışlardır.

4.5.1. Kadınlar ve Erkekler İçin Cerrahiye Giden Farklı Yollar

Kadın katılımcılar ameliyat kararını daha çok beden görünümü, kadınlık rolleri ve toplumsal beklentilerle ilişkilendirirken; erkek katılımcılar sağlık sorunları, fiziksel işlev kaybı ve yaşam kalitesindeki düşüşü ön plana çıkarmışlardır.

“Başarılı, etkili, hoş bir kadın görünümüne kilo vermeden erişemeyeceğimi düşünüyordum. Yaşadığım mutsuzluğu gidermenin en temel yollarından birinin kilo vermek olduğunu düşünüyordum.’’ *(P1)*

4.5.2. İlişkilerin ve Desteğin Toplumsal Cinsiyet Açısından Farklı Anlamları

Katılımcılar, ameliyat sürecinde aldıkları sosyal desteğin toplumsal cinsiyet rollerinden etkilendiğini ifade etmişlerdir. Erkek katılımcılar eşlerinden yoğun destek gördüklerini belirtirken, kadın katılımcılar ameliyat sonrasında dahi çocuk bakımı ve ev işleri gibi sorumluluklarını sürdürmek zorunda kaldıklarını ifade etmişlerdir.

> Süreç de zaten onun sayesinde oldu. Kendimi tamamen ona teslim ettim. Tabiri caizse beni güdüyordu. Yemek saatim geldiğinde yemeğimi getiriyordu, su içmem gerektiğinde suyumu getiriyordu. Beni hiç yalnız bırakmadı. "Eşim bana her şeyi ölçüsünde hazırlıyordu; ayranımı, proteinimi, mamamı... Hastanede mamayı suyla verince içemedim. Eşim doktorla konuştu, nasıl hazırlanması gerektiğini öğrendi. Hep bana baktı. Ben hiç zorlanmadım. *(P10)*

4.5.3. Farklı Toplumsal Cinsiyet Beklentileri Altında Yaşamak

Kadın katılımcılar, kilo kaybını kadınlık, çekicilik ve toplumsal kabul ile ilişkilendirirken; erkek katılımcılar bu süreci daha çok kişisel başarı, öz denetim ve sağlık kazanımı olarak değerlendirmiştir. Bulgular, toplumsal cinsiyetin bariatrik cerrahi deneyiminin anlamlandırılmasında belirleyici bir rol oynadığını göstermiştir.

“Toplumun görüntüye göre karar verdiğini fark ettim. Özellikle iş ortamlarında insanların sizi nasıl gördüğü birçok şeyi etkiliyor. Bu oyunun kuralını doğru bulmuyorum ama bu kurala göre oynamak zorunda olduğumu hissediyorum. Toplumda ki bu sisteme ve kurallara uyamadıkça üzülüyorum.’’ *(P1)*

4. TARTIŞMA VE SONUÇ

4.1. Bulguların Tartışılması

4.1.1. Bariatrik Cerrahiye Giden Yol

Bu araştırmanın bulguları, bariatrik cerrahi kararının ani bir tıbbi karar değil, zaman içinde gelişen psikososyal bir süreç olduğunu göstermektedir. Katılımcıların cerrahiyi "son çare" olarak tanımlamaları önceki araştırmalarla benzerlik göstermektedir (Keyte vd., 2024; Murtha vd., 2022; Ölmez & Adak, 2026; Roberson vd., 2016). Bununla birlikte bu çalışma, cerrahi kararının yalnızca başarısız kilo verme girişimlerinden değil; fiziksel ve psikolojik güçlükler, beden memnuniyetsizliği, yeme davranışları, günlük yaşamdaki kısıtlılıklar ve kilo damgalanmasının zaman içinde birikmesiyle şekillendiğini göstermektedir (Ölmez & Adak, 2026; Wysoker, 2005).

Bulgular, kilo damgalanmasının ve bireysel sorumluluğu vurgulayan toplumsal söylemlerin cerrahi kararını etkileyebileceğini göstermektedir. Ayrıca aile üyelerinin karar sürecindeki rolü, aile ilişkilerinin bariatrik cerrahi kararlarını etkileyebileceğini gösteren çalışmalarla örtüşmektedir (Cowan, 1998; Greenberg, 2003; Lee vd., 2019; Trainer & Benjamin, 2017; Wolff & Maydell, 2024).

