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“YOU DON’T KNOW THE WHOLE STORY”

UNDERSTANDING THE EXPERIENCES OF INDIVIDUALS WHO HAVE UNDERGONE LAPAROSCOPIC SLEEVE GASTRECTOMY SURGERY AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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“You Don’t Know The Whole Story”
Understanding The Experiences Of Individuals Who Have Undergone Laparoscopic Sleeve Gastrectomy Surgery: An Interpretative Phenomenological Analysis

“Bütün Hikayeyi Bilmiyorsunuz”
Laparoskopik Tüp Mide Ameliyatı Olmuş Bireylerin Deneyimlerini Anlamak: Yorumlayıcı Fenomenolojik Analiz Çalışması

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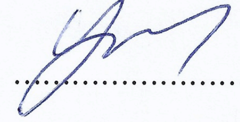

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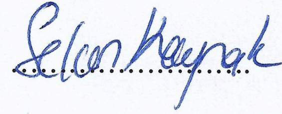

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Abstract

The aim of this study is to explore, describe and interpret how patients who have undergone laparoscopic sleeve gastrectomy (LSG) surgery make sense of their experiences and to contribute understanding and improving post-operative social and psychological support following such surgery. The focus of the study was on the changes experienced in the social and psychological meaning as well as the physiological changes experienced in the post-operative weight loss process. In-depth interviews were conducted with 8 women between the ages of 20 and 45, who have undergone sleeve gastrectomy surgery at least one year ago. Four super-ordinate themes emerged from the Interpretative Phenomenological Analysis: a) transformation, b) reasons for being overweight, c) relationship with food and d) the relationship with the others, along with 17 sub-ordinate themes. Findings related to the connection with the mother, food and the world and the connection of the weight gain with the past losses appeared noteworthy. In order to increase the positive effects of the surgery, to ensure the maintenance of these effects and to make the process better, it is necessary to understand the unique needs of individuals.. In future research, it is recommended to investigate psychological processes and needs related to weight gain and emotional state of the person before LSG surgery.

Key Words: Bariatric surgery, psychological aspects of sleeve gastrectomy surgery, psychological aspects of obesity, laparoscopic sleeve gastrectomy surgery, weight loss.

Özet

Bu çalışmanın amacı laparoskopik tüp mide (LSG) ameliyatı geçirmiş olan hastaların deneyimlerini nasıl anlamlandırdıklarını araştırmak, tanımlamak ve yorumlamak ve bu bulgular ışığında post-operatif sosyal ve psikolojik destek konusunda bariatrik alana katkı sağlamaktır. Çalışmanın odağı, ameliyat sonrası kilo kaybı sürecinde yaşanan fizyolojik değişikliklerin yanı sıra sosyal ve psikolojik anlamda yaşanan değişikliklere de ışık tutmaktır. 20-45 yaş aralığında, en az 1 yıl önce tüp mide ameliyatı geçirmiş 8 kadın ile derinlemesine görüşmeler gerçekleştirilmiştir. Elde edilen niteliksel verinin Yorumlayıcı Fenomenolojik Analizi sonucunda 4 ana tema ve bunlarla bağlantılı olarak 17 alt-tema ortaya çıkmıştır: a) dönüşüm, b) fazla kilolu olma nedenleri, c) yemekle ilişki ve d) diğerleri ile ilişki. İlgili literatürle ve çalışmanın varsayımları ile paralellik gösteren bulguların yanı sıra anneyle, dünyayla ve yemekle kurulan ilişki ve geçmişte yaşanan kayıpların kilo alımına etkisine dair veriler de öne çıkmıştır. Ameliyatın olumlu etkilerini arttırmak, bu etkilerin sürekliliğini sağlamak ve süreci daha iyi hale getirmek için bireysel ihtiyaçların anlaşılmasının gerekliliği vurgulanmıştır. İleride yapılacak araştırmalarda, kişilerin laparoskopik tüp mide ameliyatından önce kilo alımı ve duygusal durumları ile ilgili psikolojik süreçlerinin ve ihtiyaçlarının araştırılması önerilir.

Anahtar Kelimeler: Bariatrik cerrahi, laparoskopik tüp mide ameliyatının psikolojik yönleri, obezitenin psikolojik yönleri, laparoskopik tüp mide ameliyatı, kilo kaybı.

INTRODUCTION

The increase in obesity in recent years and failure of behavioral and dietary approaches for its treatment (Bult, Van Dalen, & Muller, 2008) led to the development of bariatric surgery. In recent years, Laparoscopic Sleeve Gastrectomy (LSG) surgery has become a highly preferred method in Turkey. Research has shown that bariatric interventions have psychological, physiological and social effects on patients' lives besides their surgical outcomes. Many studies in the literature have mentioned the lack of research on the understanding of the psychological and social experiences of patients after surgery. Presented research is an attempt to understand the experiences of individuals during and after LSG surgery using the Interpretative Phenomenological Analysis. The study aims to identify common themes in experiences of patients who underwent LSG and to enhancing post-operative social and psychological support following such surgery. This study focuses on the experience of people in order to support them in accordance with their individual needs. In this respect, the experiences of individuals about being overweight, the process of deciding on surgery and the factors affecting these processes were also included in order to better understand their needs.

DEFINING OVERWEIGHT AND OBESITY

Overweight and obesity are defined as having an excessive accumulation of fat that is harmful to health (World Health Organization [WHO], 2017). Body mass index (BMI) is the standard indicator for determining obesity and it is calculated by dividing the person's weight in kilograms by the square of height in meters (National Institutes of Health, 1998). BMI doesn't give any information about the body composition (muscle mass or body fat); it is used as a screening tool to detect situations that may create a risk for person's health. The BMI classification table is as follows:

Table 1. BMI Classification

Underweight	<=18.5
Normal range	18.5 - 24.9
Overweight	25.0 - 29.9
Obese	30.0 - 39.9
Extreme/Morbid obese	40+

1.1. Prevalence of Obesity

Obesity is one of the most serious health problems of the 21st century (Rutte, Luyer, De Hingh, & Nienhuijs, 2012). The prevalence of it nearly tripled in many countries of the European region between 1975 and 2016 (WHO, 2017). In The European Health Report 2015, obesity is mentioned as one of the three major risk factors for premature mortality in Europe region. In European countries, prevalence estimates for obesity and overweight in adults range from %45 to % 67. Turkey is the second country that has the highest rates of overweight (BMI >=25) and obese (BMI >=30) people (WHO, 2015).

In 2017, Turkey Statistical Institute reported that %23.9 of women were found to be obese while %30.1 were overweight according to the research conducted in 2016. In males, these rates were 15.2% and 30.1%, respectively (TÜİK, 2017). This rise in obesity rate also increases the incidence of obesity-related chronic diseases. Obesity poses a risk for a large number of comorbid diseases such as heart disease, diabetes, hypertension, and specific types of cancer (Lewington et al., 2009). It is also associated with increased mortality, and life shortening up to 10 years (Fontaine, Redden, Wang, Westfall & Nienhuijs, 2003).

1.1.1. Psychiatric Comorbidities

Past studies have documented that extremely obese patients show a high

prevalence of psychiatric comorbidities including eating disorders, anxiety and depression (Greenberg et al., 2005; Sarwer et al., 2004). 50% of bariatric patients reported having depressive symptoms during their life, while 25-30% of patients showed depressive symptoms at the time of the operation (Sarwer, Dilks & Ritter, 2012). In general, obese individuals are diagnosed with anxiety and depression three to four times more than thinner individuals (Greenberg et al., 2005). Bariatric surgery candidates show a higher prevalence of psychological comorbidities such as eating disorders, mood disorders and psychological distress along with anxiety, personality disorders, alcohol use and low self-esteem compared to obese patients who do not seek the procedure (Kalarchian, 2007).

Having a history of repeated failed weight loss attempts also contributes to individuals' experience of depressive symptoms, hopelessness with poor self-esteem and increases the likelihood of further weight gain (Wooley & Garner, 1991). These psychological disturbances lead individuals to experience social isolation, social and economic discrimination (Dixon et al., 2002; Greenberg et al., 2005).

1.1.2. Discrimination

As a result of their appearance, obese individuals are exposed to discrimination and prejudice in both social and business life. It is found that obesity is often associated with the misconception of low intellect, laziness, incompetence, and lack of willpower (Reto, 2003). Also, it is seen as a character flaw associated with gluttony and lack of self-control (Allon 1981; DeJong 1980; Harris et al. 1982). These stereotypes may affect obese individual's social and economic success by triggering prejudice and maltreatment.

Based on the common but false assumption that weight is controllable, unlike skin color- people are prone to freely express their prejudicial attitudes toward obese individuals (Cossrow, Jeffery & McGuire, 2001). Obese people have reported dealing with social exclusion, humiliation, public ridicule and mistreatment by health personnel (Carr & Friedman, 2005). Getting less payment

than non-obese employees for the same job, lower chance of getting a promotion and being hired in high-level positions are some of the problems they may encounter in business life (Carr & Friedman, 2005; Puhl & Brownwell, 2001). In Myers and Rosen's (1999) study on stigmatization among extremely obese individuals, people reported the most common stigmatizing situations they have faced in daily life as hearing hurtful comments from children, difficulties in finding suitable clothes for themselves and encountering physical barriers in daily life.

As seen above, obesity is not only a health problem but also a situation with social and psychological dimensions. Failure of behavioral and dietary approaches for extreme obesity (Bult, Van Dalen, & Muller, 2008) led to the development of and increases in surgical interventions in the recent decades.

BARIATRIC SURGERY

Bariatric surgery procedures have been used in the world for over 50 years for weight loss purposes (Sağlık Teknolojisi Değerlendirme Daire Başkanlığı, 2014) and the application of it continues to increase. Worldwide 340,768 procedures have been performed in 2011 (Buchwald & Oien, 2013). Bariatric operations are classified into three categories: restrictive (weight loss by restricting the amount of food intake), malabsorptive (causing malabsorption of nutrients) or combination of both (Rutte, Luyer, De Hingh, & Nienhuijs, 2012). It is accepted to be the most effective long-term treatment for the majority of morbidly obese patients (BMI$\geq$ 40 kg/m^2) or patients with a BMI $\geq$ 35 kg/m^2 who are diagnosed with obesity-related comorbidities such as type 2 diabetes or hypertension (Colquitt, Picot, Loveman & Clegg, 2009). It is recommended to morbidly obese and obese patients with comorbidities between the age of 18 and 65; and mostly people with the history of multiple failed weight loss attempts (Rutte, Luyer, De Hingh, & Nienhuijs, 2012). Primary goals of the bariatric surgery are for the patient to lose weight and to maintain the loss. A second goal

is to promote a greater lifestyle change by changing his/her eating habits and engaging in frequent exercise (Kubik, Gill, Laffin, & Karmali, 2013).

Typically, patients lose %20 to %35 of their initial body weight within 12-18 months after surgery (Buchwald, Avidor, & Braunwald, 2005). Recent studies have shown bariatric interventions as an effective part of the overall weight loss and management strategies (Kubik, Gill, Laffin, & Karmali, 2013). Also, they have been found to be significantly decreasing the mortality rate (Sjöström et al., 2007). Bariatric surgery is seen as a more effective treatment for morbid obesity compared to diet, exercise, radical lifestyle changes and medication (Jumbe, Hamlet, & Meyrick, 2017). Since the beginning of this decade, laparoscopic sleeve gastrectomy has become more prominent among other bariatric surgery operations (Gomberawalla, Wilson, & Lutfi, 2014). It is technically easier and relatively faster than other bariatric operations, showing excessive weight loss with a low post-op complication rate and a significant reduction in comorbidities (Tucker, Szomstein, & Rosenthal, 2008).

2.1. Mechanisms of Laparoscopic Sleeve Gastrectomy and Weight Loss

Laparoscopic sleeve gastrectomy (LSG) is a non-reversible and purely restrictive surgical procedure in which doctors remove a large portion of the stomach (approx. %80-85) and leave it about the size of a banana. It is performed using minimally invasive (laparoscopic) technique that is proven to be safe and simple (Abu-Jaish & Rosenthal, 2010). Two factors in this operation that enable weight loss are physically reducing the size of the stomach to restrict the amount of food intake, and decreasing the production of appetite-stimulating hormone called “ghrelin” (Vigneswaran & Ujiki, 2016). It was originally used as the first-stage operation of the bariatric surgery for reducing the surgical risks for high-risk patients and preparing them for the second operation (Clinical Issues Committee of the American Society for Metabolic and Bariatric Surgery, 2007). After early promising results, surgeons began to perform it as a stand-alone procedure, due to its proven efficacy in weight loss and remission of comorbidities with low risks

(Buchwald, 2012).

2.1.1. Pre-Operative Psychological Assessment

Considering the multifactorial etiology of obesity, psychological assessment is highly recommended in addition to the medical examination before the bariatric surgery (LeMont, Moorehead, Parish, Reto, & Ritz, 2004). There is no pre-defined pre-operative psychological evaluation format; psychologists generally look for signs of mental illness, especially depression, eating disorder and anxiety. Commonly, these assessments are used to identify possible contradictions to surgery in order to optimize outcomes. The psychological assessment also includes patient’s reasons for having the surgery, a detailed weight gain and diet history and expectations from the surgery (Synder, 2009). The first time when weight became problematic, important life events that may be linked to weight gain (marriage, job changes, pregnancies etc.), previous attempts at weight management and medical history of the family are also noted in the interview to completely understand the patient's condition and to assess their suitability for surgery (Synder, 2009).

2.1.2. Laparoscopic Sleeve Gastrectomy Procedure

An ideal pre-operative evaluation of LSG includes detailed medical history, a complete endocrinological examination, psychological evaluation and dietitian counseling (Abu-Jaish & Rosenthal, 2010). Age, BMI, associated comorbid diseases are other factors that are taken into account while evaluating the candidates. In the absence of any complications, patients can be discharged within 2-3 days after surgery. Post-operative follow-ups are conducted at 3, 6, 12 months, and yearly later on. Each visit includes a non-fasting blood sample (for measuring calcium, albumin, vitamin D, iron, ferritin, folic acid, zinc, magnesium, vitamin B1, B6 and B12 levels), complete blood count and dietitian counseling (Abu-Jaish & Rosenthal, 2010). A very strict diet program needs to be followed step by step to ensure post-operative physical adaptation. The 4-step post-operative diet program is as follows (Yüksel, 2016):

Stage 1 (clear liquid diet): Patients consume calorie-free, sugar-free and decaffeinated clear fluid 24-48 hours after surgery.

Stage 2 (full liquid diet): In addition to clear liquids, milk and its products, artificially sweetened yoghurt, vegetable juices, boiled and blended, drained cereals and sugar-free puddings can be consumed. In addition, protein support is also given. This diet is administered for 10-14 days.

Stage 3 (puree diet): At this stage, patients can consume solid foods as blended or mashed. Protein support continues in order to complete protein intake. The duration of this phase may be prolonged according to the patient's tolerance. Patients should avoid excessive food and pay attention to recommended serving sizes to prevent weight gain, vomiting and possible expansion or rupture of the stomach. They should drink only 30 to 60 minutes before or after meals, instead of drinking with the meal. They should avoid sugary foods and drink lots of sugar-free fluids to prevent dehydration. Patients must adopt and sustain these habits throughout their life.

Stage 4 (solid foods diet): Solid foods (well-cooked meat, etc.) are added to the patient's diet. Foods should be eaten very slowly and chewed very well to eliminate the possibility of nausea and vomiting. Daily vitamin and mineral supplements continue to be given. The dietitian adds appropriate physical activity to patient’s program. The diet program arranged by the dietitian should be followed lifelong.

2.1.3. Post-operative Period

The degree of weight loss after LSG varies among individuals, and the underlying mechanisms behind these differences are not well understood (Ogden, Lamb, Carroll, & Flegal, 2010). Almost every study in the literature emphasizes the importance of continuing hospital visits in the post-operative years to ensure the continuation of positive changes of the surgery. Despite its favorable short-term success on weight loss and comorbidities, LSG is still controversial due to lack of long-term research (Himpens, Dobbeleir, & Peeters, 2010). There are

follow-up studies done 7 (Hirth, Jones, Rothchild, Mitchell, & Schoen, 2015) and 8 years (Eid et al., 2012) after surgery; however, they have taken into account only the loss of weight, complications and mortality rates, in order to investigate the effectiveness and safety of LSG. Very little research has been done in terms of psychosocial and psychological changes in the individuals' lives.

