ORIGINAL ARTICLE

Pınar Döner Güner[1]
Rabia Kahveci[2]
Hilal Aksoy[3]
Adem Özkara[2]

[1]Mustafa Kemal University Faculty of Medicine, Department of Family Medicine, Hatay, Turkey
[2]University of Health Sciences, Bilkent State Hospital, Department of Family Medicine, Ankara, Turkey
[3]Hacettepe University Faculty of Medicine, Department of Family Medicine, Ankara, Turkey

Corresponding Author:
Hilal Aksoy
Hacettepe University Faculty of Medicine, Department of Family Medicine, Ankara, Turkey
E-mail: hilal.aksoy35@gmail.com

Received: 15.05.2019
Acceptance: 22.08.2019
DOI: 10.18521/ktd.565911

Konuralp Medical Journal
e-ISSN1309–3878
konuralptipdergi@duzce.edu.tr
konuralptipdergisi@gmail.com
www.konuralptipdergi.duzce.edu.tr

Weight Loss Experiences of Obese Individuals; Qualitative Study

ABSTRACT

Objective: Obesity is a leading preventable cause of death worldwide. Being overweight or obese has a serious impact on health. Treatment of obesity needs a comprehensive approach. Biopsychosocial approach of family physicians is invaluable in obesity management. In this study, we aimed to evaluate experiences of obese individuals during their weight-losing attempts and to explore the factors affecting success and failure of different approaches.

Methods: We conducted indepth, semi-structured, face to face interviews with 30 participants whose Body Mass Index was higher than 30). Interviews were audio-recorded and transcribed, and qualitatively analysed using a thematic framework method.

Results: 26 women and 4 men have accepted to join our study. Analysis of in depth interviews emerged 5 major themes which were: the different perception of obesity among individuals; awareness of obesity; loss of self-confidence; belief in treatment and effects on quality of life.

Conclusions: Each patient has a different need and different expectation while controlling weight. As a part of biopsychosocial approach the family physician needs to understand the factors that bring the patient to current condition and see which approach would be the best for individual patient for weight management.

Keywords: Obesity, Qualitative Research, Weight Loss

Obez Bireylerin Kilo Verme Deneyimleri; Kalitatif Çalışma

ÖZET

Amaç: Obezite dünya genelindeki önlenebilir ölüm nedenlerinin başında gelmektedir. Aşırı kilolu veya obez olmanın sağlık üzerinde ciddi bir yan etkisi vardır. Obezite tedavisi kapsamlı bir yaklaşım gerektirir. Özellikle aile hekimlerinin biyopsikososyal yaklaşım göstermeleri kilo verme sürecinde çok önemlidir. Bu çalışmada, obez bireylerin kilo verme girişimleri sırasındaki deneyimlerini değerlendirmeyi ve başarı ve başarısızlığı etkileyen faktörleri bulmayı amaçladık.

Gereç ve Yöntem: Beden kitle indeksi 30 üzeri olan hastalarla derinlemesine, yarı yapılandırılmış, yüz yüze görüşmeler yaptık. Görüşmeler ses kaydına alındı ve yazıya aktarıldı. Daha sonra tematik çerçeve yöntemi ile kalitatif analizi yapıldı.

Bulgular: 26 kadın ve 4 erkek çalışmaya katılmayı kabul etti. Derinlemesine röportajlar sonucu 5 ana tema ortaya çıktı: obezitenin bireyler arasında farklı algılanışı; obezitenin farkındalığı; öz güven kaybı; tedaviye inanç; hayat kalitesi üzerine etkileri.

Sonuç: Her hastanın kilo kontrolüne farklı bir ihtiyacı ve bundan farklı bir beklentisi vardır. Biyopsikososyal yaklaşımın bir parçası olarak aile hekimi hastayı o anki duruma getiren etkenleri anlamalı ve hangi yaklaşımın hastanın kilo kontrolünde daha iyi olacağına karar vermelidir.

Anahtar Kelimeler: Obezite, Kalitatif Çalışma, Kilo Verme

INTRODUCTION

Obesity is a significant contributor to chronic disease worldwide. Body size can be assessed using a variety of measures, including weight, height, and waist circumference. A widely utilized tool to assess overweight and obesity is body mass index (BMI). The World Health Organization (WHO) defines normal weight as a BMI of 18.5–24.9 kg/m, overweight as a BMI of 25–29.9 kg/m^2, and obesity as a BMI of 30 kg/m^2 or greater(1). Obesity is further subcategorized into class I (30–34.9 kg/m^2), II (35–39.9 kg/m^2), and III (40 kg/m^2 or higher)(2).