Temel Psikolojik İhtiyaçlar Kuramı (Ryan & Deci, 2000) açısından değerlendirildiğinde, tekrarlayan başarısız kilo verme girişimleri yeterlik duygusunu, artan fiziksel kısıtlılıklar ise özerklik algısını zayıflatmış olabilir. Damgalanma ve sosyal dışlanma deneyimleri de ilişki kurma ve ait olma ihtiyacını olumsuz etkileyebilmektedir (Karakitsiou vd., 2024; Matacin & Simone, 2019). Sosyal

Karşılaştırma Kuramına göre (Festinger, 1954) ise katılımcılar bedenlerini toplumsal ideal beden standartlarıyla karşılaştırmış ve bu durum beden memnuniyetsizliğini artırmış olabilir (Betz vd., 2019; Doğan vd., 2024). Genel olarak bulgular, bariatrik cerrahiye giden yolun bireysel bir kararın ötesinde, zaman içinde biriken psikolojik, sosyal ve toplumsal etkenlerin şekillendirdiği kümülatif bir süreç olduğunu göstermektedir.

4.1.2. Erken Ameliyat Sonrası Dönemin Zorlukları

Araştırmanın bulguları, bariatrik cerrahi sonrası erken dönemin yalnızca fiziksel iyileşmeyi değil, aynı zamanda önemli psikolojik ve davranışsal uyum süreçlerini de içerdiğini göstermektedir. Önceki çalışmalar da ameliyat sonrasında duygusal sıkıntılar, beden algısı sorunları ve çeşitli psikososyal güçlüklerin görülebildiğini bildirmektedir (Groven vd., 2015; Keyte vd., 2024; Sarwer vd., 2008). Bu çalışma ise bu güçlüklerin önemli nedenlerinden birinin, hızlı fiziksel değişim ile daha yavaş gerçekleşen psikolojik uyum arasındaki uyumsuzluk olabileceğini göstermektedir. Katılımcılar, yeni fiziksel sınırlara uyum sağlamaya çalışırken beklentilerinin, yeme isteklerinin ve beden algılarının aynı hızda değişmediğini ifade etmişlerdir. Ayrıca beklentiler ile ameliyat sonrası deneyimler arasındaki farklılık, erken dönemde yaşanan geçici pişmanlık ve belirsizlik duygularını açıklayabilir (Cowan, 1998; Kubik vd., 2013).

Bulgular, ameliyat sonrasında bireylerin yemekle ilişkilerini yeniden yapılandırmak zorunda kaldıklarını göstermektedir. Katılımcılar, yemek yeme istekleri ile bedenlerinin tolere edebildiği miktar arasında çatışma yaşadıklarını belirtmişlerdir. Bu durum, bariatrik cerrahinin kalıcı yeme davranışı değişiklikleri gerektirdiğini gösteren önceki çalışmalarla örtüşmektedir (Keyte vd., 2024; Snyder, 2009). Ayrıca Türkiye'de misafirperverliğin bir parçası olan yemek ikramı kültürünün ve sosyal normların yeni beslenme düzenine uyumu zorlaştırabildiği görülmüş olup, bu bulgu önceki araştırmaları desteklemektedir (Güney & Göbel, 2025). Katılımcılar, bedenlerine uyum sürecinde ise yabancılaşma, eski benliklerine ilişkin kayıp duyguları ve değişen bedenlerini kabullenmede güçlük yaşadıklarını ifade etmişlerdir. Bu bulgular, ameliyat sonrasında beden memnuniyetsizliğinin yalnızca görünümle sınırlı olmadığını

göstermektedir (Doğan vd., 2024; Ivezaj & Grilo, 2018; Kubik vd., 2013; Varns vd., 2018).