In a study by McMahon et al. (2006), it was determined that obese patients lost 15-20 kg during the first 3 months after surgery due to loss of appetite, lack of desire for eating, and early satiety feeling. In the same study, psychological difficulties that may be experienced by the patients were more frequently seen in the 18th-24th months after surgery (McMahon et al., 2006). Following one year after the surgery involves getting used to the required changes in the eating regimen and coping with side effects such as pain, vomiting, and discomfort of surgery (Ogden, Hollywood, & Pring, 2014). The first year after surgery is also characterized by a dramatic weight loss. Many patients find it difficult to adapt to their new body image, although they have positive thoughts on improving health conditions, increasing self-esteem, and keeping their eating under control (Aydın, 2012).

Numerous studies and reviews have reported post-operative general improvement in health-related quality of life, self-esteem, and body image in patients who succeeded in achieving post-operative weight loss (Hout, Boekestein, Fortuin, Pelle, & Heck, 2006). On the other hand, failure to lose weight or weight regain is associated with an increase in depressive symptoms (Bocchieri, Meana & Fisher, 2002). It is very important for patients to have realistic expectations from the surgery. Therefore, patients are asked their goal weight and the time frame they set their mind to achieve this goal (Synder, 2009). Even if the weight loss is achieved, if pre-operative expectations are not met with the results, patients may have to deal with negative psychological consequences (Kubik, Gill, Laffin, & Karmali, 2013). In order to better cope with these situations, both before and after surgery, patients are encouraged to participate in support groups and to take individual counseling (Livhits et al., 2010).

PSYCHOLOGICAL ASPECTS OF LSG

Traditionally, the weight loss rate and control of comorbidities are taken into account for evaluating the results of bariatric surgery (Brolin, 2002), but it is also very important for patients to improve their quality of life and social functioning. LSG is a purely restrictive surgery that requires a major change in nutrition habits and food intake. Besides the surgical intervention, it requires a great deal of patience, adaptation and effort in the post-operative period (Aydın, 2012). It takes time for patients to adapt psychologically. LSG candidates need to be highly motivated because the long-term and successful outcome of surgery depends on the nutritional and lifestyle changes of the patient (Yüksel, 2016). It is not only a weight changing process but also a life changing process with all its components. It includes a healing process with completely new eating habits and restrictions, weight loss, possible weight regain, changes in body shape and possible deformations of the skin and the body. All of these may affect one's body perception, self-perception and social self in the long-term (Jumbe, Hamlet & Meyrick 2017). In addition to social and mental support from the medical care staff, the sense of taking control of their life has a positive impact on patients' post-operative psychological health (Kubik, Gill, Laffin, & Karmali, 2013).

Some of the psychological issues that patients appear to struggle with after surgery are suboptimal weight loss, body image dissatisfaction, and addiction.

3.1. Suboptimal Weight Loss

Approximately 20% of the patients cannot reach the expected post-operative weight loss or begin to regain weight in the first years after surgery (Sjöström, et al., 2004). These situations are associated with poor adaptation to the post-operative diet or the return of old eating habits, rather than factors related to surgery (Kalarchian, et al., 2002).

3.2. Body Image Dissatisfaction

Extreme weight loss after surgery is associated with improvements in body image (Adami, et al., 1998). Unfortunately, some patients report dissatisfaction with body image because of the excess skin and most of the patients seek plastic surgery due to loose, sagging skin of the belly, breasts, and arms (Sarwer, Thompson, Mitchell, &Rubin, 2008). Studies show that cosmetic surgery improves body image post-operatively, but 5% to 15% of patients show symptoms of body dysmorphic disorder (Sarwer, & Crerand, 2008). In one study, 70% of the patients reported residual body image dissatisfaction after weight loss surgery due to sagging skin, even if 90% were satisfied with their overall appearance (Kinzl, Traweger, Trefalt & Biebl, 2003).

3.3. Addiction

The literature on the occurrence of addictions (to substances, alcohol, sex, gambling etc.) following bariatric surgery has grown in recent years. The theory behind it is that patients may develop another addiction after surgery to replace their pre-operative addiction to food. Although there is no direct link between weight loss and the development of an alcohol use disorder (AUD) following surgery, one study found that patients with a lifetime history of AUD might be at higher risk for developing AUD after surgery compared to general population (Suzuki, Haimovici, & Chang, 2010). While Roux-en-Y gastric bypass is associated with the risk of developing an AUD, there is no reported evidence for other types of bariatric surgeries (Steffen, Engel, Wonderlich, Pollert, & Sondag, 2015).

3.4. Disordered Eating

A review article suggests that the requirement of following a strict, small portion diet program after surgery may alleviate the binge eating behavior (Hout, Boekestein, Fortuin, Pelle, & Heck, 2006). On the other hand, especially those who have pre-operative eating disorders continue to suffer from

psychological distress about eating after surgery (Hout, Boekestein, Fortuin, Pelle, & Heck, 2006). Also, the fear of weight regain reinforces the rigid eating behavior and excessive control. Post-operative monitoring for eating behaviors is highly recommended to identify patients who may benefit from additional psychological counseling, (Niego, Kofman, Weiss, & Geliebter, 2007).

3.5. Post-operative Psychosocial Outcomes

Studies have demonstrated some improvements in psychosocial status after bariatric surgery including employment opportunities, social relations, and health-related quality of life (Jumbe, Hamlet, & Meyrick, 2017). In the first year after surgery, depressive symptoms, self-esteem and body image improve dramatically (Bocchieri, Meana & Fisher, 2002). Benefits appear to endure over the next 4 years after surgery. However, due to lack of information on long-term psychological consequences, little is known on whether these effects last for a long time or whether they are limited to the first years after surgery (Hout, Boekestein, Fortuin, Pelle, & Heck, 2006).

PURPOSE OF THE STUDY

Although the number of patients who have undergone sleeve gastrectomy surgery in recent years is increasing, qualitative research in this area is limited (Malone & Alger-Mayer, 2004). In many studies in the literature, operative success is often measured by post-operative weight loss, changes in BMI, quality of life and improvements in comorbidities. There is much research that consolidates its success on weight loss and improvements in comorbid diseases, but empirical evidence about the psychological and psychosocial effects on patient's lives after bariatric surgery is lacking (Jumbe, Hamlet, & Meyrick, 2017). Weight loss surgery is not just about weight loss; it has many different layers and components as mentioned above. As indicated in many studies in the

literature, there is a need for more research on how patients have passed through the surgery process and what they have experienced after the surgery.

Studies that deeply examine the processes that individuals experience after surgery are very rare. Most of the psychological studies compare the pre and post scores on depression, anxiety, and quality of life and try to find a meaningful connection with weight loss. This study aims to look deeply at the experiences of the overweight/obese individuals who have undergone sleeve gastrectomy surgery for weight loss. The ultimate goal of the research is to create a better understanding of the different aspects of undergoing a sleeve gastrectomy surgery, with a particular focus on the psychosocial, psychological changes associated with this surgery.

SIGNIFICANCE OF THE STUDY

In recent years, sleeve gastrectomy surgery has become a highly preferred method in Turkey. Considering this, sleeve gastrectomy operation was selected for this study. Many empirical studies exist in the literature regarding the success of the operation and the post-operative period. This study aims to approach this important life event from an experiential point. It is an attempt to create a picture of how all the components brought by the surgery are experienced by the patients. This study aims to explore, describe and interpret how participants of this study make sense of their sleeve gastrectomy surgery experiences.

Interpretative phenomenological analysis (IPA) allows us to take a closer look at the patients' post-operative experiences and to find common themes from their subjective experiences at the end. The aim is to provide more comprehensive information about the post-operative process to patients who consider having sleeve gastrectomy surgery. Hopefully, the findings of this study will contribute to giving more thorough information about the post-operative process to individuals who are considering having a sleeve gastrectomy.

METHOD

6.1. The Primary Investigator (PI)

I am a female student at the Istanbul Bilgi University, Clinical Psychology Graduate Program, adult track, with several weight gain/loss experiences during my adolescence due to health problems and dietary changes. In all these experiences I realized that the physical changes in my body due to weight changes and physical activity affected my psychological status, my social relationships and the way I see my body as a woman. In recent years, I noticed that the number of people who had laparoscopic sleeve gastrectomy has increased in my social environment. I saw that some of them adapted to this situation very easily and have continued to loss weight but some of them experienced a totally different process and regained weight after surgery. I had the chance to observe changes in their relationship with food. As I talked to people who had undergone surgery, I noticed that it is much more complicated process than it looks. As a person who experienced the results of multiple weight changes and its effects on my psychological, social and emotional status, I have wondered about the mechanisms that underlie LSG and how people experience this surgery.

6.2. Participants

Participants of this study were women between the ages of 20 and 45, who have undergone sleeve gastrectomy surgery at least one year ago. Although this study was not designed to only interview with women, all interviews were conducted with women because only one male participant applied for the study. After the approval of the Ethics Committee for Social Sciences of Istanbul Bilgi University, the PI announced the study in her close environment, mail groups and social media to reach participants who meet the criteria of the study. An online page with research details, participation requirements and a short application form was prepared and added to the research announcement. The participants who

completed the application form were contacted by e-mail or telephone. The process of seeking the participant ended when the pre-determined target of 8 participants was reached. A total 8 women were interviewed for the study.

6.3. Procedure

The PI did face-to-face interviews with 8 participants. The informed consent form (Appendix 1) was given to participants before the interview and interviews didn't start before reaching a mutual understanding of the purpose of the study. No misleading information was given about the content. The participant read and signed the informed consent form. The Demographic information form (Appendix 2) was filled by the participants before the interviews which includes questions about participants' age, gender, education, occupation, marital status, health status, operation date, self-reported height and whether he/she has received dietitian support and psychological support throughout the process. Pre-operative weight, current weight and total weight loss information was taken orally during the interview. It was thought that it would be more convenient for the participants to give this information while talking to the researcher.

The interviews lasted between 55 to 95 minutes. Interviews were held in an environment where participants felt comfortable talking about their experiences. Interviews started with an open-ended question "Could you please tell me about your sleeve gastrectomy operation story?" (Appendix 3) to let the participants use their own words and concepts to express their experience. Some questions were skipped when the participant already answered them while talking. Additional questions were asked in cases where clarification was required.

6.4. Data Analysis

Interpretative Phenomenological Analysis (IPA: Smith, J. A., Flowers, P., & Larkin, M. (2013) was used to access and understand the unique experiences of LSG patients. The interviews were audio recorded and transcribed verbatim by the

PI to Microsoft Word. The PI changed the names of the participants for confidentiality purposes. After transcription process, transcriptions were uploaded to MAXQDA software program, and the PI coded the sentences or/and words one by one. After the coding process was completed, the researcher initially acquired nearly 2000 codes. Some sentences were coded more than once because they contained more than one phenomenon. PI carefully developed the main codes and then the themes. For example, twenty-five percent of the codes involved some kind of transformation experienced in the process, so transformation became a main theme. Both the participants' words and the PI's interpretations were taken into account in the formation of the themes.

6.5. Trustworthiness

IPA aims to provide a detailed examination of the experience of people about important life events. It requires both a phenomenological point of view, which is the examination of conscious experiences in depth and detail; and the hermeneutic approach that takes into account the researcher's point of view. Although IPA makes it possible to explore complex experiences, its methodology creates a challenge in balancing the researcher's point of view and the viewpoint of the participants. To overcome this challenge, the PI noted her own reflections during the interview process. Also, she discussed them with the research team before developing main themes in order to avoid biases regarding analysis and interpretation.

In order to check the compatibility of the codes with the content of the interview, a colleague who was not involved in the research coded one of the interviews independently from the researcher. They were compared in terms of content and code compliance, and some changes were made in the coding where necessary.

The real names and descriptive features of the participants were not used at any stage of the study. In order to preserve confidentiality, the PI used headphones while transcribing the interviews and used only her own computer

throughout the process. Research materials were only accessible to the research group during the research period and kept in encrypted files. Audio recordings were destroyed after the research was completed.

RESULTS

This section is organized according to the four super-ordinate themes emerged in the analysis: a) transformation, b) reasons for being overweight, c) relationship with food and d) the relationship with others.

In this section some important information about participants, the descriptions of super-ordinate and related sub-ordinate themes, how they emerged from the data, and some excerpts from the narratives will be presented. During the interviews, participants often changed the subject of the sentences when expressing their own experiences. They started with "I" and continued with "you", like they were talking about the PI's experience or they finished their sentences with more general statements like "People do that". In order to conserve this change in language, this observation was taken into account when the narratives were translated into English.

The original names of the participants were replaced by nicknames before the coding process. Below, you will find the participants' occupations, relationship status, pre and post-operative weights, the duration of the weight loss period and important events they mentioned while losing weight. In the order of interviews conducted, the nicknames of the participants are Neshwa, Buse, Sıla, Zehra, Berrak, Bahar, Hande and Merve. The information regarding their ages, occupations and current relationship status can be seen in the Table 2.

Table 2. Demographics of participants

Participant	Age	Occupation	Current relationship status
Neshwa	27	Accountant	Single
Buse	23	Lawyer	Single
Sıla	35	School counselor	Single
Zehra	29	Photographer	In a relationship
Berrak	43	Social researcher	Divorced
Bahar	40	Kindergarten manager	In a relationship
Hande	44	Housewife	Married
Merve	30	Research coordinator	Single

The following table shows the pre-op comorbidities and important information related to weight and the pre and post-operative process:

Table 3. Information related to the pre and post-operation process

Participant	Pre-op weight	Pre-op BMI	Post-op weight	Pre-op comorbid diseases	Weight loss time (months)	Current weight
Neshwa	106	38,9 Obese	69	Menstrual irregularity, diabetes	6	85
Buse	135	47,3 Morbid obese	63	Diabetes, circulatory disorder, polycystic ovarian syndrome (POS), insulin resistance	6	83
Sıla	98	38,3 Obese	58	Diabetes, goiter	14	65
Zehra	105	38,6 Obese	69	-	12	70
Berrak	108	42,2 Morbid Obese	68	Sleep apnea, high cholesterol	12	72
Bahar	100	34,6 Obese	60	Insulin resistance	6	70
Hande	93	37,3 Obese	61	Liver fattening, cholesterol, plantar fasciopathy, lumbar hernia	3	67
Merve	115	43,8 Morbid Obese	52	Liver fattening, diabetes (first stage)	12	57

In the post-operative weight-loss process, participants experienced improvement in all the diseases in the above table. However, they also mentioned that they had different problems and difficulties due to rapid weight loss after surgery. During the weight loss process, Neshwa fainted once while she was driving and had an accident due to longtime hunger. Buse experienced severe complications and had long-term hospitalizations due to rapid weight loss 2 months after surgery. She went to 11 different doctors, but she didn't get a definite diagnosis. Basically, her symptoms were said to be due to her weakened immune system. Also, she said she became obsessed with food and started to set strict rules on food after surgery. There have been times that she didn’t eat or drink only water due to loss of appetite and desire to lose weight fast. She said she experienced both anorexia and bulimia-like experiences during her weight loss process. Throughout the weight-loss process, Sıla fainted several times due to low blood pressure and dehydration.

Laparoscopic sleeve gastrectomy surgery is recommended for obese individuals with recurrent unsuccessful weight loss experiences and comorbidities. Surgery was not the first choice for any of them; all had failed weight loss attempts. The methods they tried to lose weight were to work with famous dietitians, to receive regional weight loss therapy, to take hypnotherapy, to take weight loss pills and to do detox diets. While some of them were useless, others helped them to lose weight, but the results weren't permanent and they ended up gaining weight.

7.1. TRANSFORMATION

This main theme is organized around the processes of change experienced by participants in different areas. Due to the restrictive nature of the LGS, patients’ eating habits and their food intake dramatically changes immediately after surgery. In connection with this, they talked about the physical and psychological changes they experienced and the changes they experienced in

social relations. Under this main theme, rebirth, “fitting in”, social relationships, perception of self and bodily changes sub-ordinate themes will be explored.