The prevalence of overweight and obesity is escalating worldwide and obesity is a leading preventable cause of death. Obesity, has become both economical and social problem that countries try to solve. Obesity has become widespread in children as well as adults. Childhood obesity is one of the most important causes of chronic vasculer diseases and has a strong tendency to track into adulthood if left untreated(3). WHO reported that the number of obese individuals in Turkey was 16.092.644 in the year of 2016 and the obesity prevalence was 29.5% This was the highest prevalence rate in European countries(4). Family physicians have an important role at the management of preventable diseases and biopsychosocial approach of family physicians in obesity management is invaluable. Treatment of obesity needs a comprehensive approach. As a part of biopsychosocial approach the family physician needs to understand the factors that bring the patient to current condition and see which approach would be the best for individual patient for weight management. The approach would include diet and nutrition, effective physical activity and changing behaviours, besides psychological support. It is argued in the literature that cultural differences affect eating behaviours and also disease management processes(5-14).

It is also known that the success of different and comprehensive approaches is still limited, probably due to many social, psychological, cultural and individual factors that need to be further evaluated(15-18).

Some qualitative studies have tried to focus on the individual factors and experiences during management of obesity in order to understand how the situation could better be managed(19-26).

But we have not found any qualitative study related to obesity management from Turkey.

In this study, we aimed to evaluate experiences of obese individuals during their weight-losing attempts and to explore the factors affecting success and failure of different approaches.

MATERIAL AND METHODS

Design, Sample and Data Collection: We carried out a qualitative study with obese patients who were referred to the dietary unit of a training and research hospital. We included adult patients whose body mass index (BMI) were above 30 kg/ m² and who had different previous experiences about losing weight. We excluded the patients with any other chronic diseases associated with obesity, or had an obesity surgery, in order to avoid any other significant effects on management due to these conditions. Persons with these characteristics were interviewed without sample selection. Collecting additional data was stopped when we believed that no additional information could be obtained. We piloted three interviews before ending up with a guidance for a semi-structured interview. Although we had a list of open-ended questions after piloting, we modified these throughout our interviews with the patients. The interviews were performed from September 2011 to November 2011. All interviews were recorded digitally, and the records were transcribed including all emphases and special expressions. While transcribing the interview, all special expressions were stated.

Ethics: Ethical approval (231/2011) was obtained from the Hospital Ethics Committee where the study was conducted. All interviews were audio-taped with permission from the participants, and were transcribed. All participants gave written permission including their signature and were given verbal information about the purpose of the study.

Data Analysis: Data were analyzed using a thematic framework method(27). We analyzed the interviews following each interview. Each patient gave us different ideas which led us to review our interview process continuously. We continued the interviewing process until no new information came up and we reached saturation.

The transcribed interviews were open-coded separately, at first by two researchers and transcripts were reviewed for consistency. All inconsistencies were discussed and consensus on the final concepts were reached. Then these two researchers and another one researcher reviewed transcripts of the groups and categorized the responses based on similarity. Later, reviewers discussed their findings and had a consensus on five domains to discuss experiences during weight management. All researchers had experience in qualitative studies.

Data analysis was conducted by researchers. Our analysis was guided by grounded theory techniques whereby we read and re-read transcripts, coded, and identified categories/themes. Researcher added her own opinions about patients' body language and voice tone, gesture, facial expression and then these important clues were used during analysis.

The numbers of patients expressing a theme were grouped by quantifiers as follows: 'a few' 0–5 persons; 'some' 5–15 persons; 'many' 15–25 persons; 'most' 25–30 persons.

RESULTS

Thirty (4 male, 26 female) participants were included in the study. The patients' characteristics are listed in Table 1. The ages of the participants

were between 18 and 57. When classification was made according to age ranges;
50-59: 4 patients
40-49: 4 patients
30-39: 15 patients
20-29: 6 patients
Younger than 20 years old:1,

It was observed that female patients were more willing to talk about obesity problem. The analysis revealed five main themes; obese people' aspect of obesity, awareness level of obese people, obesity self-confidence relationship, beliefs of the obese individuals to treatment and effects of obesity on quality of life.

Each theme will be separately presented below, with related quotations inserted.

1. Obese people' aspect of obesity

1.1 In terms of health: A huge majority of the patients think that obesity will affect their health negatively. They clarify their thoughts by statements like 'I am worrying' and 'I am afraid of'. Also, the patients who still have health problems think their problems are related with obesity. Thus they say that they want to lose weight in order to solve their problems and become healthier.

A 52-year old patient, with an ashamed and worried facial expression and with a timid voice tone, said that because of her kilos, not only herself but also her relatives have trouble. Because of this situation, the patient that her life quality is affected, wants to lose weight as soon as possible. Kilo problem seemed to have affected the patient both physically and psychologically.