Araştırmada katılımcılar, psikolojik güçlükleri için çoğunlukla cerrah veya diyetisyenlerden destek almaya çalıştıklarını belirtmiş; bu durum ameliyat sonrası hizmetlerde psikososyal desteğe yönelik önemli bir boşluğa işaret etmektedir (Fabricatore vd., 2006; Ogden vd., 2019; Ogle vd., 2016). Ayrıca kilo kaybı sonrasında da görünüşe yönelik yargılayıcı yorumların devam ettiği ve bazı katılımcıların olumsuz tepkilerden kaçınmak amacıyla ameliyatlarını gizledikleri görülmüştür. Bu bulgular, kilo damgalanmasının ameliyat sonrasında da farklı biçimlerde sürdüğünü gösteren çalışmalarla uyumludur (Garcia vd., 2024; Greenberg, 2003; Sutton vd., 2009; Trainer & Benjamin, 2017; Wolff & Maydell, 2024). Temel Psikolojik İhtiyaçlar Kuramı (Ryan & Deci, 2000) açısından değerlendirildiğinde, yeni yeme davranışlarının geliştirilmesi yeterlik duygusunun yeniden kazanılmasıyla, psikolojik olarak anlaşılma ve desteklenme gereksinimi ise ilişki kurma ihtiyacıyla ilişkilendirilebilir. Sosyal Karşılaştırma Kuramına göre (Festinger, 1954) ise katılımcılar eski bedenleri, değişen bedenleri ve ulaşmayı bekledikleri ideal beden arasında karşılaştırmalar yapmış; bu durum psikolojik uyumun ve beden memnuniyetinin zaman almasını açıklayabilir (Doğan vd., 2024; Gaudrat vd., 2021). Genel olarak bulgular, erken ameliyat sonrası dönemin bireylerin bedenleri, yeme davranışları ve sosyal çevreleriyle yeni ilişkiler geliştirmelerini gerektiren kapsamlı bir psikososyal uyum süreci olduğunu göstermektedir.

4.1.3. Kalıcı Değişim İhtiyacı

Bu araştırmanın bulguları, katılımcıların zamanla bariatrik cerrahinin tek başına kalıcı kilo kontrolü sağlamaya yeterli olmadığını fark ettiklerini göstermektedir. Önceki çalışmalar da ameliyat sonrası kilo kaybının sürdürülebilmesi için kalıcı davranış değişiklikleri, beslenme önerilerine uyum ve uzun dönem yaşam tarzı değişikliklerinin gerekli olduğunu, kilo geri alımının ise önemli bir risk olmaya devam ettiğini ortaya koymaktadır (Choban vd., 2002; Keyte vd., 2024; Kushner & Sorensen, 2015; Snyder, 2009). Bu çalışma ise katılımcıların ameliyat sonrasında cerrahinin sınırlarını fark ederek kilo yönetiminde kendi sorumluluklarını daha fazla benimsediklerini göstermektedir. Bu bulgu, bariatrik cerrahinin uzun dönem kilo yönetiminde

davranışsal ve psikolojik etkenleri ortadan kaldırmadığını gösteren önceki araştırmalarla da uyumludur (Cowan, 1998; Ogden vd., 2019).

Temel Psikolojik İhtiyaçlar Kuramı (Ryan & Deci, 2000) açısından değerlendirildiğinde, ameliyat sonrası süreçte yeni yeme alışkanlıklarının geliştirilmesi ve günlük yaşamın yeniden düzenlenmesi, bireylerin yeterlik ve özerklik duygularının güçlenmesine katkı sağlamış olabilir. Bu araştırmanın önemli katkılarından biri, cerrahinin değişimi tek başına sağlayan bir müdahale değil, değişim için bir fırsat sunduğunu göstermesidir. Katılımcılar zamanla bariatrik cerrahiyi fiziksel bir çözümden çok, öğrenmeyi, öz düzenlemeyi, psikolojik uyumu ve yeni alışkanlıkların geliştirilmesini gerektiren uzun bir sürecin parçası olarak değerlendirmişlerdir. Genel olarak bulgular, bariatrik cerrahinin kalıcı değişimi tek başına sağlayan bir çözümden ziyade, uzun dönemli davranış değişikliği ve öz düzenleme gerektiren bir sürecin başlangıcı olduğunu göstermektedir.

4.1.4. Bariatrik Cerrahi Sonrası Yaşamın Dönüşümü

Bulgular bariatrik cerrahininin kilo kaybının ötesinde yaşamın birçok alanını kapsayan geniş bir dönüşüm süreci olduğunu göstermektedir. Önceki çalışmalar ameliyat sonrasında yaşam kalitesi, fiziksel işlevsellik, benlik saygısı, beden algısı, psikolojik iyi oluş, fiziksel aktivite ve sosyal işlevsellikte iyileşmeler bildirirken, bu kazanımların her bireyde aynı şekilde yaşanmadığını ve zamanla değişebildiğini göstermektedir (Cherick vd., 2019; Choban vd., 2002; Keyte vd., 2024; Murtha vd., 2022). Ayrıca hızlı bedensel değişimlerin kimlik uyumunu zorlaştırabileceği, beden memnuniyetsizliği ve içselleştirilmiş kilo karşıtı tutumların kilo kaybına rağmen devam edebileceği belirtilmektedir (Perdue vd., 2020; Sicilia vd., 2026; Wolff & Maydell, 2024). Bu çalışma ise ameliyat sonrası değişimlerin birbirinden bağımsız değil; yemekle ilişki, beden algısı, özgüven, sosyal yaşama katılım, kişilerarası ilişkiler ve günlük yaşamın birlikte dönüşümünü içeren bütüncül bir psikososyal süreç olduğunu göstermektedir.