7.1.1. Rebirth: “Like a baby”

All of the participants described the surgery as a rebirth or some kind of a fresh start. They talked about that their post-operative processes like being a baby again. In fact, bariatric surgeons already use this analogy to describe the stages of post-operative feeding process and try to make sure that patients understand the new volume of their stomachs. The most commonly mentioned infancy-like experiences were; starting with liquids and continuing with purees and finally passing on to solids, feeling satiated with little amount of food and vomiting. Merve mentioned that as:

> “I was fed with only liquid for a while and then with puree for a while. I just lived like a baby”.

Other experiences that support the concept of rebirth were eating kids menu because of the new size of their stomach, and hearing things like “You look like a child” after losing weight. They also perceived the operation like a second chance to start things from the beginning, in their relationship with food, with other people and with themselves.

> “I tell people that nothing happened, I just removed half of my body and threw it down the window, a part of the person in me committed suicide.” (Sıla)

They talked about this operation like a new starting point to rewrite their lives. Bahar mentioned she had the operation on her birthday. Zehra and Neshwa referred to their pre-operative selves as “old me”.

"I ignored my past. I don't even want to look at my old pictures. I don't want to see them. There is only future for me now." (Hande)

Despite all the difficulties they experienced in the post-operative period, all participants expressed their gratitude for this new opportunity that came through the surgery.

7.1.2. "Fitting in"

Participants reported that it had been hard to fit in as an obese person. In this sense, the most mentioned subject related to post-operative changes involved the changes in clothing. They mentioned that prior to surgery, they had to wear clothes that were not appropriate for their age or style because they could not find suitable clothes for their own bodies. Due to not fitting in the clothes they wanted to wear, they had experienced difficulty expressing themselves as they wished.

"You start to look like a tomboy. You are taking on that identity. You say; if no one accepts me like that, I'm going to be masculine." (Zehra)

Not being able to fit into the available clothes and sizes was a major problem. Sıla said that in high school she had to wear a male shirt and added:

"No matter what the price, model, color you have, if it fits you, you had to take it, because you had no alternative."

While they were experiencing a great sense of exclusion in this regard before surgery, the change in experience after surgery was a dramatic. Shopping that they had dreaded before has become an enjoyable activity. As they began to fit into clothes, they began to shop according to their own tastes and began to express themselves better. They also talked about increasing self-confidence about spoke

of a great sense of freedom because they no longer had to settle for the options offered to them. Sıla expressed it as:

> "You liked a shirt but you think it's expensive or you liked the shirt but you didn't like some part of it, you can just go to the store next door and get a similar one. But it wasn't like that before."

> "It was very interesting, instead of choosing the stores that have clothes that fit you, buying from all the stores. It was something else." (Bahar)

While talking about their feelings about fitting into the sizes of famous stores, they frequently mentioned about feeling accepted by the society, feeling confident and free. For them, it was clear that the function and meaning of clothes changed. Sıla expressed how her anxiety about not being able to find any clothes that fit her body transformed into confidence:

> "My only purpose was to find clothes that fit me and cover my body (….) I definitely can find something in any store now."

Hande expressed her feelings about her transformation process as:

> "My brother and me went to shopping... (Her eyes filled with tears) Why do I get so emotional about this? I went shopping after losing weight; I was jumping like a child in the store. I was so happy (crying) because wearing sizes smaller than 40… I can't explain… I was jumping in the store, laughing, jumping. It's something I can't forget."

Participants also talked about the physical barriers they had to face in daily life and remembered their concerns about whether they would literally fit into the standards set in many places like buses, elevators, and amusement parks.

"I've always had this fear. When I went to an amusement park or play center in high school, the first thing I looked at was how much or under weight they took." "…The first thing you think about every step you take is your weight. I went on a Black Sea trip 2 or 3 months before my surgery, for example; there was zip lining, you were flying between the two mountains, and everyone was in the queue. The first thing I did was to ask, "What is the upper weight limit?" and "Does this carry me?"" (Sıla)

"I went to an amusement park once and my seatbelt didn't close… I wasn't cared at all, I mean, I wasn't showing it but of course people care about these stuff. I must be absolutely annoyed. And I forced the attendant to close my belt that day." (Buse)

They mentioned that they had a constant fear that they would not fit in the seats and places made according to standard norms. After losing weight, as they started to fit in there was a decrease in the concerns about physical barriers in daily life. It seems like, as they begin to fit in to the norms of the society -fitting in to their seats, fitting in to their sizes- they begin to find themselves a place in that society.

"I'm thin now and I can do anything I want and I don't have to ask anyone anything." (Sıla)

7.1.3. Social relationships: From isolation to crowds

All the participants talked about some sort of social isolation and avoidance especially when they were talking about the period they had reached their peak weights. Neshwa and Sıla said they had never had a romantic relationship before. The other participants said the following things on that issue:

"I was avoiding having a boyfriend." (Zehra)

> "The last time I had a boyfriend was in 2007, when I was a freshman. I've never had a boyfriend since then"…"I haven't flirted with people for a long time." (Merve)

> "It wasn't something I noticed much as a child, but I've never had someone special in my life until I was 28." (Bahar)

In addition to avoiding romantic relationships, they also talked about avoiding social relations and a sort of isolation.

> "It gets worse as the age progresses, and I was never even out when I gained a lot of weight. I was watching TV series all day, eating all day at work, watching movies, doing nothing else. I wasn't seeing anyone, not even a hairdresser. So basically, you are not living. I've lived like this for 2 years." (Zehra)

> "I didn't want to get out of the house anymore. I became withdrawn." (Hande)

> "For example, when I reached my top weight -I'm a person who has been holidaying with my friends since I was 15- I haven't been on vacation with my friends for 2 years." (Merve)

They mentioned that there were changes in their social lives and romantic relationships or in their approach to romantic relationships after the weight loss after surgery. As a result of losing weight and an increase in their self-confidence after the operation, they started to socialize more comfortably. They felt they were more comfortable in the environments they were away from before. There was a noticeable increase in communication with the outside world and people.

> "I have a really good relationship. I had a relationship for the first time in my life. This is all new Zehra's life after surgery." (Zehra)

> "You want to get into crowds more. You want them to see you, let them see you." (Hande)

> "I've had my flirtatious period and I had new friends. I mean, I'm pretty fed in social sense… As you lose weight, you start to fuel from other things emotionally. You socialize, you flirt, and you spend time with others." (Merve)

Participants also reported being more open and assertive with their ideas and feelings to those around them. While before the surgery, Sıla had hesitations about saying she was hungry, she said, "Now, I say I am hungry".

Similarly, Zehra expressed it as:

> "I used to eat alone. Some people eat with their friends, say "Come on lets go somewhere and eat" but I couldn't do that. I don't know if it is about being shy or something like that but it changed now. For example, I eat whatever I want with my boyfriend. He even tells me how comfortable and natural I am but he didn't know what it was like before."

> "PI- How is it now, when something forces you….
> Hande- I can say it. When I don't like something, I can say it. For example, I can say I don't want to go there. You can go but I am not coming. I am not sure whether my aim was to adapt to the environment or to enter into society before, I can't tell. Right now, if I don't want to do something, I can say that I don't want to do it. I say, "It doesn't fit me, I don't like it, I am not going to do it.""

They also said that they began to respond to the criticisms about their weight they received from people around them and that they cared less than before. Hande expressed her pre-operation reactions to comments on her weight as:

> "I used to stay quiet or I used to sleep. I was doing it to prevent them from hurting me. Now, it is changed."

Neshwa mentioned how her attitudes changed towards people who criticize her about her weight:

> "Normally, my mom says something about my weight, I get annoyed and I eat even when it's 3 a.m. I used to eat whatever I can find. I used to open the refrigerator and I'd eat it. But now it doesn't affect me, neither my mom's nor her friends' comments. (When she regained weight after surgery) Yes, I gained weight and I am happy with that. You know, I make fun of them and I like it."

7.1.4. Perception of self: A burst of self-confidence

Along with the prejudices and judgments of others, the participants also seem to have had negative thoughts and judgments about themselves on different areas in relation to their weight. For example going to a job interview became dreaded:

> "Come on, they won't choose you. You can't do it. Just forget about it. I was constantly giving myself feelings of worthlessness." (Berrak)

> "I remember very well. You became very shy and you always underestimate yourself." (Hande)

> "I said to myself, I deceived myself for years. I wasn't self-confident but of course I didn't tell anybody that." (Neshwa)

The issue of romantic relationships was another one.

> "As I said, I was thinking why should they look at you? Even though there was a potential, I was destroying it all by myself." (Merve)

> "Like I said, I used to think that they wouldn't like me as a woman anyway." (Sıla)

When referring to their pre-operative perception of selves, they often described a woman who was shy, nonassertive, self-conscious and had negative thoughts about herself. Even if they described themselves as funny, cheerful, successful in some areas, they frequently talked about these negative opinions about themselves as well. And they explained the changes in these negative views about themselves after the surgery with some examples. All of them said they experienced an increment in self-confidence related to weight loss.

> "Now I am thin. I did accomplish lots of things in my life while I was fat; now I can do whatever I want and I don't have to ask anyone's permission. Being thin brought me this." (Sıla)

> "After losing weight, you experience a burst of self-confidence." (Zehra)

> "Why wouldn't they pick me? Excuse me, what do they have that I don't have? I am not talking about a narcissistic thing like; 'they will of course choose me because I am awesome,' but I am not feeling lowly either. Not anymore." (Berrak)

In addition to self-confidence and self-worth, they not only said they felt more free, but also felt more like a woman.

> "I haven't felt this way even when I wasn't overweight. This is a whole new situation for me. I can say that feeling like a woman is something very new to me." (Berrak)
>
> "I started to become a woman." (Zehra)
> "I could definitely say that I feel more like a woman." (Sıla)

Overall, they talked about how they care about and trust themselves much more than before, and how they quit being silent in the face of comments that upset them about their bodies and their weight. Even though they gained weight after the surgery, they felt the same way:

> "I went to surgery with 106 kilos, now I'm 85. I have more or less 12-15 kilos to lose but I don't have that lack of self-confidence as before." (Neshwa)

7.1.5. Bodily changes

The three most frequently cited issues about bodily changes were: changes in physical health, perception of the physical body, and internal experiences of the body. All participants mentioned both positive and negative experiences when talking about physical changes.

7.1.5.1. Physical health

In the process of weight loss following surgery, there was improvement in comorbid diseases they had before surgery, such as insulin resistance, diabetes, polycystic over syndrome and fatty liver.

> "My cholesterol was on the rise, heart palpitations due to cholesterol, distress, sweating, and shortness of breath... Now, they are all gone." (Berrak)

> "I do not have to take any drugs because my sugar level is normal now." (Merve)

> "That anxiety of "I can get diagnosed with diabetes any moment" is gone now." (Sıla)

There was also a report of a great improvement in respiratory problems, joint pain and movement restrictions. There was an increase in energy levels along with physical improvements.

> "Those feelings are great. For example, you're walking, your back is not aching, and your knees don't hurt." (Zehra)

> "I used to be like disabled, now I can run (laughing)." (Berrak)

> "I used to use public transport less often; I usually went by taxi everywhere. I use a lot of public transport right now because I have to use metro to go to work. Before, it was very difficult for me to walk from Teşvikiye to Osmanbey subway station (laughing). These may seem like such short distances, but for a person of 115 kilos, it was actually something that consumed energy and was hard. Well, that kind of things happened." (Merve)

They also mentioned that after the weight loss, the mismatch between their body and mind was eliminated.

> “Human brain works fast and if you are overweight you can’t work fast. It’s like lightspeed and -how should I put this…- walking speed. One goes at walking speed; one goes at the speed of light, so mind fights with the body.” (Berrak)

They mentioned negative physical experiences such as life hair loss, fatigue, and vitamin deficiency, as well as positive changes that enhance their quality of. Zehra said that she always mentions the hair loss to people who ask her if she recommends the surgery:

> “I finally got my hair back; but even though I took my vitamins, it was poured out of my hair because the body is in a state of shock. I saw my hair on the floor when I was working.”

Overall, while experiencing positive developments in their physical difficulties and diseases, they experienced negative physical experiences due to the effects of surgery and rapid weight loss. There were those who experienced conditions such as heart palpitations inability to walk, fainting from hunger after the surgery, and pneumonia due to the weakening of the immune system:

> “So, I lost all my excess weight in 6 months. My body was shaken. I had pneumonia at the end of 6 months; I was hospitalized for 5 days. So I couldn't walk, I couldn't breathe, I had a very serious heart palpitation.” (Bahar)

While they attributed negative experiences like this to rapid weight loss, they were happy about all the positive changes once the negative experiences were behind them.

7.1.5.2. Perception of the physical body

Two important points stand out about their perceptions of their body: their feelings about their appearance and changes in the way they feel/experience their bodies. They talked about their pre-weight loss bodies as something to hide, cover or avoid. For example, they avoided looking in the mirror and felt like they were trapped inside their bodies.

> “It's too bad to look in the mirror every morning and not to like yourself. So you're looking at it and saying, “What am I going to do with this body?”” (Zehra)

After weight loss, they seemed to come to a place where they didn’t feel the need for hiding or covering themselves, as they felt good about their bodies. As differently from before, they said they were taking more photos of themselves, shared photos on social media, and started doing things that made them stand out more. Although they talked about sagging skin, body deformations and the need for aesthetic surgery, they said that they established a better bond with their bodies than before.

> “When you look in the mirror you see a body that you don't hate; you see a body that you begin to like.” (Sıla)

They described how they discovered features that they had not realized before in their bodies such as their waist region. When they referred to their overweight bodies, they were prone to describe themselves as round shaped. They used words like “tombik”, “tosbik”, “yuvarlak” that mean round and plump in Turkish. Below, Sıla describes how she saw herself before the surgery, and her astonishment at her new discovery after the weight loss:

> “After a while you take the shape of a round. You don’t have a waist region; your breasts don’t look like breasts anymore. You become a human that lost her human body form… I discovered some parts of my body after weight loss. For example, I have bones here (showing the collarbone). I told my doctor that there is a bump there and he said “These are your bones and you are seeing them for the first time.” I was like Oh! I have a waistline too!” (Sıla)

7.1.5.3. Internal experiences of the body

In addition to physical changes, participants also talked about different experiences of their inner perceptions of their bodies, involving a complex internal adaptation process in the face of bodily changes. Even though they have lost a lot of weight physically, they often expressed themselves still feeling overweight.

> “Your soul, I mean… I still feel like I am overweight. I still feel fat inside because I haven't changed, I'm still that person inside.” (Bahar)

In connection with this, they said they are still turning to big sizes while shopping instead of looking for their current size. Although a long time has passed since their surgery, they are still mentally not fully used to their current body.

> “To me, I am still fat. My brain still doesn’t get used to moving from size 54-56 to 42. This (showing her head) still can’t comprehend… Sometimes, I still need to check it. Yes, I feel it. Yes, these are my hands, I am controlling them, and I am moving them. Although it has been 3 years since my surgery, I still feel that way.” (Sıla)

> “I still think I am overweight. When I go to a store, I ask the girl “Does this fit me?” and she says, “Of course, why wouldn’t it be?” I feel so weird when I wear an outfit and I am like “Oh, okay.”” (Zehra)

7.2. REASONS FOR BEING OVERWEIGHT

All the participants shared some explanations for how they gained weight and became obese. Genetic factors, mothering, and losses were the most common factors they mentioned during the interviews. Being overweight is frequently mentioned as a characteristic of the family.

7.2.1. Genetic Factors

The participants reported that most of the diseases they had before the surgery (insulin resistance, diabetes etc.) were also present in other family members. They put forward genetic factors more frequently than their eating habits. Factors such as the fear of haing to use medications throughout their lives and the fear of the probability of suffering from those diseases like their loved ones have been influential in their decision to have surgery.

> “Due to our eating habits, we are an overweight family. And the same goes for our extended family.” (Bahar)

Some participants had at least one family member who had LSG like them.

