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CLINICAL RESEARCH

The Psychology of Bariatric Patient: What Replaces Obesity? A Qualitative Research with Brazilian Women

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Abstract
Background Obesity has serious implications on a woman's quality of life and body image. We propose a qualitative investigation aimed at understanding the postoperative significance of bariatric surgery for women suffering from morbid obesity and how these factors influence the outcomes, with an emphasis on body image and on the possible psychological complications that may jeopardize the operation's success.
Subjects and Methods This study uses a clinical qualitative method, through a semidirected interview with open-ended questions in an intentional sample, closed by saturation, with seven women operated in a period of 1.5–3 years, following the definition of emergent categories and qualitative content analysis.
Results Bariatric surgery is a procedure that brings about rapid physical, social, and emotional changes, and it is seen by patients as a possibility of being reinstated and accepted socially. The reencounter with the feminine body after surgery is experienced as a means of reinstatement but also with a feeling of defenselessness, which may lead to the development of phobic symptoms. Imbalance in family and conjugal relationships may be factors that discourage the continuation of the treatment. The patient sees the skin folds, flaccidity, and the scars as therapeutic failures, which can lead to a constant quest for plastic surgery.
Conclusion We observe the necessity of studies that allow the health team to identify those aspects of a patient's psychological makeup which would be expected to improve or worsen their prognosis and to provide the necessary preoperative and postoperative psychosocial interventions.

Keywords Bariatric surgery · Obesity · Qualitative method · Morbid obesity

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Introduction

In Brazil, as well as worldwide [1, 2], the prevalence of obesity has reached epidemic proportions and has become a national health problem [3, 4].

Psychological consequences of extreme obesity are anxiety, depression, low self-esteem, and negative body image [5–7]. Obesity discrimination, social isolation, and stigma experiences [7, 8] start in the earliest social contacts [9], and this prejudice may contribute to depression, eating disorders, body image disturbance, and other suffering [2, 10, 11].

These factors are undoubtedly more marked for women than for men, and some studies suggest that, especially for

them, the desire to improve their physical appearance and to avoid embarrassment is the most common motivators for the surgery [6, 12, 13].

The surgical treatment not only leads to substantial weight loss reduction but also to an improvement in quality of life [14–16] and body image [6], diminishing of psychopathology [17] and abnormal eating behavior [18], and enhancement of psychosocial functioning [19–21]. The most significant psychosocial gain of the surgery is the experience of reinsertion and social acceptance [22].

The impact of this dramatic weight loss brought about by the surgery on the psychological and social well-being of these women is yet to be fully understood. Thus, the objective of the present study is to understand the gamut of meanings for women to undergo bariatric surgery, the impact that this represents in their lives, and the psychosocial complications. By understanding the elements of subjectivity of these patients, we would provide the multidisciplinary team with a privileged access to the motivations that enable patients to face the challenge of keeping their weight stabilized.

Subjects and Method

This study had a clinical qualitative design, a particularization of the qualitative method applied to a specific health framework that permits us to understand the life experiences and the process of the suffering of the individuals in relation to a determined problem in the health–illness process. Thus, this method adopts a humanistic model, seeking to interpret scientifically the meanings that individuals' life experiences acquire [23]. Hence, the present work had an exploratory, nonexperimental character. We believe that it is extremely useful for physicians themselves to make use of qualitative methods. Qualitative researchers study their subjects in their natural settings, in an attempt to interpret phenomena in terms of the meanings that people attribute to them [24, 25]. Such methods have their own characteristics in relation to sample composition, data analysis, and the possible generalizations from the results (Table 1). The data collection instrument was the semidirected interview with open-ended questions [26] in an intentional sample, in other words, one which is made up of a small number of people, chosen deliberately in function of the importance they have in relation to the given theme and considered bearers of social representation [23, 26, 27]. This approach had the aim of ensuring that the matter was discussed in depth with the interviewees. The sampling technique used for qualitative research does not require statistical representation in relation to the subject population, i.e., it does not need the use of randomized studies.

Table 1 Sample characterization by individual: gender, age, marital status, and time since surgery

Name	Age	Sex	Time since surgery	Civil status
P1	49	F	3 years	Married
P2	33	F	2 years and 2 months	Married
P3	37	F	1 year and 6 months	Married
P4	39	F	1 year and 11 months	Single
P5	45	F	2 years and 11 months	Separated
P6	28	F	1 year and 6 months	Married
P7	49	F	1 year and 11 months	Widow

This produces data with the aim of reformulating, deflecting, complementing, and/or clarifying initial hypotheses. The study sample consisted of seven women operated in the surgical service of the General Hospital of University of Campinas (UNICAMP), a tertiary public university hospital, located in the city of Campinas, state of São Paulo, in the southeast region of Brazil, in a period of 1 year and 6 months to 3 years. This interval was previously established and excludes the first postoperative 12 months, during which time strong elements of denial and a disproportional increase of self-esteem occur.

The sample was closed at this number by utilizing the saturation criterion [28]. Thus, it was considered that the incorporation of additional interviews would make little significant contribution with regard to the objectives initially considered. The interviews were taped with the permission of the patients. The transcriptions from the interviews formed the corpus for the study and were subjected to qualitative content analysis [29]. After applying the categorization strategy [23, 27], the categories for this study were selected. Qualitative analysis of a text does not infer categories from the frequencies of the analysis units (or from other mathematical approaches). The phenomena thus identified can then be interpreted so as to generate concepts capable of generalization in other settings. The emerging categories were validated by peer reviewers from the Laboratory of Clinical Qualitative Research, UNICAMP.