Temel Psikolojik İhtiyaçlar Kuramı (Ryan & Deci, 2000) açısından değerlendirildiğinde, fiziksel olarak daha aktif olmak ve yeni alışkanlıklar geliştirmek yeterlik duygusunu, günlük yaşam üzerinde daha fazla kontrol sahibi olmak özerklik duygusunu, sosyal yaşama yeniden katılmak ise ilişki kurma ihtiyacını desteklemiş

olabilir. Sosyal Karşılaştırma Kuramına göre (Festinger, 1954) ise ameliyat öncesinde katılımcılar bedenlerini toplumsal ideal bedenlerle karşılaştırırken, ameliyat sonrasında daha çok eski bedenleriyle karşılaştırmış ve bu durum beden kabulü ile özgüvenin artmasına katkı sağlamış olabilir (Doğan vd., 2024; Sicilia vd., 2026). Kilo kaybı sonrasında da dış görünüşe yönelik değerlendirmelerin devam etmesi, sosyal karşılaştırmaların tamamen ortadan kalkmadığını göstermektedir. Genel olarak bulgular, bariatrik cerrahinin bireylerin kendileri, bedenleri ve günlük yaşamlarıyla kurdukları ilişkiyi dönüştüren kapsamlı bir psikososyal süreç olduğunu ortaya koymaktadır.

4.1.5. Bariatrik Cerrahi Deneyiminde Toplumsal Cinsiyetin Rolü

Bu araştırmanın bulguları, toplumsal cinsiyetin bariatrik cerrahi sürecindeki deneyimleri şekillendiren önemli bir etken olduğunu göstermektedir. Önceki çalışmalar kadınların erkeklere kıyasla daha fazla beden memnuniyetsizliği ve dış görünüşe ilişkin kaygılar yaşadığını, bariatrik cerrahi geçiren bireylerin çoğunluğunu kadınların oluşturmasının ise sağlık nedenlerinin yanı sıra toplumsal beden normları ve görünüş beklentileriyle de ilişkili olabileceğini göstermektedir (Colosimo vd., 2025; Gregory vd., 2013; Groven vd., 2015; Kochkodan vd., 2018; Mahony, 2008). Bu çalışmada da kadın ve erkek katılımcıların bedenlerini değerlendirme biçimleri, cerrahiye yükledikleri anlamlar, destek deneyimleri ve ameliyat sonrası değişimleri yorumlayışları bakımından farklılaştıkları görülmüştür.

Feminist Kuram açısından değerlendirildiğinde, kadın katılımcılar beden ağırlığını kadınlık, çekicilik ve toplumsal değer ile ilişkilendirirken; erkek katılımcılar daha çok sağlık, fiziksel işlevsellik, bağımsızlık ve kontrol üzerinde durmuşlardır. Bu bulgular, kadınların ince beden ideallerine yönelik daha yoğun toplumsal baskıyla karşılaştığını gösteren önceki araştırmalarla uyumludur (Lin & Kulik, 2002; Paul vd., 2023; Seekis & Barker, 2022). Ayrıca kadın katılımcıların ameliyat sonrasında bakım almaya ihtiyaç duyarken aynı zamanda bakım verme sorumluluklarını sürdürmeleri, toplumsal cinsiyet rollerinin iyileşme sürecini de etkileyebileceğini düşündürmektedir (Etuk vd., 2025).