> “My big brother had this surgery first, being overweight runs in our family.” (Hande)

> “At the end of the 4th day of my post-op, I went home and took my mother to the hospital and said: You are having this surgery right now. There is nothing to be afraid of, so you will have it too. At that time she was 122 kilos and had a heart problem.” (Berrak)

7.2.2. Mothering

Although there was no specific question about childhood eating habits, mothers' relations with food and feeding styles in this research, important information about these issues appeared in interviews. Participants described their mothers' feedings styles, their relationship with food and the importance of mothers' care-giving styles while talking about their relationship with food as adults. In one-way or another, they experienced problems related to nutrition in infancy and childhood. In addition to nutrition related problems, they expressed feelings of deficiency in terms of emotional nourishment.

> "They said, I didn't get any breast milk during my infancy and I was vomiting any food I ate in few minutes." (Sıla)

> "They say that the reason I gained weight was psychological. My mom and dad divorced when I was 3-4 years old, and then I started to gain weight." (Buse)

> "I was seeing a psychologist before I had surgery and she told me that I was trying to fill the void caused by lack of love by eating. And she told me to channel my attention to other things." (Zehra)

> "How did we (herself and her big sister) gain weight? Probably eating behind my mom's back." (Zehra)

> "My mother has very strict rules about not getting processed foods and packed products. When I was a kid, no chocolate or cotton candy was ever bought from outside, and my mother would make all of them at home. My friends always say, "It is surprising that your mother didn't invent a fruit tree yet." I think we were growing curious because we were kept away from the food. Me and my brother. When we had our own pocket money,

our curiosity and need increased even more. When we were coming home from school, we would go to the supermarket and buy some chocolate, eat until we came home, and pretend like it never happened (laughing) and eat at home too. Such a life began. The habit of secret eating began at those times. But the whole family is always very insistent about eating. They still are." (Bahar)

According to Bahar above, her family seems to have given her mixed messages about eating:

> "My family has always told me that I'm overweight and I have to lose weight. Always. It never ended. They'd take my plate from in front of me during eating. That would make me so angry, I'd feel so offended. Because everyone was overweight in our family and I was the only one who was banned from eating like that. Maybe it was because of my gender, I don't know. I still can't understand it and they can't explain it either."

Strict rules, complex messages and prohibitions about food and eating seem to have led them to hide what they eat from their mothers. While explaining their relationship with food, they often spoke of their unmet needs in their romantic relationships and in their relationships with their mothers.

> "I've always waited for admiration. At that time, I wanted my mother to appreciate me. My mother would never appreciate me because, you know, this is how she is. She never… I mean, of course she loves us, we are her children but she is not a tactile person at all. On the contrary, I am a very tactile person. I like to cuddle, kiss, to say "dear". I'm that kind of a person. My mom is a person who doesn't show her love. As such, I became a person who waited for appreciation." (Neshwa)

Berrak said that her emotional needs, which were not met in her marriage, had an impact on having a divorce and on her relationship with food:

> "I don't think that my divorce had an effect on my decision to have the surgery, but I think my weight did. Because, like I said, when you can't get something emotionally… I think it's related to that, there's no other logic, there is no other explanation for being emotionally attached to food I guess."

They said that they had turned their focus to food because they had not been able to get the support they needed in childhood nor in adulthood. At this point, one of the most striking details had to do with the experiences of the participants about their past losses.

7.2.3. Losses

All participants mentioned at least one loss they had in their lives. While the death of a loved one was the most frequent loss, having a divorce, parents' divorce, long-term frustration and getting cross with the roommate, and bankruptcy were among the mentioned losses. They all mentioned that they gained weight in the periods when they were experiencing difficult emotional events. Eating and sleeping were the two main coping mechanisms they mentioned.

> "My father was diagnosed with cancer and I gained weight during that time. Totally, it took 3 years of my life. This disease and that loss… I mean, it was impossible for him to beat the cancer, so you're trying to stand up straight and at that time I held on to eating…. I gained 25-30 kilos after I lost my father" (Zehra)

All of the people they mentioned having lost were people with very important places in their lives, people who gave them emotional support and made them feel understood. Neshwa who could not establish a connection with her mother as she wanted, said the following about her deceased father and grandmother:

> "That was a very difficult time. I was so lonely; I didn't want to talk to anyone. Everyone knows how much I hold dear my dad and my grandmother… My grandma and I were like buddies. I mean, I'd tell my grandmother everything. In the same way, she used to give me advice because she was older and blah, blah, blah. I mean, I wouldn't stay home; I'd stay at my grandma's. I didn't have much to do with my mother. I was always alone or talking to my grandma."

Likewise, Sıla had close relations with her grandparents and lost them.

> "I was with them since I was 3. I lived with them until I was 15-16 years old. When my parents split their houses, I wanted to stay with them with my own will. First, my grandfather died. And my grandmother died a year after my surgery. At that time my grandmother gave unconditional and great love to me. I feel the absence of that love now."

Buse, who linked her weight gain with her parents' divorce, also had two major losses affecting her life. Shortly after her grandmother's death, she had lost her uncle, who was more important to her than her father was. Already depressed after her grandmother's death, Buse said that she suddenly decided to undergo surgery when she lost her uncle.

Bahar said that she gained weight since she started to live alone and she spoke about the divorce of her parents as follows:

> "My mother and father were separated. Both of them said we could go live with either of them. We did not understand the reason for this separation and we said that we would not go with either of them. We said we would continue to stay in our own home. At that time, my brother was 18 and I was 13 years old. We stayed at our home and they left."

Merve mentioned that she gained weight as a result of a disagreement with her roommate whom she had been a friend with for 16 years:

> "We had a crisis and didn't talk to each other for 1,5 years while living at the same house. I didn't use the common areas at all and spent more time in my room. And since what you call the room is already made up of a bed and a wardrobe, I was either constantly reading something in bed or watching something and eating all the time."

Finally, Hande talked about a different loss and the experience of finding comfort with food.

> "PI- Are there life events that affected your weight gain?
> Hande- Yes. Bankruptcy. After the bankruptcy, I saw 96-97 kilos. Back then; I put all my attention on a computer game because you want to leave some things behind. I'm a person who thinks I'm going to forget it if I give my attention to something else. I gave my full attention to that game and I got through that period, but you are always sitting in front of a computer… You do nothing. You wake up and sit and then you stand up and go to sleep. My body swelled up and I was 96 kilos."

All these examples show that participants used food as a soothing mechanism during periods of emotional difficulty. Few of them received psychological support in these processes and used psychiatric medications. Some of them said

that things would have been very different if they had taken psychological support at the time they had these losses instead of waiting to do so after surgery.

> "I didn't need psychological support after my surgery. I thought about it in the beginning, but did not feel the need after that. On the other hand, now, when I look back, I think that I needed more psychological support then." (Merve)

7.3. RELATIONSHIP WITH FOOD

When talking about their relationship with food, participants described a wide variety of situations and feelings, such as if they were talking with a human being. Their relationship with food involves stress and struggling, as well as receiving support, being happy and feeling satisfied. Addiction, control and emotion regulation were the most prominent sub-themes of the relationship with food.

7.3.1. Addiction: "My brain still wants it"

While the participants talked about their relationship with food during the interviews, the word "addiction" was frequently used. They often mentioned their relationship with sugary and high-carbohydrate foods as addiction. They all said that they did not eat much in quantity but the food preferences caused them to gain weight.

> "My precious, how nicely, I ate. What a relief! People feel high under the influence of heroin, that's exactly what happens to me while I eat." (Berrak)

After the surgery, while there was no change in their interest in these foods, they were able manage due to loss of appetite; but as time passed after surgery and

their appetite increased, they said they had difficulty managing it. Especially after a considerable amount of weight loss, they talked about an intense craving for forbidden foods with high calorie and low protein like rice, pasta, chocolate and pastry. They described the struggle they had between eating and not eating those kinds of foods, and all of them admitted that they sometimes eat even though they know they will vomit shortly after eating.

> "I should confess that sometimes you make yourself throw up. Those kinds of things happen. For example, I shouldn't be eating pasta or rice but I want to eat, so I eat and I vomit." (Zehra)

According to what they said, eating something that differs from what they wanted to eat does not satisfy them.

> "If I want to eat something and if I had something specific in my head to eat -for example, I want to eat pistachios and I am eating tons of something else not to eat it- I never feel relieved. This (showing her head) doesn't feel that relief. That stress and anxiety don't go away. I feel relieved after I eat that pistachio." (Berrak)

> "Not any food, only eating the food I crave for makes me feel satisfied." (Bahar)

Some described their eating habits like a curse they wanted to get rid of:

> "You lose weight but the idea of eating, the obsession of eating, the desire to eat… I am absolutely damned and I am stuck… You're trying to get rid of it while you are living with it." (Berrak)

Berrak also added that her appetite and her desire to eat came back after a while she lost weight. When she told her doctor about this, he decided that she could not

get through this without support and referred her to a psychiatrist. She was given a psychiatric drug as an appetite suppressant and she received psychological support for a while. She said the psychological support helped but at the time of the interview she was still feeling the same about food. The fact that a person is never satisfied without eating what she wants shows the intensity of the need for that thing and basically the fact that nothing can replace the main thing that will meet this need. This raises the question of whether the dissatisfaction of the people is related to food or to another unmet need? Is it about hunger or an emotional need? They say that they don't eat only when they're hungry, and they feel the need to eat when they don't feel physically hungry. The inability to get what is needed can lead to a constant feeling of dissatisfaction, disappointment and deprivation. The passion of people to eat what they want can be an expression of this concept.

> "My brain wants it, even if I am not hungry; my brain still wants to eat." (Zehra)

Overall, they described the absence of food as something that caused intense stress. Especially, in the case of deprivation, they turned to forbidden foods and eat lots of them. The idea of dietig evokes the feeling of deprivation in all. Especially the day before the surgery or the day before the diet began, they said they ate too much. This may show the intensity of the need and the concern for the inability to meet this need. Buse who sometimes starves herself and doesn't eat anything for days, mentioned a constant shuttling between eating too much and starving herself.

> "The idea of dieting pushes me to eat like I've not eaten in months. That's the breaking point; if I know that I am going on a diet tomorrow, I start eating like you are trying to take my plate from me." (Buse)

Correspondingly, they expressed their relationship with food, not only with hunger, but also with desire, and separating hunger from desire, they often

explained their eating behaviors by associating them with emotional states. They underlined that there was no change in desire after surgery, even though there were changes for a while due to decrement of ghrelin hormone.

> “Ok, you took the satiety hormone (referring to “ghrelin”) but it’s not about hunger, it’s not because I am hungry. I’m enjoying it, it makes me happy or I use it as a punishment when I get angry with myself… I mean;,I replace everything with food. Instead of happiness, instead of reward, I eat; instead of everything… Now, I am not hungry but my brain -I mean, I am really full right now- but my brain pokes me saying: “Can I eat something now?”” (Berrak)

> “For about a year I never consumed any dessert -I am incredibly addicted to dessert- I regret the day I started again (laughing).” (Merve)

They also mentioned different addictive behaviors that they put in the place of they could not eat. They talk about things like doing too much sports, desire for caffeine, and shopping.

> “Something happened. I was never a fan of tea or coffee. I used to drink tea with breakfast and that would be all. Now, I have this desire for coffee and tea because you need caffeine to be in fine fettle… And when I could not eat, my desire to shop increased.” (Hande)

Instead of replacing the food with something else, or developing dependence on something different, they also reported that they developed different behaviors in accordance with food restrictions. Berrak talked about a tactic she developed when she couldn't eat what she wanted, or when she couldn't eat as much as she wanted as following:

> “People were crying because of not eating, they were having crying jags. No, I didn’t do it that way. How did I get through this process? I saw that I have a problem with food and that I want to get food all the time. I watered down the buttermilk as much as possible. It's not forbidden; you can drink as much as you want. I watered it down; it smells like food, but its just water. On the one hand, I am drinking water and also fooling my brain like I was eating something. I went through that process very comfortably. By fooling myself… (Laughing). I am still doing it, when I have the attacks. I water down some buttermilk and I calm down. I try to go back to normal."

7.3.2. Emotion regulation: “Do people talk to their food? I do”

Eating seems to have a very important function for all participants: emotion regulation. They spoke of eating as the most important and even the only method they used to relax when they were experiencing difficult feelings such as sadness, anxiety, unworthiness and stress. Food was something that is always there for them to comfort them, but without the criticism and judgment. From time to time, they talked about their relationship to food as talking about a bond with a human being:

> “Think about it, I am 42 years old - let’s not count like 10-15 years of it- I probably bonded with food from the beginning of my puberty. I ate whenever I got angry and I felt happy after I ate. I ate when I felt happy too and that made me feel happier… I mean, food is like my bro. I’ve been living with this for 22-25 years now and it is impossible for me to stop it. Or it is possible but I can’t do it; I am just not capable of doing it? One or the other. I couldn’t figure that out. I don't know if I can solve it with the help of my psychologist.” (Berrak)

In this context, they often expressed their relationship with food as “not normal” or “problematic”.

> “I guess my relationship with food was never normal. I am thinking of before (the surgery). As far as I remember, when I get angry… When I get mad, when I feel bad… Something happens and I just eat. When people feel unmotivated, they lose their appetite but I eat, I always eat.” (Buse)

They were all well aware of their strategies and the underlying deficiencies that made them develop these strategies.

> “I know that problems related to eating are not just about genetics; I know it’s also emotional because I used to feed myself with sugar. Sugary foods, high carbohydrate foods… I was a person who ate more when I felt stressed.” (Bahar)

> “Whatever I need that moment, if you can’t find it; you get that from the food. Whatever you need. For example, being understood by someone or laughing. Do people talk to their food? I do (laughing)… Human beings are social creatures and they need to connect -not dependence, we need connection-. Would I be the same if I had received love, trust and understanding from another person? Is it my excuse or can it be true? I can’t say it’s just because of that, but I definitely see a connection between them.” (Berrak)

Participants gave many examples of how they had failed to contain themselves in some situations. They talked about eating when they felt bored, helpless and the times they had trouble sleeping.

> “When my father was sick, I went on vacations two or three times, and you suffer a pang of conscience. Because you want to see him all the time, you want to be there for him. You can’t travel, you can’t have fun and you can’t always expect support from your friends. You can’t do this. So, I let

> myself eat. I don’t want to say that’s the reason I gained weight but… Someone is dying at your house, your father is dying, he gets chemotherapy everyday. You feel stressed, unhappy at work and at your home too. I thought eating would be the best of a bad habit.” (Zehra)

When they failed to regulate themselves and could not get the support or understanding they needed from others, they said the next stop was always food. As time went by and these needs continued to be, they skipped the first 2 steps and made it to the third step, the food, and made that a strategy. On the other hand, it seems like they can manage their relationship with food when they get what they need emotionally (support or understanding) and physically (a hug or the presence of someone they feel safe with). For example, Neshwa mentioned that she lost weight more easily when she went on long-term holidays to her cousins in Dubai. She explained the difference in living with her mother in Istanbul as follows:

> “When I hear something -especially from my mother- I start to eat. I eat out of anger, and these days I fail to follow my diet requirements because of that. But at least I make more healthy choices. At least I don’t eat a burger or pizza… I'm very comfortable and I'm losing weight very easily at my cousin’s house in Dubai. The only reason I go to that house -of course I miss them too- is because I feel good about my health there. As I said, my cousin approaches me like a father and his sister approaches me like a mother. I get things that I don’t get from my mother; compassion, hugging, and physical contact. I feel good, that makes me happy and it motivates me.”

7.3.3. Control: “Never ending struggle”

One of the things that will not come as a surprise when we talk about addiction and emotion regulation is control. Being obsessed with food and

constantly trying to control one's eating behavior and not being able to do so were two extreme points that participants experienced at different levels from time to time. Even though they mentioned that they gained some healthy eating habits after the operation, the examples they gave on this subject were much fewer than the examples they gave on others. Because of that reason, developing healthy eating habits were not included under this sub-theme.

> "It became an obsession for me after surgery. I was writing down what I ate and taking pictures of what I ate; I was getting on the scales everyday, I was weighing my food before and after cooking etc. I don't know if I was such a person like this before surgery. I was writing notes everywhere like "You are not going to eat anything. You are not going to eat anything." (Buse)

Other participants didn't mention such obsessive behavior as Buse experienced, but they all gave examples of not being able to control their eating behavior from time to time.