The research project was approved by the Ethical Research Committee of the Faculty of Medical Sciences of UNICAMP.

Results

Improvement in Body Image: Acceptance and Defenselessness

Weight loss after surgery leads to marked improvement in body image and attractiveness, and it would be one of the

main reasons for postsurgical psychological improvement, better social integration, and an enhanced quality of life.

The loss of weight is experienced as a valuable opportunity to recover a place in society. However, it is also a motive for apprehension and fear due to the visibility that they begin to have for other people and the loss of the protected position bestowed by their obesity.

> Nowadays I am a more eager person, I feel like doing things and even go out from time to time…But the problem is dating…I just can't…..I'm ashamed…. P5

After all the effort to find their place in the world again and to be admired, they are faced with the reappearance of their feminine bodies: a new situation with which they are unable to cope.

> It was as if I was inside a cocoon, there was no outside world and whatever happened inside that cocoon was good for me…….getting fat, losing weight, getting fat, losing weight, it was fine. P4

On leaving the "cocoon," represented by the excess of body fat, there is a feeling of lack of protection and for this reason, at the same time that they achieve this condition of being admired, phobic symptoms appear.

> You feel a little more desired... but I haven't learned to cope with this situation yet. P2

The feeling of helplessness is evident in these women who lost their protective place and have to face the world. What obesity justified, that is, their isolation in relation to others and the feeling of rejection, must now be reexpressed in a new structure, in which obesity plays no part.

It is a period in which new life experiences emerge, which go from feelings of genuine happiness to clear expressions of jealousy, mistrust, fear, and envy felt by others.

Sometimes, it happens that the patient's obesity may serve certain functions which satisfy the needs of the family system, and the patient's weight loss may be perceived by her most immediate environment as an undesirable and threatening phenomenon. In the same way, for some women, partners' jealousy is a new factor, which they are not used to dealing with, and an imbalance is created in the relationship with their partners, thus jeopardizing the advantages gained by the improvement in the quality of life and by the couple's experiences of resocialization which result from the weight loss and its consequences.

> Now my husband has begun to talk like this: Why are you going out? To show off? P3

When these reactions of others begin to appear, having believed that their social acceptance was guaranteed by the weight loss, they may feel deeply disillusioned, which in turn can be a demoralizing and discouraging factor in the process of weight loss.

The Problem of Skin Folds, Flaccidity, and Scars

After some time, some patients are still discontent with their bodies. The same issue of shame that had previously been attributed to obesity is now attributed to flaccidity, skin folds, and scars.

> Now I'm no longer fat but I have flab, loose skin and everybody looks at me the same way. P6

These marks of obesity are elements that strongly contribute to the frustration of their expectations of once again having a beautiful, healthy, and functional body.

> When I'm dressed, I'm no longer ashamed, you know... Now, without my clothes on, that's another story. Because I'm all flaccid. I'm ashamed. P5

Due to this perception, the risk of isolation is great, demanding special attention from the psychological team.

> I'm withdrawing....Before it was because I was obese, now am I withdrawing because I'm thin? P4

At this point, the expectation of undergoing corrective plastic surgery is experienced with the same anxiety and urgency as they did when awaiting bariatric surgery. The desire to carry out corrective plastic surgery can lead the medical team to recommend successive plastic surgeries if they misunderstand the emotional needs of these women.

Discussion

We believe that, by using a qualitative method of scientific investigation, we can get closer to the subjective meanings of human experience in a given context, with results that show both validity and reliability. However, in view of the complexity of the field of study, we inevitably had to restrict our conclusions to some categories that are identified by the researcher at the time of the research. For this reason, other research possibilities remain open for future studies.

Our study offers some markers to assist the professional in his decision with regards surgery and can help in developing a specific assessment protocol of the psychosocial aspects of candidates for bariatric surgery, especially those questions specifically related to women. It allows the health team to identify factors that may negatively or positively affect prognosis, so that an appropriate psychosocial plan can be developed.

It is important to identify those aspects of a patient's psychological makeup which would be expected to improve

or worsen their prognosis and to provide the necessary preoperative and postoperative psychosocial interventions.

The results of our study show that special attention from the health team should be given to the conflicts related to patients' sexuality, mainly the jealousy aroused in partners and shame, to their feelings of helplessness and the phobic symptoms that can appear after weight loss. In view of these changes, it is crucial that patients and their partners be psychologically prepared before surgery, thus avoiding problems that can jeopardize the possibility of benefiting from the advantages gained by the weight loss.

For some women, besides psychotherapeutic treatment focusing on helping those with morbid obesity better adjust their eating habits, it should also encompass aspects related to the defensive function obesity has for these women, since for them, the reencounter with the feminine body involves a reemergence of conflicts that were hidden by the obesity.

Excessive concern about the skin folds, flaccidity, and scars can lead the medical team to recommend plastic surgery, in order to satisfy patients' demand with regard to their body image rather than emphasize the necessity for psychological care. However, as a result of massive weight loss, extensive plastic surgery is a medical necessity, and, for this reason, the health team should be primed to prepare the patient and her partner for continued adjustment and self-acceptance after these procedures.

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