Sosyal Karşılaştırma Kuramı (Festinger, 1954) açısından ise kadınların daha çok toplumsal güzellik ve kadınlık idealleriyle, erkeklerin ise sağlık ve fiziksel yeterlilik gibi farklı toplumsal ölçütlerle kendilerini değerlendirdikleri görülmektedir. Bu çalışma, toplumsal cinsiyetin yalnızca kadın ve erkekler arasındaki farklılıkları açıklayan bir değişken olmadığını; karar verme sürecinden beden algısına, sosyal desteğe, bakım sorumluluklarına ve ameliyat sonrası değişimlerin anlamlandırılmasına kadar tüm bariatrik cerrahi deneyimini etkileyen kesitsel bir boyut olduğunu ortaya koymaktadır. Bununla birlikte, örneklemdeki kadın ve erkek katılımcı sayısının sınırlı olması nedeniyle bu bulgular genellenebilir farklılıklar olarak değil, bu örnekleme özgü toplumsal cinsiyet örüntüleri olarak değerlendirilmelidir.

Genel olarak bulgular, bariatrik cerrahinin kolay ve tek başına yeterli bir çözüm olmadığını; fiziksel, psikolojik, duygusal ve sosyal uyumu gerektiren kapsamlı bir süreç olduğunu göstermektedir. Bununla birlikte, katılımcıların büyük çoğunluğu yaşadıkları güçlükleri uzun dönem kazanımlarla karşılaştırdıklarında yeniden bariatrik cerrahi olmayı tercih edeceklerini ve başkalarına da önereceklerini ifade etmişlerdir. Bu bulgu, bireylerin bariatrik cerrahinin olası yararları kadar psikososyal güçlükleri hakkında da gerçekçi biçimde bilgilendirilmelerinin önemini ortaya koymaktadır.

4.2. Uygulamaya Yönelik Öneriler

Bu araştırmanın bulguları, psikolojik desteğin yalnızca ameliyat öncesi değerlendirme ile sınırlı kalmaması, ameliyat öncesinden başlayarak uzun dönem izlem sürecini kapsayacak şekilde sürdürülmesi gerektiğini göstermektedir. Psikolojik danışma; ameliyata hazırlık ve beklenti yönetimi, duygu düzenleme, yemekle ilişkinin yeniden yapılandırılması, beden algısı ve kimlik değişimlerine uyum, kilo damgalanmasıyla baş etme ve sosyal desteğin güçlendirilmesi gibi alanlara odaklanmalıdır (Cowan, 1998; Geller vd., 2019; Kubik vd., 2013).

Bulgular, bariatrik cerrahinin yeme davranışlarının duygusal işlevlerini tek başına değiştirmediğini ve uzun dönem başarının kalıcı davranış değişikliği ile öz düzenlemeye bağlı olduğunu göstermektedir (Choban vd., 2002; Keyte vd., 2024; Kushner & Sorensen, 2015; Snyder, 2009). Bu nedenle psikolojik danışmanlar,

bireylerin alternatif baş etme becerileri geliştirmelerine, yeni alışkanlıkları sürdürmelerine ve kilo geri alımı durumunda öz suçlama yerine bireysel, psikolojik ve çevresel etkenleri birlikte değerlendirmelerine yardımcı olabilir. Bu süreçte Kabul ve Kararlılık Terapisi (ACT), Mindfulness Temelli Yeme Farkındalığı Eğitimi (MB-EAT) ile öz şefkat ve beden kabulünü destekleyen yaklaşımlardan yararlanılabilir (Braun vd., 2021; Gilbert, 2014; Kristeller & Wolever, 2014; Weineland vd., 2012).

Araştırma, psikososyal desteğin bireyin yaşadığı kültürel ve sosyal bağlamı da dikkate alması gerektiğini göstermektedir. Özellikle Türkiye'de misafirperverlik kültürünün bir parçası olan yemek ikramı ve sosyal normlar ameliyat sonrası beslenme düzenine uyumu güçleştirebilmektedir (Güney & Göbel, 2025). Ayrıca beden algısı, kimlik değişimleri, fazla deri, kilo damgalanması ve ameliyatın gizlenmesi gibi konuların psikolojik danışma sürecinde ele alınması önemlidir (Doğan vd., 2024; Garcia vd., 2024; Ivezaj & Grilo, 2018; Perdue vd., 2020; Sutton vd., 2009; Trainer & Benjamin, 2017; Varns vd., 2018; Wolff & Maydell, 2024).

Bulgular, sosyal desteğin ameliyat öncesi karar verme sürecinden başlayarak ameliyat sonrası uyuma kadar önemli olduğunu göstermektedir. Bu nedenle uygun durumlarda aile üyelerinin ve yakın çevrenin sürece katılımı ile akran destek gruplarının psikososyal uyumu destekleyebileceği düşünülmektedir (Keyte vd., 2024; Lee vd., 2019; Ogle vd., 2016). Ayrıca psikolojik danışmanların toplumsal cinsiyete duyarlı bir yaklaşımla kadın ve erkeklerin farklı psikososyal gereksinimlerini dikkate almaları önerilmektedir (Colosimo vd., 2025; Kochkodan vd., 2018).