> "It is really bad to feel that helpless. You can't manage a stressful situation, but a tiny chocolate controls you." (Berrak)

> "If I feel unhappy that day, I go to a supermarket, buy some chocolate and chips and eat them. I eat them all. There is no such thing as "eating some of it". I'll eat until I'm done." (Zehra)

They talked about memories such as eating 1 pack of pasta or one tray of pastry by themselves. When they start eating, they can't stop until they finish, and when they want to stop themselves, it turns into a battle.

> "Let's say I resist one day, but I feel extremely weak. It's like I am fighting but in the end it wins anyway. I have to be strong, I have to work

and get things done. I can't fight with it all the time. I am moving around the refrigerator. You come and go, come and go… No, I am not going to eat it! I promised my doctor, I am going to fail… Eventually I eat, the fight ends and then I can concentrate on my job." (Berrak)

7.4. RELATIONSHIP WITH THE OTHERS

The presence of a third person in the relationship of the participants with food was remarkable. We have seen in other themes that the presence or absence of someone has a great impact on people's relationship with food. This theme is organized around the need for the other and the concept of being and not being understood and supported by the other.

7.4.1. Being constantly observed by the others: "Like an experimental subject"

In addition to their own adaptation processes, participants talked about their the adjustment processes of those in their environment to the changes brought by the surgery. What they eat, how they eat, how much they eat... While trying to adapt some new habits, they also talked about their efforts to explain these to those around them. Failure to meet people's expectations, criticism, being judged by others and feeling under pressure were the other issues mentioned under this sub-theme.

"It is very frustrating. Answering their questions… Even though they know the answers, they always ask the same questions. "Are you sure you're full?" Especially in the first weeks after surgery, when I hadn't lost much weight yet. Now they are like 'Oh, you are thin, so you must be full but I asked this question anyway.'" (Merve)

One of the things that didn't change for the participants after the operation was being constantly observed by others. Although their body, weight and eating habits changed, the criticisms and observations continued after the operation. They mentioned that surgery had a tabloidlike aspect for people; it automatically gives them a topic to talk about.

> "They are looking what I eat. They are like "What is she going to eat?" Imagine you are in a crowded birthday party, people are looking curiously "What is she going to eat?" "Oh, you ate bread!" "Isn't it too much for you?" "Oh! You ate as much as I ate!". Sometimes I feel like a monkey or a lab mouse. For example, yesterday we were at my friend's house and I ate something. Then, she gave me the second plate and I was like "Is she testing me?" She knows that I cannot eat that much." (Zehra)

She added that she is avoiding eating with people who made such comments. Especially after losing weight, they talked about not being able to please the people around them. Before, while they were criticized for being overweight, now they are being criticized for being thin or looking tired.

> "It is impossible to please people. Someone says, "You look beautiful", other one says "Ohh! You look old, you seem tired, and you got ugly."" (Hande)

> "Most people tell me this, "You are not that skinny yet". It's been 2 years and I am 70 kilos now but they expect me to be 50 kilos because I had surgery. What does it even mean to be "that skinny" anyway? I am wearing size 38-40 now and I'm healthy, my body mass index says I am at a normal weight." (Zehra)

Especially after surgery, their bodies, weight and what they eat do not only concern themselves but also everyone around them. It seems that there are certain

concepts that people associate with this surgery, regardless of the difficulties or possible outcomes of it. They expect people to be very thin or fit -just because they had this operation- without taking into account their personal and physical differences. Even if they are feeling satisfied with their current bodies and their weight, they seem to continue to struggle with the norms in people's minds.

7.4.2. Not being understood by the others: "Not as easy as you think"

Participants frequently spoke of their need to be understood by others. They said they needed a more insightful instead of a judgmental attitude. While talking about this issue, they described the attitudes of family members, friends and health personnel involved in their processes. Although the subject and content of the issue changed throughout the process, the judgmental attitudes always remained the same.

> "People directly say that to your face "You are fat because you eat too much." They say "You can lose weight if you stop eating bread, pasta and rice." How do you know? I don't like pasta, I don't eat rice but I'm still fat!" (Sıla)

The same people made comments about her losing too much weight after surgery. Sıla resentfully expressed her feelings about this as following:

> "Have you ever lost 20 kilos just like that? You don't know the whole story. I've gone through a lot of stages until I got here, and you don't know the whole story."

They said that people thought everything was over after surgery, but that everything actually started with surgery. Neshwa gave the following example on this:

> “The day I had my surgery, thanks to mom and her friends (laughing), they filled the room with food. I was out of surgery and I had cakes, pastries right in front of me, right under my nose. Then my doctor came in and got angry with my mom saying, “This girl just got out of surgery, and if she sees these foods, she will crave”. Because when I told the doctor about these processes… I mean… He knew I was a trencherman. He said to my mom: take these out of her eyes, this is a hospital, pull yourselves together.”

All participants gave similar examples on this issue. They explained that the surgery process was not as simple as it was thought and they experienced a lot of trouble in this regard. All of them said that the reason for participating in this research was to contribute to the understanding of this issue. They all said things similar to the following:

> “People think it’s easy, but it’s not. They think that you just have the surgery and you lose weight, but it’s not like that. That’s why I wanted to talk to you.” (Buse)

They said the same for not only their families or friends who had no knowledge of the surgery, but also for some of the doctors and dieticians involved in their processes. There were participants who were very pleased with the support from their doctors during the process, and others who were not.

> “My doctor didn’t come to my room to check on me; he sent his assistant. After I got home, my fever went up and they didn’t even answer our calls.” (Buse)

> “If you don't die, doctors believe that everything will be okay. Yes, everything got better but I got through it very hard.” (Bahar)

> "I lost only 800 grams the week following the surgery and it was impossible for me to go off my diet because I was just drinking liquids. My dietitian bawled me out for still being obese, that my brain was obese and I that would never lose weight. For me, a person who has undergone this operation has tried everything and has run out of options. The psychological aspect of this is very difficult compared to other people with weight problems. After all this tiredness, you have just undergone this surgery and someone says self-righteously, "You can't do this." This is not fair." (Zehra)

7.4.3. The need for the other: "It's nice to feel you're not alone"

In a process that others were so involved in, the participants often spoke of their need for a "supportive other", both emotionally and physically. There had been times when people needed physical help throughout the process. In such cases, almost all of them were able to get support from their environment. Neighbors, friends or coworkers brought food, helped when they were sick or helped when they had difficulty walking. Aside from such supports, people experienced many situations in which they felt lonely.

Participants were divided into two on this issue: the ones who received support from their medical team and the ones who did not receive that support. Although participants had different experiences on this subject, the fact that both groups mentioned that this was a very important need was what made this a sub-theme. The ones who were satisfied with the doctor who performed their operations frequently expressed their gratitude towards them. Those who trusted their doctors and those who were sure of their support spoke positively about their processes even if they had severe complications after surgery. They said that it was very reassuring to have someone who could be reached if needed. The ones who felt supported by their personal trainer, dietitian, psychologist or surgeon

after surgery talked about a much better recovery and weight loss process. And they continued their follow-up controls regularly.

> “My doctor was very supportive in the post-operative period. I’ve never had this feeling “Oh my God! What am I going to do now?” I really trust him. Still, I know that he is just a phone call away.” (Sıla)

> “Not like a parent. Not in a hierarchical way like that. It’s like they were saying: We really want to help you. It’s a more equitable relationship. It’s nice to feel you’re not alone. (Berrak)

Buse who cut off communication with her doctor, dietitian and her psychologist after surgery mentioned that she joined a whatsapp group where she could talk to other people who had the same surgery. She said she provides the support she needs through this group.

> “I was telling them when I had an opinion about surgery. It has been a year and a half since we started it. Because we're not so many people, everybody knows and loves each other. This was a larger group, but we gathered and opened another group. They know I'm gaining weight but no one says: “If you gain weight then don’t eat it”. She knows because she's been through the same thing.”

Zehra who hadn’t offered psychological support as a part of the surgery process and who was scolded by her dietician when she couldn’t lose weight said that people in the surgical team should know better what patients have been through in this process. She said that the most important thing for people who have struggled with this problem throughout their life is the existence of someone to support them in this process and added:

> "I think a good surgeon, a good dietitian and a psychologist - but I think this psychologist should have training about this surgery- I think my journey would have been much better with the combination of 3."

In addition to the surgical team and their parents, they often talked about the importance of the support from their friends and close relatives.

> "My friends who followed my process with me asked "How do you feel?" or "Do you have a problem about your health now?"" (Merve)

> "My friends were like "You are doing great, keep going." I receive social support from them." (Berrak)

Overall, the need for an uncritical, supportive and understanding person who can stand by their side whatever happens was at the forefront during all interviews.

> "I needed someone. Maybe a friend, a psychologist or a dietitian, someone who can stand by me." (Neshwa)

DISCUSSION

The main purpose of this study is to understand the experiences of people who have undergone laparoscopic sleeve gastrectomy (LSG) surgery, in order to add an experiential perspective to the studies already in the literature and to make connections with them. The research sample consisted of eight women participants; age 23 to 44 years old, who had undergone LSG surgery between 2 to 4 years ago. They were asked to share their experiences about their weight gain, the decision to take surgery, the operation and the post-operation process. The participants stated that the reasons for having this operation were the failure of the methods they had tried before and fear of the health problems they might have in the future.

Semi-structured in-depth interviews started with the open-ended question of “Could you please tell me about your sleeve gastrectomy operation story?” The data was analyzed using the Interpretative Phenomenological Analysis (IPA) (Smith, J. A., Flowers, P., & Larkin, M., 2013). IPA made it possible to hear and understand these individuals’ experiences in a deep and detailed way. Although every participant had a unique story, they talked about common experiences that later formed the main themes. In addition to the positive and negative experiences and changes experienced during the operation, common themes emerged in terms of people's weight gain experiences before surgery and their relationship with food.

Four super-ordinate themes emerged from the analysis: a) transformation, b) reasons for being overweight, c) relationship with food and d) the relationship with the others. The super-ordinate themes consisted of seventeen sub-ordinate themes: a1) re-birth, a2) “fitting in”, a3) social relationships, a4) perception of self, a5) bodily changes; b1) genetic factors, b2) mothering, b3) losses; c1) addiction: “my brain still wants it”, c2) emotion regulation “do people talk to their food? I do”, c3) control; “a never ending struggle”; d1) being constantly observed by the others: “like an experimental subject”, d2) not being understood by the

others: “not as easy as you think”, d3) the need for the other: “it’s nice to feel you’re not alone”.

The results of this study were consistent with the previous literature on obesity, psychological aspects of obesity and bariatric surgery. The main similarity between the themes provided by the participants was about transformation. In this section, transformation and the related processes, the reasons for being overweight, the relationship with the food and the relationship with the others will be examined in terms of possible psychological foundations and their compatibility with the literature.

As expected, in this study, the primary motivation to have surgery was to see improvements in one’s health status. However, the transformation experience that participants talked about show that there is something beyond their expectations. As in many other studies in this field, participants define the post-surgical process as a “rebirth” and a “fresh start” in many ways (Bocchieri, Meana & Fisher, 2002), independent of all other experiences they had in the process. In accordance with research results in the field, it was once again seen that there was a great improvement in the pre-operative comorbidity of individuals with post-operative weight loss (Tucker, Szomstein, & Rosenthal, 2008). In addition to this, there was an increase in their self-esteem, health-related quality of life and body image in patients who achieved weight loss as a part of their transformation (Hout, Boekestein, Fortuin, Pelle, & Heck, 2006). Along with weight loss and bodily changes, participants talked about the increment in self-confidence especially in social relations and work life (Griauzde, Ibrahim, Fisher, Stricklen, Ross & Ghaferi, 2018). The post-surgical weight loss alleviated pre-operative limitations, especially in the terms of physical mobility.

One of the greatest benefits of surgery is the inner relaxation that results from “fitting in” to the norms (fitting into bus/amusement rides’ seats and dress sizes) put forward by the society (Bocchieri, Meana & Fisher, 2002). In a systematic review research on patient experiences after bariatric surgery, it was

seen that patients talked about being able to fit into seats in public places and experiencing a dramatic improvement in being able to do their daily activities (Coulman, Mackichan, Blazeby, & Owen-Smith, 2017). People talk about an increment in their self-confidence with the weight loss and show more courage in standing their ground against other people's comments. As people see that they are able to lose weight and succeed, changes are also seen in this area. They find a place in society as they begin to fit into social expectations and clothes. Although there has been no change in the state of being observed and monitored by others after weight loss, there are changes in people's reactions to this situation.

Although people mentioned an increment in self-confidence with the effect of weight loss after surgery and extreme weight loss is associated with improvements in body image (Adami, et al., 1998), body dissatisfaction was also quite a common emphasis. Unfortunately, some patients reported dissatisfaction with body image because of the excess skin and most seek plastic surgery due to loose, sagging skin of the belly, breasts, and arms, (Sarwer, Thompson, Mitchell, & Rubin, 2008). Although they do not feel it as intensely as before, they are still talking about a certain amount of dissatisfaction due to body deformations. This duality is also valid for the changing health status after surgery. While a significant reduction in comorbidities (Tucker, Szomstein, & Rosenthal, 2008) was observed for all participants, on the other hand, vitamin deficiencies and complications (fainting, hair loss, weakening of the immune system etc.) due to rapid weight loss (Lupoli et al., 2017) and restrictions on the amount of eating again show that surgery is not a miraculous solution by itself (Bocchieri, Meana & Fisher, 2002). The co-existence of both positive and negative experiences throughout the process supports the need to look at this issue more thoroughly.

The purpose of some of the questions in this research was to explore participants' own explanations about the reasons for being overweight and the connections they had established. The factors that people suggested for reasons to be obese were parallel with the literature. Although high-calorie intake,

particularly energy-intensive foods, large portions, sugary drinks, fast food consumption and lack of physical exercise are often suggested as the causes of obesity (Rosenheck, 2008), genetic factors, speed of metabolism and mental illness are also significant correlates (Cutler, Bleich, Murray, & Adams, 2008). Research shows that the effects of genetic factors -frequently mentioned by the participants- on obesity should not be underestimated. Whitaker, Wright, Pepe, Seidel, and Dietz found that children with at least one parent who are obese are likely to become obese adults when they grow up and the risk of having diseases such as insulin resistance, diabetes and cardiovascular diseases after adolescence are also on the rise (Levine & Smolak, 2001 as cited in; Thomson & Smolak, 2009). Even though body shape and weight have a genetic basis, body image is not entirely related to them; it is the internal and subjective representation of physical appearance and bodily experience (Fisher, 1990). Especially in early years of childhood, comments from parents have a great impact on the person's body image (Levine & Smolak, 2001 as cited in Thompson & Smolak, 2009). In addition to modeling and parenting attitudes, there has been an intergenerational transition in shaping the eating habits. Similar behaviors were observed in mother-daughter pairs especially in the regulation of food intake (Fisher & Birch, 2001). The image of the body revolved around clothing choices, eating habits and relationships with parents.

The relationship with the parents, especially with the mother came up frequently while talking about the relationship with food and eating habits. Food is seen as the most concrete symbol of the maternal object (Beattie, 1988). Beattie (1988) says that women act out almost every aspect of the ambivalent struggle with the real and internalized mother by controlling food intake and body shape.

Studies point to a link between disturbed parent-child attachment and disturbances in eating patterns and body image (O'Kearney, 1996; as cited in Steinberg & Phares, 2001). In the early stages of childhood, factors such as the feeding behavior of the mother and the food that the child is exposed to more often are effective in shaping the child's eating behavior (Fisher & Birch, 2001).

As some participants mentioned, when mothers prefer to restrict foods high in fat and sugar in order to create a healthy diet for their children, this creates a paradoxical effect on children's eating behavior. Excessive pressure and restriction pose a risk for obesity and overweight (Fisher & Birch, 2001). Restriction and external control on food may cause children to eat more of the prohibited foods by creating a "forbidden fruit" effect and may cause them to ignore physical signs such as hunger (Thompson & Smolak, 2001). These restrictions may change the function and focus of food and eating behavior. When eating needs are disconnected from physical cues, eating behavior is no longer a physical need; it gains other meanings and is associated with other things (Thompson & Smolak, 2001). When the determinant of eating behavior is no longer a sign of hunger or satiety and no longer corresponds to a physical need, the issues of control and a never-ending struggle begins as the participants mentioned. Failing to stop oneself while eating, not feeling satiety and increasing the amount of food intake indicate the person's need for soothing and how s/he has difficulty in getting a response to their needs. At the same time, the disconnection of a person from his/her own body is interpreted as moving away from his/her emotional needs. The need for food and the strong bond with the food shows how much the person needs to take in. In a study that examined the role of attachment in weight loss in bariatric patients, it was reported that the obese group showed significantly higher levels of anxious attachment compared to the non-obese control group (Nancarrow, Hollywood, Ogden, & Hashemi, 2017). The same study also showed that the attachment style sets in childhood and persists life-long and in this sense, it is said that using food as an emotion regulator can lead to weight gain and obesity (Nancarrow, et al., 2017).

As all the participants in this study have experienced in the past, interfering only with an individual's eating habits does not give long-term results. The relationship of the person with food has a lot to do with that person's relationship with life, with other people and with herself. Kinoy (2001), a psychotherapist working with patients with eating disorders, put forward that

every patient’s story must be told to understand the fears, conflicts, meanings and deficiencies that underlie that person’s eating behavior. When these are understood, there will be changes in people's relations with food. Kinoy also says that we should consider the relationship of people with food as a metaphor that reflects their relationship with the world (Kinoy, 2001). During this study, participants used different metaphors about their relations with food. Talking with the food, using the food as both punishment and reward and seeing the food as a buddy were some of them. It is seen that the food-related restrictions do not affect everyone the same after surgery. In this study, there were participants who experienced anger and deprivation due to a limited amount of food, and there were also participants who easily adapted to restrictions. Many used food as a way of relax when they encountered situations in which it was difficult to cope. Some of them were frustrated by restrictions, while others adapted more easily to developing new habits. This may be due to differences in the place, meaning and function of food in people's life. Even though a strict and small portion diet after surgery can alleviate impaired binge-eating behavior, this situation can also create more stress in individuals who had impaired eating behaviors before surgery (Hout, Boekestein, Fortuin, Pelle, & Heck, 2006). As in this study, people can develop disordered eating habits or strategies after surgery in order to lose or not to gain weight again. Therefore, it is very important to understand the nature of eating habits particularly well before the surgery and to monitor the process after surgery (Niego, Kofman, Weiss, & Geliebter, 2007).

Almost every participant expressed that the reason underlying their over-eating habits was psychological, referring to events such as the divorce of their parents and the death of an important person. They suggested that the failure to cope with losses and difficult incidents properly in the past might have had an impact on their later life. They said that rather than in the post-operative period, receiving psychological support at the time they had these losses would have made a huge difference for them. Bruch (1973), who put forth the psychosomatic theory of eating behavior, argued that individuals could over-eat as a result of

misinterpretation of internal states such as anxiety and depression as signs of hunger. According to Bruch's theory, when a person misinterprets these feelings and develops an eating behavior in this way, he/she cannot develop a different method to deal with these feelings. Therefore, difficult and uncomfortable feelings can lead to over-eating (Bruch, 1973). In this respect, emotions become dangerous because the person does not have the necessary methods for coping. Experiencing emotions becomes intertwined with food. Bad emotions are suppressed by food or food is used as a sedative; on the other hand, positive emotions are rewarded with food for celebration. In time, heading for the refrigerator may become an automatic behavior in case of feelings of sadness, boredom or anxiety. Besides, negative comments about their bodies, which are a source of stress and anxiety, can also cause people to over-eat. In particular, negative comments made within the family have a strong impact on the child's development of body image dissatisfaction, eating disorders and overall psychological functioning (Steinberg & Phares, 2001). When all this is considered, food is no longer a physical need and takes on a complex meaning.

Obesity is a complex disease that can result from both genetic and environmental factors. For obese patients, habits and desires about food can override physiological needs, as is the case with substance dependencies (Wang, Volkow, Thanos, & Fowler, 2004). When food is used as a coping method, this situation brings along the themes of control, withdrawal and addiction. As in this study, in a qualitative study of food intake after the first 2 years of bariatric surgery, it was seen that people compared their food cravings with alcohol and drug addiction (Geraci, Brunt, & Marihart, 2014). It has been discussed over decades that certain types of foods may have a potential for addiction and that some forms of over-eating may represent a dependent behavior. Overeating doesn't classify as addiction in DSM V as food is not considered as a dependable substance. Basically, we are all dependent on food for our survival, so we can experience some of the specified criteria due to DSM V, like suffering from withdrawal or tolerance. But, when we disregard the component of physiological

dependence, obese people still suffer from other criteria, consuming more than planned and failed attempts at cutting food consumption (Gold, 2004). Signals affecting food intake come from internal sources (satiety, hunger) that directly regulate food intake and regulate emotional responses (anxiety, stress) as well as from the environmental sources (food related cues) (Patel & Schlundt, 2001).

Heidegger suggested that the symptoms of eating problems were similar to those of addiction, and that dependent behavior is in the person's interaction with the outside world, rather than in the person itself (Heidegger, 1927; as cited in Van Deurzen, Arnold-Baker, & İçöz, 2017). Individuals have a need to connect with people to receive love and support that they need but they also deprive themselves of real relationships by contacting food. Similarly, in this study, while talking about the feelings of anger and not being understood by the others ("not as easy as you think"), they also mentioned their needs for the other ("it's nice to feel you're not alone"). There is also confusion between the desire to establish a connection and the instinct to avoid contact. From a relational perspective, eating/not eating may represent love or affection that is longed for, a sense of control or a trusted "friend" ("food is like my buddy"). Food doesn't expect anything in return; it doesn't leave or disappoint the person. It makes great sense when we think about those who speak to their food or see it as their buddies. They can put the food as a substitute for the love (Van Deurzen, Arnold-Baker, & İçöz, 2017) or understanding they were deprived of as children. From an existential point of view, people mostly use food to repress the feelings of helplessness, loneliness, and uncertainty (Van Deurzen, et. al, 2017). The person uses food to both punish and to reward or soothe herself/himself. Either way, even though it may seem like they are in control, as mentioned in this study, there may be confusion about who controls whom. Since the real needs are never properly met, the emotions are only suppressed and hunger continues. Over-eating serves many functions. Along with the sadistic, destructive control of the object needed, it also soothes, and alleviates inner rage and tension (Beattie, 1988).

In addition to fulfilling physical and emotional needs, there is also social

aspect of food. In particular, the female body has certain social meanings: to attract a man, to breed from him and to establish a family (Costanzo & Woody, 1984). Mothers and daughters face the same expectations in terms of gender identity, social roles and gender roles. In a patriarchal culture, mothers treat their daughters and sons differently with the effect of social expectations (Orbach, 1998). Research shows that especially mothers with daughters feel the pressure about arranging their children's eating habits as a result of societal messages on thinness in female (Costanzo & Woody, 1984). *("My family has always told me that I'm overweight and I have to lose weight. Always. It never ended. They'd take my plate from in front of me during eating…I was the only one who was banned from eating like that. Maybe it was because of my gender, I don't know. I still can't understand it and they can't explain it either.")* When women's wishes or bodies are in conflict with such societal expectations or when they feel stressed, we see its manifestation in their bodies and in their relations with food (Orbach, 1998). A part of this stress is related to the appearance of their bodies as a social rather than individual being. Others always determine the standards of beauty that women must follow in society. This affects the person's connection with her own body, the way she looks at herself and changes the meaning that she places on her eating behavior. When they start to lose touch with the physiological signals of hunger and satisfaction and suppress these mechanisms, food and eating gains more complex psychological meanings (Eichenbaum & Orbach, 1983).

Some participants reported avoiding eating with other people or felt the need for hiding what they ate from others because they felt that they are constantly being observed or judged about what they ate. Some said that instead of meeting a need, eating became a social show and they failed to cope with the stress that it created. Some said that eating is a means of socializing and in some cases the only entertainment is to come together and eat with friends. The content of these relationships and what people receive from those relationships play a role in socializing with others or isolating themselves. Patel and Schlundt found that the mood and social context have an effect on increasing the risk of over-eating

(Patel & Schlundt, 2001). Based on the same study, they refer to the necessity of teaching people to deal with difficult situations and emotions in weight control and weight loss programs. People in their study reported that they were not feeling prepared for changes in their bodies and lifestyles, as well as not feeling fully supported by medical professionals after they left the hospital (Ogden, Avenell, & Ellis, 2011).

Losing weight in a healthy way leads to improved physical well-being as well as increase in self-esteem, but it doesn't do much about what is in the person's soul. There is an idea that being fat helps people to keep one's distance from the outside world. It makes it difficult to reach the person physically and somehow emotionally. In this research, all participants talked about how they moved away from social life as they gained weight. As they gained weight, they had problems in doing things that allowed them to connect with the outside world such as not being able to tie their shoes, walk down the street without being breathless, and not being able to fit in the seats on the bus. All these are linked to physical reasons, but there is also an emotional side. Participants talked about how they distanced themselves from their social environment or avoided romantic relationships. In every example there is a decline in human contact and contact with the outside world. For such examples, compulsory eating is thought to be related to an unconscious desire to get fat (Orbach, 1998). Obesity is a very hard situation and people suffer from emotional, physical and social difficulties related to that, but could this also be something that serves people in a psychological way? If it could be, it is very important to explore the underlying meanings of that for every individual, in order to provide her psychological as well as a body-oriented intervention.

Psychotherapist Susie Orbach (1988), who is well respected for her studies on women's eating problems, discovered in one of her studies that the most common benefit of being fat is sexual protection. The fat prevents them from being seen as sexual. Also it is discovered that, this kind of physical protection

makes it possible for them to contain their feelings. All participants except the two in the current study mentioned they don't have any romantic partners and added that they stay away from contact because of this question in their mind: Why would he be interested in me? Before surgery, they were certain that it was because of their weight, but after losing weight, they surprisingly mentioned that they realized that it had nothing to do with their weight. Was fat obstructing them or protecting them?

An obesity and eating disorder specialist Michael D. Myers says that the majority of obese individuals have a history of sexual abuse, and in a sense weight gain helps them to protect their bodies (Myers, 2011). There was no mention of this experience in this research. However, romantic relationship possibilities were one of the things that participants believed that being thin would bring to them. In some way, they felt that being overweight reduced the likelihood of having a romantic relationship; but also on the one hand, they kept themselves from establishing a romantic bond with someone. After losing weight, those who did not have a romantic relationship talked about their awareness of the fact that it was not just about their weight. In this way, it may be that the fat is not only a bodily but also an emotional shield. Although food symbolizes relaxation, the basic needs of the person are never met in the way they want. Studies on weight loss programs found that obese women increase the food intake when they experience feelings that are hard to deal with such as anxiety and anger (Ganley, 1989; Arnow et al., 1992; Steptoe et al., 1998 as cited in Patel, K., & Schlundt, D., 2001).

Orbach (1998) explains compulsive eating as an attempt to substitute something that one believes that no one can give her. Although they talk about the desire to reach the ideal body and being thin is associated with being attractive, beautiful and healthy, it can have unconscious meanings. If fatness represents an armor or protection, thinness may represent vulnerability and neediness. This means that being thin would also reveal the needs of the individual and make her

vulnerable (Eichenbaum & Orbach, 1983). In this sense, surgery is a physical intervention that takes place in the presence of all these dynamics.

Losing weight and bodily changes increase individuals' self-confidence, but at the same time cause them to face other situations. They see that some of the problems that were previously loaded on weight pre-operatively continued after losing weight. A qualitative study in the same field shows that when weight is no longer an issue, these patients face the fact that they were using weight as an excuse not to achieve certain goals, or as a way of protecting themselves against painful fears or rejections (Bocchieri, Meana & Fisher, 2002). This finding supports the idea that weight can be both a burden and a function that protects the person. When they fail or cannot cope with difficulties, they will no longer be using weight as a defense mechanism. In this case, she may fit into social standards with her new body, but how will she cope with being unarmed in the outside world?

This study has once again shown how relevant the relationship a person has with her own body is physically and emotionally linked to the relationship one has with the world and others. It is seen that the relationships of the individuals with their parents -especially with their mothers- and the emotion regulation strategies they develop accordingly have an effect on the social and romantic relationships they have with other people. In one study (Maras, Obeid, Flament, Buchholz, Henderson, Gick, & Goldfield, 2016) significant relationship was found between attachment styles and BMI. It was observed that the BMI of the children with insecure attachment was higher than those with secure attachment. Additionally, the insecure attachment style in childhood has proven to increase the risk of being overweight and obesity during adulthood (Goossens, et al., 2012). Researches on this subject suggest that early attachment styles should be taken into account when designing programs to combat obesity in youth. (Maras, et al., 2016)

Bariatric surgery is not a miraculous method of ensuring a perfect solution, but it can provide a permanent and effective solution and can change people's lives. A multidisciplinary teamwork should be in place so that the person can adapt to this change and change the way of life and the relationship with the food (Yücel, Akdemir, Gürdal Küey, Maner, & Vardar, 2013). The findings of a recent study in Turkey showed that although blood tests and endocrinology examinations are performed completely, the psychological support was missing. Participants in this study mostly talked about a psychological evaluation that was done to see if they had any psychiatric illnesses. However, this is a process that does not end with the operation; on the contrary, it starts with the operation. The relationship with food, the function of food in people's life, eating behaviors and the reasons of obesity should be taken into account because all of them are tested and challenged after a medical intervention. So, people need to be prepared for that.

Ogden et al. (2011) argue that while surgery creates a dramatic change in weight and body, the problems associated with food and eating patterns remain exactly the same. Although the person gets rid of what she sees as a problem -weight- the need for psychological support continues. Also, as in this research, it has been seen in other studies; people can still feel fat in their thin bodies, behave that way and relate to others that way after weight loss (Faccio, Nardin, & Cipolletta, 2016). It leads to a mismatch between the physical body and the sensation of the body (Alegria & Larsen, 2015). The body changes rapidly, but the self, the self-view and the feelings of the physical body do not change at the same speed. People need to be supported in order to adapt to the change of the situation they have experienced for years –being overweight/obese- and perhaps have lived throughout their lives. In this sense, Griauzde and her colleagues (2018) argue that it would be easier for the person to cope with post-operative difficulties, if more personalized interviews are carried out by the bariatric team about psychosocial difficulties that the patient is currently experiencing and what the surgery can bring. They argue that examining the self-perception of the person and her relations with others before the operation makes it easier to design a

personalized process and would make it much easier for the person to cope with the post-surgical process. They emphasize that changing the eating habits or social habits before surgery instead of the post-operative period will reduce the post-operative struggle of the person (Griauzde, et al., 2018). In a qualitative research on maintaining weight loss after surgery, Liebl, Barnason, & Hudson (2016) explain the importance of the support received from family and friends. Positive support helps one to prioritize his/ her personal health (Liebl, Barnason, & Hudson, 2016). It is very important to adjust the nature of the relationship according to the needs of the person. In order to do this, one should put aside the assumptions about the person's weight and the process in which they live and try to understand their meanings and relational aspects for them (Van Deurzen, et. al, 2017).

In sum, one of the most prominent findings of the research is the effect of the need and unmet emotional needs of the person since childhood. Not being able to learn how to deal with emotionally difficult situations and not being able to listen to body signals, or not receiving emotional support properly in childhood changes the relationship with food, which is the easiest thing to replace. The fact that all the participants in the study had at least one story of an important loss and what they said related to coping or inability to cope with these situations support this possibility. The relationship with the other affects the relationship with the world and the person's social and personal existence in this world. Although weight is attributed to genetic reasons and it seems to be the only reason that interferes with many things, the fact that this is not the case after weight loss shows us what needs to be investigated in this regard: early relationships (with parents, especially with the mother), and coping mechanisms and dynamics of relationship with food. In addition to the great advantages provided by the surgery, it is necessary to investigate the relationship between the person and the food and to provide psychological support for the regulation of this relationship. The fact that these are taken into account by both the surgical team and patients can help people to maintain the effects of surgery and to maximize its positive

outcomes.