Son olarak, psikolojik danışmanların bariatrik ekip içerisinde yalnızca ameliyat öncesi değerlendirme yapan bir uzman değil, ameliyat öncesinden uzun dönem izleme kadar sürece aktif olarak katılan disiplinler arası ekibin bir üyesi olması önerilmektedir (Fabricatore vd., 2006; Nieves-Khouw vd., 2009; Ogden vd., 2019; Sarwer vd., 2019). Bulgular ayrıca Temel Psikolojik İhtiyaçlar Kuramının (Ryan & Deci, 2000), Sosyal Karşılaştırma Kuramının (Festinger, 1954) ve Feminist Kuramın bariatrik cerrahi sürecindeki psikososyal deneyimleri açıklamada yararlı kuramsal çerçeveler sunduğunu göstermektedir. Bu çalışma, psikolojik ihtiyaçların süreç boyunca değişebileceğini, sosyal karşılaştırmaların yalnızca diğer bireylerle değil, bireyin geçmiş ve değişen benliğiyle de gerçekleşebileceğini ve toplumsal cinsiyetin karar

verme, sosyal destek, damgalanma ve iyileşme süreçlerini şekillendiren kesitsel bir etken olduğunu ortaya koymaktadır.

4.3. Gelecek Çalışmalar için Öneriler

Bariatrik cerrahi alanındaki araştırmalar son yıllarda artmış olsa da çalışmaların büyük bölümü kilo kaybı, cerrahi komplikasyonlar ve yaşam kalitesi gibi tıbbi sonuçlara odaklanmış; psikososyal süreçler ise görece sınırlı düzeyde incelenmiştir (Keyte vd., 2024; Ogden vd., 2019). Özellikle Türkiye'de bariatrik cerrahi sürecindeki psikososyal deneyimleri ele alan çalışmaların sınırlı olması, bu alanda daha fazla nitel, nicel ve karma yöntem araştırmasına ihtiyaç olduğunu göstermektedir.

Gelecek araştırmalarda benzer ameliyat sonrası dönemlerde bulunan, aynı cerrahi yöntemi geçirmiş veya benzer demografik özelliklere sahip daha homojen örneklemlerle çalışılması, farklı aşamalarda ortaya çıkan psikososyal gereksinimlerin daha ayrıntılı incelenmesine katkı sağlayabilir. Daha büyük ve toplumsal cinsiyet açısından daha dengeli örneklemler kullanılarak toplumsal cinsiyetin beden algısı, sosyal destek, bakım sorumlulukları ve psikolojik uyum üzerindeki etkisi daha kapsamlı biçimde araştırılabilir.

Bulgular, psikososyal deneyimlerin zaman içinde değiştiğini göstermektedir. Bu nedenle aynı bireyleri ameliyat öncesinden başlayarak uzun dönem ameliyat sonrası sürece kadar izleyen boylamsal araştırmalar, psikolojik uyum, kimlik yeniden yapılanması, beden algısı ve sosyal ilişkilerdeki değişimleri daha ayrıntılı ortaya koyabilir. Ayrıca gelecekte yapılacak araştırmalarda bireylerin yanı sıra aile üyeleri, partnerler ve bariatrik ekipte görev alan sağlık profesyonellerinin görüşlerinin birlikte incelenmesi, kişi ve aile merkezli bakım modellerinin geliştirilmesine katkı sağlayabilir.

Son olarak, ameliyat öncesi psikoeğitim, uzun dönem psikolojik danışmanlık, akran destek grupları, aile temelli müdahaleler ile beden algısı ve duygu düzenlemeye yönelik psikososyal programların etkililiğini değerlendiren çalışmalara ihtiyaç bulunmaktadır. Ayrıca Sosyal Karşılaştırma Kuramı, Temel Psikolojik İhtiyaçlar Kuramı ve Feminist Kuram gibi farklı kuramsal yaklaşımlar temelinde yürütülecek

nicel ve karma yöntem araştırmaları, bariatrik cerrahi sonrası psikolojik uyumun daha kapsamlı anlaşılmasına katkı sağlayacaktır.

H. THESIS PERMISSION FORM / TEZ İZİN FORMU

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