8.1. Clinical Implications

When I decided to do this research, I met with a bariatric surgeon, a dietitian and a psychologist from his team to learn more about the process. They were offering lifelong psychological support to their patients after the surgery and organizing monthly group therapies to maintain post-operative changes and acquired habits. It seemed like they actually built the system that includes a team consisting of a surgeon, dietitian and a psychologist, mentioned in the articles in the bariatric field. That surgeon said that this research was nonsense and not scientific. He said he could find me over a hundred participants if I chose to apply a depression scale before and after the surgery, instead of doing this. He said, "We are changing people's lives, it is impossible for them to have bad experiences about that." He was right about one thing, they are changing people's lives and that change of one's life is a more complex experience than comparing two scores. It does not necessarily involve bad experiences, but it is a life event that brings many changes in different areas to one's life and requires adaptation to these changes.

On the other hand, the dietitian and the psychologist were very supportive of this research. The psychologist talked about the contents of her interviews with patients and mentioned the difficulties that patients often experienced in their weight loss process. She said that the patients tried to look better in their appointments with their doctors and that they revealed the negative aspects of the process in the sessions with her. She added that although they offered psychological support as part of the process, some patients refused to receive psychological support. Through this surgery, people feel freed from something they have long suffered in their lives, and they are beginning to get closer to the body they dreamed of throughout their lives. In this process, their bodies are changing rapidly, but they are also experiencing many psychological changes and these are worth paying attention to. The results of this research support this idea

too. This isn’t just about losing weight; it's about rebuilding your body and your life (work life, relationships, perception of yourself etc.) along with it.

In addition, the popularity of the surgery has increased considerably in recent years and it seems that the operation is performed for people who do not provide the conditions for performing it. This may cause LSG to be perceived as a cosmetic surgery. From the outside, it looks like you're just having surgery and losing weight quickly and going on with your life. In this case, it is possible for clinicians to be less aware of possible other effects of surgery than the better-publicized positive effects. Why do they still feel fat, even though their bodies have changed? How was it for them to be fat? How did being fat mean to them? We need to ask these questions to help them process this change and digest their experiences. All participants of this research said that they wanted to participate in this research to show that it was more than what was seen. They wanted to tell me what they were going through. Also, when talking about their own experiences, continuous subject changes (Started with “I” and continued with “you”, like they were talking about the PI’s experience) can be thought of as a reflection of their difficulties in accepting/owning their experiences. These show how much they need to process this process of change. Perhaps the interviews were the first step in their processing of their experiences.

In almost every article on bariatric surgery, researchers stress the importance of psychological support in addition to medical support. Pre-operative psychological support is said to be as necessary as blood tests and endoscopy. Only three of the participants of this research had met a psychologist once before surgery. Others were not offered such an option. One of the participants said that she wanted to talk to a psychologist at her own wish to make sure she was doing the right thing, based on what she read about the surgery. One of the participants said that she had this surgery with her big sister with bipolar disorder. Her sister’s psychologist supported her to have that surgery but she said that her sister’s psychologist was very ignorant about this issue and she could not help them at all.

She sincerely wished that psychologists and dieticians had more knowledge about this issue and to strive to be more supportive to them, especially because this operation is so widespread. In recent times, we began to hear “the bariatric psychologist” title more often in Turkey. Although it is a very new field in our country, I think that the findings of this study will contribute to the psychologists working in this field.

In this process, I believe that it is very critical for both health personnel (surgeon, dietitian and the psychologist) and the patient to understand what this surgery will/may bring to patient. It is very important for people to understand what this restrictive nature of this surgery will bring to them, especially for people who already have problematic relationships with food. Healthcare personnel should be aware of difficulties that patient may face with during the process. If a person is using eating as a coping strategy in the face of difficulties, it is very important that they understands that they wouldn’t be able to continue in the same way after surgery. According to findings of this research, in the field of psychological support, it would be helpful to take into account the followings:

Patients’ relationship with food,
Place and functions of food in their lives,
Important life events and traumas affecting their lives and changing their relationship with food,
Their self-perceptions,
Reasons for being overweight,
Their attachment styles and their unmet needs and
Presence of their support mechanisms.

Understanding the main reasons for gaining weight and supporting the person in this sense may also facilitate the adaptation to post-operative changes. Basically, people need support and understanding through this process. We should try to understand them and try to look at them from their perspective. We should

understand the content of this surgery and the change that this operation has created in people's lives, and give the necessary importance to the experiences they have had in this sense.

8.2. Limitations & Future Research

Although the number of the participants of this study and the use of IPA provided an opportunity to deeply understand the people's experiences of LSG surgery, they also impose a limitation on the generalizability of the findings. These findings could be supported with quantitative studies in the future.

The participants of this study were all women. This wasn't intentional but it appeared that way due to lack of male applicants. Even though this situation allowed us to have more detailed information about women's processes, it made the study inadequate to see the effects of the LSG independent of gender. For this reason, future studies should also include men while exploring the effects of LSG surgery.

Case studies and qualitative research related to bariatric surgeries are very important. This study showed that it is not all about the physical body or the amount of weight people lost; it is much more than that. Especially the psychological difficulties experienced by the patients seemed to be mostly untold in their processes. To be able to address and understand these difficulties is very important in terms of providing the necessary support for bariatric patients.

Although it wasn't one of the main questions of this research, all participants mentioned their relationships with their mothers while referring to the development of their relationship with food. All of them mentioned some childhood memories with food and talked about memories in the process of attachment (failure to thrive, vomiting the breast milk, eating food hiding from mother etc.). Doing qualitative studies on the relationship between the attachment styles and eating behavior, relationship with food and obesity may contribute to the field.

It turned out that all participants had at least one history of lost (loss of

loved ones, having a divorce, divorce of parents and going bankrupt). When I asked them if they could go back would they like to get psychological support after surgery, all of them said that they would have preferred to get psychological support during the period they experienced the losses, long before they had their surgery. In light of these data, it may be useful to conduct studies on the relationship between eating behaviors and how people deal with losses and intense emotional situations.

References

Abu-Jaish, W., & Rosenthal, R. J. (2010). Sleeve gastrectomy: a new surgical approach for morbid obesity. *Expert Review of Gastroenterology & Hepatology,4*(1), 101-119. doi:10.1586/egh.09.68

Adami, G. F., Gandolfo, P., Campostano, A., Meneghelli, A., Ravera, G., & Scopinaro, N. (1998). Body image and body weight in obese patients. *International Journal of Eating Disorders,24*(3), 299-306. doi:10.1002/(sici)1098-108x(199811)24:3<299::aid-eat7>3.0.co;2-h

Alegría, C. A., & Larsen, B. (2015). “That’s who I am: A fat person in a thin body”: Weight loss, negative self-evaluation, and mitigating strategies following weight loss surgery. *Journal of the American Association of Nurse Practitioners,27*(3), 137-144. doi:10.1002/2327-6924.12158

Allon, N. (1981). “The stigma of overweight in everyday life.” *Psychological Aspects of Obesity: A Handbook*. New York: Van Nostrand Rheinhold.

Aydın, E. (2012). *Bariatrik Cerrahi Uygulanan Bireylerin Ameliyat Sonrası Yaşadıkları Güçlüklerin Belirlenmesi* (Unpublished master's thesis). Gazi Üniversitesi.

Barrett A., Burch M. (2015) Sleeve gastrectomy: procedure and outcomes. In: Youdim A. (eds) *The Clinician’s Guide to the Treatment of Obesity. Endocrine Updates.* Springer, New York, NY

Beattie, H. J. (1988). Eating disorders and the mother—Daughter relationship. *International Journal of Eating Disorders,7*(4), 453-460. doi:10.1002/1098-108x(198807)7:43.0.co;2-2

Bocchieri, L. E., Meana, M., & Fisher, B. L. (2002). A review of psychosocial outcomes of surgery for morbid obesity. *Journal of Psychosomatic Research,52*(3), 155-165. doi:10.1016/s0022-3999(01)00241-0

Brolin, R. E. (2002). Bariatric surgery and long-term control of morbid obesity. *Jama,288*(22), 2793. doi:10.1001/jama.288.22.2793

Bruch, H. (1973). Eating *Disorders: Obesity. Anorexia Nervosa and the Person Within.* New York: Basic Books.

Buchwald, H., Avidor, Y., & Braunwald, E. (2005). Bariatric surgery. A systematic review and meta-analysis. *American College of Cardiology Current Journal Review,14*(1), 13. doi:10.1016/j.accreview.2004.12.068

Buchwald, H. (2012). *Buchwalds atlas of metabolic & bariatric surgical techniques and procedures*. Philadelphia: Elsevier/Saunders.

Buchwald, H., & Oien, D. M. (2013). Metabolic/bariatric surgery worldwide 2011. *Obesity Surgery,23*(4), 427-436. doi:10.1007/s11695-012-0864-0

Bult, M. J. F., van Dalen, T., & Muller, A.F. (2008). Surgical treatment of obesity. *European Journal of Endocrinology, 158,* 135-145.

Carr, D., & Friedman, M. A. (2005). Is obesity stigmatizing? Body weight, perceived discrimination, and psychological well-being in the United States. *Journal of Health and Social Behavior, 46,* 244-259.

Clinical Issues Committee of the American Society for Metabolic and Bariatric Surgery. (2007). Sleeve gastrectomy as a bariatric procedure. *Surgery for Obesity and Related Diseases,3*(6), 573-576. doi:10.1016/j.soard.2007.06.009

Colquitt, J. L., Picot, J., Loveman, E., & Clegg, A. J. (2009). Surgery for obesity. *Cochrane Database of Systematic Reviews*. doi:10.1002/14651858.cd003641.pub3

Cossrow, N. H. F., Jeffery, R. W., & McGuire, M. T. (2001). Understanding weight stigmatization: a focus group study. *Journal of Nutrition Education, 33,* 208-214.

Costanzo, P. R., & Woody, E. Z. (1984). Parental Perspectives on Obesity in Children: The Importance of Sex Differences. *Journal of Social and Clinical Psychology,2*(4), 305-313. doi:10.1521/jscp.1984.2.4.305

Coulman, K. D., Mackichan, F., Blazeby, J. M., & Owen-Smith, A. (2017). Patient experiences of outcomes of bariatric surgery: A systematic review and qualitative synthesis. *Obesity Reviews,18*(5), 547-559. doi:10.1111/obr.12518

Cutler, D. M., Bleich, S., Murray, C., & Adams, A. (2008). Why is the developed

world obese? *Annual Review of Public Health*, *29*

Dejong, W. (1980). The stigma of obesity: the consequences of naive assumptions concerning the causes of physical deviance. *Journal of Health and Social Behavior,21*(1), 75. doi:10.2307/2136696

Dixon, J. B., Dixon, M. E., O"Brien, P. E. (2002). Body image: Appearance orientation and evaluation in the severely obese. Changes with weight loss. *Obesity Surgery, 12,* 65-71.

Eid, G. M., Brethauer, S., Mattar, S. G., Titchner, R. L., Gourash, W., & Schauer, P. R. (2012). Laparoscopic sleeve gastrectomy for super obese patients. *Annals of Surgery,256*(2), 262-265. doi:10.1097/sla.0b013e31825fe905

Faccio, E., Nardin, A., & Cipolletta, S. (2016). Becoming ex-obese: Narrations about identity changes before and after the experience of the bariatric surgery. *Journal of Clinical Nursing,25*(11-12), 1713-1720. doi:10.1111/jocn.13222

Fisher, J. O., & Birch, L. L. (2001). Early experience with food and eating: Implications for the development of eating disorders. *Body Image, Eating Disorders, and Obesity in Youth: Assessment, Prevention, and Treatment.,*23-39. doi:10.1037/10404-001

Fisher, S. (1990). The evolution of psychological concepts about the body. In T. F. Cash & T. Pruzinsky (Eds.), *Body images: Development, deviance, and change* (pp. 3-20). New York, NY, US: Guilford Press.

Fontaine K. R., Redden, D. T., Wang, C., Westfall, A. O., and Allison, D. B. (2003). Years of life lost due to obesity. *Journal of the American Medical Association*, vol. 289, no. 2, pp. 187–193.

Geraci, A. A., Brunt, A., & Marihart, C. (2014). The Work behind Weight-Loss Surgery: A Qualitative Analysis of Food Intake after the First Two Years Post-Op. *ISRN Obesity,2014*, 1-6. doi:10.1155/2014/427062

Gold, M. S. (2004). Eating disorders, overeating, and pathological attachment to food: Independent or addictive disorders? Binghamton, NY: Haworth Medical Press.

Gomberawalla, A., MD, Willson, T. D., MD, & Lutfi, R. (2014). Predictors of success after laparoscopic sleeve gastrectomy. *Bariatric surgical practice and patient care,0*(0). doi:10.1089/bari.2014.0010

Goossens L, Braet C, Van Durme K, et al., (2012) The parent-child relationship as predictor of eating pathology and weight gain in preadolescents. *Journal of Clinical Child & Adolescent Psychology* (41), 445–457.

Greenberg, I., Perna, F., Kaplan, M., & Sullivan, M. A. (2005). Behavioral and psychological factors in the assessment and treatment of obesity surgery patients. *Obesity Research, 13,* 244-249.

Griauzde, D. H., Ibrahim, A. M., Fisher, N., Stricklen, A., Ross, R., & Ghaferi, A. A. (2018). Understanding the psychosocial impact of weight loss following bariatric surgery: A qualitative study. *BMC Obesity,5*(1). doi:10.1186/s40608-018-0215-3

Harris, M. B., Harris, R. J., & Bochner, S. (1982). Fat, four-eyed, and female: stereotypes of obesity, glasses, and gender. *Journal of Applied Social Psychology,12*(6), 503-516. doi:10.1111/j.1559-1816.1982.tb00882.x

Herpertz, S., Kielmann, R., Wolf, A. M., Langkafel, M., Senf, W., & Hebebrand, J. (2003). Does obesity surgery improve psychosocial functioning? A systematic review. *International Journal of Obesity,27*(11), 1300-1314. doi:10.1038/sj.ijo.0802410

Himpens, J., Dobbeleir, J., & Peeters, G. (2010). Long-term results of laparoscopic sleeve gastrectomy for obesity. *Annals of Surgery,252*(2), 319-324. doi:10.1097/sla.0b013e3181e90b31

Hirth, D. A., Jones, E. L., Rothchild, K. B., Mitchell, B. C., & Schoen, J. A. (2015). Laparoscopic sleeve gastrectomy: long-term weight loss outcomes. *Surgery for Obesity and Related Diseases,11*(5), 1004-1007. doi:10.1016/j.soard.2015.02.016

Hout, G. V., Boekestein, P., Fortuin, F., Pelle, A., & Heck, G. V. (2006). Psychosocial functioning following bariatric surgery. *Obesity Surgery,16*(6), 787-794. doi:10.1381/096089206777346808

Jumbe, S., Hamlet, C., & Meyrick, J. (2017). Psychological aspects of bariatric surgery as a treatment for obesity. *Current Obesity Reports,6*(1), 71-78. doi:10.1007/s13679-017-0242-2

Kalarchian, M. A., Marcus, M. D., Wilson, G. T., Labouvie, E. W., Brolin, R. E., & Lamarca, L. B. (2002). Binge eating among gastric bypass patients at long-term follow-up. *Obesity Surgery,12*(2), 270-275. doi:10.1381/096089202762552494

Kalarchian, M. (2007). Psychiatric disorders among bariatric surgery candidates: relationship to obesity and functional health status. *American Journal of Psychiatry,164*(2), 328. doi:10.1176/appi.ajp.164.2.328

Kinoy, B. P. (2001). *Eating Disorders* (2nd ed.). New York: Columbia University Press.

Kinzl, J., Traweger, C., Trefalt, E., & Biebl, W. (2003). Psychosocial consequences of weight loss following gastric banding for morbid obesity. *Obesity Surgery,13*(1), 105-110. doi:10.1381/096089203321136683

Kubik, J. F., Gill, R. S., Laffin, M., & Karmali, S. (2013). The impact of bariatric surgery on psychological health. *Journal of Obesity, 2013*, 1-5. doi:10.1155/2013/837989

Lewington, S., Sherlikeretal, Clarke, R., Emberson, J., Halsey, J., Qizilbash, N. , . . . Whitlock, G. (2009). Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. *The Lancet,373*(9669), 1083-1096. doi:10.1016/s0140-6736(09)60318-4

LeMont, D., Moorehead, M. K., Parish, M. S., Reto, C. S., & Ritz, S. J. (2004). Suggestions for the pre-surgical psychological assessment of bariatric surgery candidates. American Society for Metabolic and Bariatric Surgery.http://asmbs.org/wp/uploads/2014/05/PsychPreSurgicalAssessment.pdf.

Liebl, L., Barnason, S., & Hudson, D. B. (2016). Awakening: A qualitative study on maintaining weight loss after bariatric surgery. *Journal of Clinical Nursing,25*(7-8), 951-961. doi:10.1111/jocn.13129

Livhits, M., Mercado, C., Yermilov, I., Parikh, J., Dutson, E., Mehran, A., . . . Gibbons, M. M. (2010). Behavioral factors associated with successful weight loss after gastric bypass. *The American Surgeon,76*(10), 42-1139.

Lupoli, R., Lembo, E., Saldalamacchia, G., Avola, C. K., Angrisani, L., & Capaldo, B. (2017). Bariatric surgery and long-term nutritional issues. *World Journal of Diabetes,8*(11), 464. doi:10.4239/wjd.v8.i11.464

Malone, M., & Alger-Mayer, S. (2004). Binge status and quality of life after gastric bypass surgery: a one-year study. *Obesity Research,12*(3), 473-481. doi:10.1038/oby.2004.53

Maras, D., Obeid, N., Flament, M., Buchholz, A., Henderson, K. A., Gick, M., & Goldfield, G. S. (2016). Attachment Style and Obesity: Disordered Eating Behaviors as a Mediator in a Community Sample of Canadian Youth. *Journal of Development & Behavioral Pediatrics,*(37), 762-770.

McMahon, M. M., Sarr, M. G., Clark, M. M., Gall, M. M., Knoetgen, J., Service, F. J., . . Hurley, D. L. (2006). Clinical management after bariatric surgery: value of a multidisciplinary approach. *Mayo Clinic Proceedings,81*(10). doi:10.1016/s0025-6196(11)61179-8

Myers, A., & Rosen, J. C. (1999). Obesity stigmatization and coping: relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity, 23,* 221-230.

Myers, D. M.D. (2011, December 27). Eating behaviors and moods. Retrieved May 04, 2019, from http://www.weight.com/weight/behaviors?page=3

Nancarrow, A., Hollywood, A., Ogden, J., & Hashemi, M. (2017). The Role of Attachment in Body Weight and Weight Loss in Bariatric Patients. *Obesity Surgery,28*(2), 410-414. doi:10.1007/s11695-017-2796-1

National Institutes of Health (1998). Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults: the evidence report. *PsycEXTRA Dataset.* doi:10.1037/e565682010-001

Niego, S. H., Kofman, M. D., Weiss, J. J., & Geliebter, A. (2007). Binge eating in the bariatric surgery population: a review of the literature. *International Journal of Eating Disorders, 40,* 349-359.

Ogden, C. L., Lamb, M. M., Carroll, M. D., & Flegal, K. M. (2010). Obesity and socioeconomic status in adults: United States 1988–1994 and 2005–2008. NCHS data brief no 50. Hyattsville, MD: National Center for Health Statistics.

Ogden, J. Avenell, S. & Ellis, G (2011). Negotiating control: patients' experiences of unsuccessful weight-loss surgery. *Psychological Health. 26*, 949-964.

Ogden, J., Hollywood, A., & Pring, C. (2014). The impact of psychological support on weight loss post weight loss surgery: a randomized control trial. *Obesity Surgery,25*(3), 500-505. doi:10.1007/s11695-014-1428-2

Eichenbaum, L., & Orbach, S. (1983). *Understanding women a feminist psychoanalytic approach*. New York: Basic Books.

Orbach, S. (1998). *Fat is a feminist issue: The anti-diet guide for women; Fat is a feminist issue II*. London: Arrow.

Patel, K., & Schlundt, D. (2001). Impact of moods and social context on eating behavior. *Appetite,36*(2), 111-118. doi:10.1006/appe.2000.0385

Puhl, R., & Brownwell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research, 9,* 788-805.

Reto, C. S. (2003). Psychological aspects of delivering nursing care to the bariatric patient. *Critical Care Nursing Quarterly, 26* (2), 139-149.

Rosenheck, R. (2008). Fast food consumption and increased caloric intake: a systematic review of a trajectory towards weight gain and obesity risk. *Obesity Reviews*, *9*, 535-547.

Rutte, P. W., Luyer, I. H. J. T. De Hingh, & Nienhuijs, S. W. (2012). To sleeve or not to sleeve in bariatric surgery? *International Scholarly Research Network Surgery, 2012*, 1-5. doi:10.5402/2012/674042

Sağlık Teknolojisi Değerlendirme Daire Başkanlığı. (2014, December). Türkiye'de obezite tedavisinde obezite cerrahisinin yeri. Retrieved January 6, 2018, from http://www.bing.com/cr?IG=81C39783B193438281C58658CCD9AF18&CID=1530C0184E0369D929AFCB774FAC686F&rd=1&h=5NKgFPX4EIqQu1uGBM6mFQlOoVfLzMeRRphPmKocjjQ&v=1&r=http%3a%2f%2fhta.gov.tr%2fpdf%2fObezite%2520Cerrahisi%2520Rapor%252025%252004%25202014.pdf&p=DevEx,5063.1

Sarwer, D. B., Cohn, N. I., Gibbons, L. M., Magee, L., Crerand, C. E., Raper, S. E. et al. (2004). Psychiatric diagnoses and psychiatric treatment among bariatric surgery candidates. *Obesity Surgery, 14,* 1148-1156.

Sarwer, D. B., & Crerand, C. E. (2008). Body dysmorphic disorder and appearance enhancing medical treatments. *Body Image,5*(1), 50-58. doi:10.1016/j.bodyim.2007.08.003

Sarwer, D. B., Thompson, J. K., Mitchell, J. E., & Rubin, J. P. (2008). Psychological considerations of the bariatric surgery patient undergoing body contouring surgery. *Plastic and Reconstructive Surgery,121*(6). doi:10.1097/prs.0b013e3181772aa8

Sarwer, D. B., Dilks, R. J. & Ritter, S. (2012). Bariatric surgery for weight loss. *Encyclopedia of Body Image and Human Appearance*, (1), Academic Press, San Diego, California, USA.

Sjöström, L., Lindroos, A., Peltonen, M., Torgerson, J., Bouchard, C., Carlsson, B., . . . Wedel, H. (2004). Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *New England Journal of Medicine,351*(26), 2683-2693. doi:10.1056/nejmoa035622

Smith, J. A., Flowers, P., & Larkin, M. (2013). *Interpretative phenomenological analysis: theory, method and research.* London: Sage.

Steffen, K. J., Engel, S. G., Wonderlich, J. A., Pollert, G. A., & Sondag, C. (2015). Alcohol and other addictive disorders following bariatric surgery: prevalence, risk factors and possible etiologies. *European Eating Disorders Review,23*(6), 442-450. doi:10.1002/erv.2399

Steinberg, A. B., & Phares, V. (2001). Family functioning, body image, and eating disturbances. *Body Image, Eating Disorders, and Obesity in Youth: Assessment, Prevention, and Treatment.,*127-147. doi:10.1037/10404-005

Suzuki, J., Haimovici, F., & Chang, G. (2010). Alcohol use disorders after bariatric surgery. *Obesity Surgery,22*(2), 201-207. doi:10.1007/s11695-010-0346-1

Synder, A. G. (2009). Psychological assessment of the patient undergoing bariatric surgery. *The Ochsner Journal,*(9), 144-148.

Thompson, J. K., & Smolak, L. (2009). *Body image, eating disorders, and obesity in youth: An integrative guide for assessment and treatment.* Washington, DC: American Psychological Association.

Tucker, O. N., Szomstein, S., & Rosenthal, R. J. (2008). Indications for sleeve gastrectomy as a primary procedure for weight loss in the morbidly obese. *Journal of Gastrointestinal Surgery,12*(4), 662-667. doi:10.1007/s11605-008-0480-4

Türkiye İstatistik Kurumu (TÜİK). (2017, May 31). Türkiye Sağlık Araştırması, 2016. Retrieved January 04, 2018, from http://www.tuik.gov.tr/HbPrint.do?id=24573

Van Deurzen, E., & Arnold-Baker, C. (2017). *İnsan Meselelerine Varoluşçu Bakışlar* (F. J. İçöz, Ed.). İstanbul: Aletheia Kitap.

Vigneswaran, Y., & Ujiki, M. B. (2016). Sleeve gastrectomy: indications, procedure and outcomes. *Obesity Care and Bariatric Surgery* (55-65). New Jersey: World Scientific.

Wang, G., Volkow, N. D., Thanos, P. K., & Fowler, J. S. (2004). Similarity Between Obesity and Drug Addiction as Assessed by Neurofunctional

Imaging. *Journal of Addictive Diseases,23*(3), 39-53. doi:10.1300/j069v23n03_04

Wooley, S.C., & Garner, D. M. (1991) “Obesity treatment: the high cost of false hope,” *Journal of the American Dietetic Association*, 91(10), 1248–1251.

World Health Organization. (2015). *The European health report 2015: targets and beyond, reaching new frontiers in evidence*. Copenhagen: WHO Regional Office for Europe.

World Health Organization (WHO). (2017, October). Obesity and overweight. Retrieved January 04, 2018, from http://www.who.int/mediacentre/factsheets/fs311/en/

Yücel, B., Akdemir, A., Gürdal Küey, A., Maner, F., & Vardar, E. (Eds.). (2013). *Yeme bozuklukları ve obezite tanı ve tedavi kitabı* (Vol. 15, Çalışma Birimleri Serisi). Ankara: Türkiye Psikiyatri Derneği Yayınları.

Yüksel, A. (2016). Bariatrik cerrahi operasyonu geçiren morbid obez bir hastanın 3 yıl sonraki beslenme durumu: olgu sunumu. *İzmir Kâtip Çelebi Üniversitesi Sağlık Bilimleri Fakültesi Dergisi,1*(1), 39-45.

Appendix 1: Informed Consent Form

BİLGİLENDİRİLMİŞ ONAM FORMU

Sayın katılımcı,

Bu çalışma, İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Gökçe Naz Kamar tarafından, Prof. Dr. Hale Bolak Boratav danışmanlığında, tüp mide ameliyatı geçiren bireylerin ameliyat süreci ve sonrası deneyimlerini anlamak amacıyla yüksek lisans tezi kapsamında yürütülmektedir. Bu çalışmanın sonuçlarının tüp mide ameliyatı sonrası sağlanan ruhsal ve sosyal destek çalışmalarına katkı sağlayacağı düşünülmektedir.

Araştırma, 45-60 dk. sürecek yüz yüze bir görüşmeyi kapsamaktadır. Çalışmanın amacına ulaşması için sizden beklenen, tüp mide ameliyatı deneyiminizi ve sonrasında yaşadıklarınızı rahat hissettiğiniz ölçüde ve olabildiğince açık bir şekilde paylaşmanızdır. Araştırmaya katılım gönüllülük esasına dayanmaktadır. Katılımınız için size herhangi bir ödeme yapılmayacaktır.

Görüşme öncesinde demografik bilgiler içeren kısa bir form doldurmanız istenecektir. Formda katılımcıya ait isim bilgisi yalnızca görüşmeyi gerçekleştiren araştırmacı tarafından bilinecek ve görüşme tamamlandıktan sonra araştırmacının belirlediği farklı bir isimle değiştirilecektir. Görüşmeler sırasında ses kaydı alınacaktır. Görüşme boyunca istediğiniz zaman herhangi bir sebep belirtmeksizin görüşmeyi sonlandırabilir ve araştırmadan ayrılabilirsiniz.

Eğer araştırmanın amacı ile ilgili verilen bu bilgiler dışında daha fazla bilgiye ihtiyaç duyarsanız Psk. Gökçe Naz Kamar’a gnkamar@fontepsikoloji.com e-posta adresinden ulaşabilirsiniz.
Katılımınız için şimdiden teşekkür ederiz.

☐ **Onam Formunu okudum ve bu araştırmaya katılmayı kabul ediyorum.**

Tarih:

Katılımcının Adı-Soyadı:

İmzası:

Appendix 2: Demographic Information Form

DEMOGRAFİK BİLGİ FORMU

Ad-Soyad:

Cinsiyet:

Doğum Tarihi:

Eğitim Durumu:

Meslek:

Medeni Durum:

Ameliyat Tarihiniz:

Boyunuz:

Ameliyat olduğunuz sırada sahip olduğunuz yandaş hastalıklar (diyabet, kalp rahatsızlıkları, vb.):

Ameliyat sürecinde size (hastaneniz tarafından) psikolojik destek imkanı sağlandı mı?

Süreç boyunca kendi imkanlarınızla herhangi bir psikolojik destek aldınız mı?

Ameliyat sürecinde size (hastaneniz tarafından) diyetisyen desteği sağlandı mı?

Evet ise;
Ameliyat sonrasında diyetisyen kontrollerinize düzenli olarak devam ettiniz mi?

Appendix 3: Interview Questions

ARAŞTIRMA SORULARI

1. Tüp mide ameliyatı deneyiminizden bahseder misiniz?

2. Ameliyattan önce hayatınız nasıldı?

3. Ameliyat olmaya nasıl karar verdiniz?

4. Ameliyat kararı vermenizde neler etkili oldu? (zorluklar, insanların tepkileri vs.)

5.Ameliyat süreci ve hastane yatışınız nasıldı? (ameliyat sonrası komplikasyon yaşadınız mı?)

6. Ameliyattan beklentileriniz nelerdi?

7. Tüp mide ameliyatı hayatınızı nasıl etkiledi? (yeme alışkanlıkları, günlük yaşantı, okul/iş hayatı, ilişkiler, bedeninize bakışınız…)

8. Kişilik olarak sizi nasıl etkiledi? (kendinize bakışınızı nasıl etkiledi?)

9. Ameliyattan sonra kilo vermeye başladığınızda sosyal çevrenizden nasıl tepkiler aldınız?

10. Hayatınızda neler değişti?

11. Bu süreçte nelere ihtiyaç duydunuz? (sosyal, psikolojik, fiziksel olarak?)

12. Bu süreçte neler size yardımcı oldu, neler iyi geldi?

ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

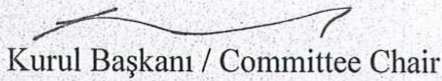
Başvuru Sahibi / Applicant: Gökçe Naz Kamar

Proje Başlığı / Project Title: Understanding the Experiences of Individuals Who Undergo Sleeve Gastrectomy Surgery/An Interpretative Phenomenological Analysis

Proje No. / Project Number: 2019-20024-25

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Ret/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 12 Şubat 2019

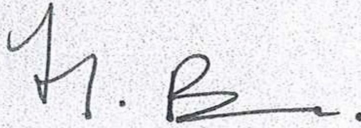


Kurul Başkanı / Committee Chair

Doç. Dr. Itır Erhart

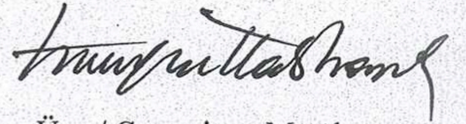
Üye / Committee Member

Prof. Dr. Aslı Tunç



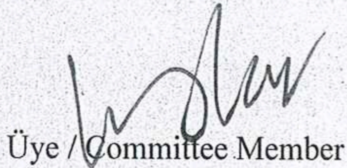
Üye / Committee Member

Prof. Dr. Hale Bolak



Üye / Committee Member

Prof. Dr. Turgut Tarhanlı



Üye / Committee Member

Prof. Dr. Koray Akay

Üye / Committee Member

Prof. Dr. Ali Demirci