"…extra kilos are affecting, I don't want to walk around, I am panting for breath, I don't want to climb up stairs, when there is somebody with me I become torment for them. I say 'let's immediately get into the car'; neither I nor people walking with me enjoy anything from walking."(Patient number:9)

1.2 Obesity in terms of aesthetic: Most of the patients want to solve their problem to seem better aesthetically in addition to become healthier. While putting the reasons for losing weight in an order, some of the patients say that seeming aesthetically well is the preliminary reason. Most of those having an aesthetic approach told they have problems in choosing dresses, actually the suitable ones. By the expression that both their words and body language reflect, it was observed that they felt quite bad about this situation.

Body Mass Index (BMI) of our 26 year-old, married housewife patient was 48.9. While telling that she thinks losing weight is important for health, she expressed she does not have a problem with health, after bit silence she said -in a accented voice- actually the main reason for losing weight is about the physical appearance and she continued speaking by telling an event she lived about this. The patient was observed quite sad and ashamed while telling the event she has lived.

"…it causes health problems, most simply you cannot pick yourself up from where you sit down (a small silence). Also as appearance, mostly as appearance (!) (making her voice higher and more stressed) At the time, I do not have any problems about my age, but as physical appearance I have, when I walk around with my husband, there are some people looking at" him and then me and saying 'uvvvvvvv'." (sadly) (patient number:18)

1.3 The Feelings and point of view to obesity being affected by the environment: Most of the patients who has taken place in the study, claimed that individuals in their neighborhood make negative comments about their extra kilos many times. It was observed that many of these patients were not pleasant about these comments and critics. Few patients said they were not being affected negatively of what people around them say because they know that those comments and critics are for their goodness.

Another, 31 year-old married woman patient:

"… yes, yes even my father (voice tone stressed, resentful and not admitting) …. Also my husband says the most." (sad, resentful expression) (Patient number:4)

1.4 Approaching obesity from an economical perspective: A small number of the patients said obesity affected their economy negatively. There were some patients who said special dresses, special diet, and extra expenses for slimming down methods put extra burden on their budget. Few patients said they could not continue to diet because they could not afford economically.

32 year-old married, housewife patient, said she did not conform to the suggested diet, because having the whole content of the diet was difficult economically.

"…. Actually buying capacity is important, a small piece of grilled meat patty, you cannot find at the moment, or grilled meatball or cutlet, like that …" (Patient number: 15)

2. Awareness level of obese people

2.1 Obesity being accepted as a problem need to be solved: All of the patients were like minded about obesity being a health problem. Patients were approaching differently to obesity as a problem to be solved. They were considering obesity in health, aesthetic and psychological points of view.

2.2 Knowledge about the complications that can occur: Patients totally were like minded about the complications, knowing obesity may affect health negatively. However, just some of the patients had complete information about what the complications may be.

"…definitely, the heart disease, diabetes also cholesterol, all illnesses are occurring because of overweight, also including cancer according to me all illnesses are due to overweight…"

A small number of patients' family had health problems that obesity causes or accompanies. Thus they had anxiety and fear about the probability that

they have same problems. These feelings had been effective at applying to the doctor.

3. Obesity self-confidence relationship

3.1 Being kid and hearing hurtful words: Some of the patients told that they are being kid and people say hurtful words to them because of their kilos. Some of these patients verbally mentioned the worry that this situation caused. A part of them did not mention verbally but from their body language it was observed that they were hurt and disappointed and sometimes got angry.

18 year-old single woman patient told she was upset by her friends talking about her extra kilos. When she began to remember an event she had lived and tell it, she stopped a bit, at the continuation of her speaking she got calm and was observed that she had a quite upset face expression.

"… actually my friends are sometimes kidding, I am getting upset than I overcome it (waiting a bit)…my friends say 'You are too fat, you do not fit into door…' " (patient number: 22)

Our 57 year-old housewife married patient said she was upset by her husband's imitations about her kilos. It was observed that she did not mention any sadness from her husband's words because she thinks he is right.

"…my husband says 'I don't carry on my back', he says 'you are carrying 30-40 kilos sack on your back ', 'think yourself' he says, I am worrying but he is also right, thus …I do not know anymore…" (Patient number: 2)

3.2 Touchiness: One of our patients said that even if it is not verbally said "too fat" to herself, it is made feel by some words and behaviors.

A patient said it is made feel somehow especially while buying clothes.

"…. I have this problem mostly when I am buying clothes. I did not come across to verbally kidding but from their glances I understand that" I am to fat" …When I hear the sentence "there is not this size on our store" I got too upset…" (Patient number: 25)

3.3 Feelings (sadness, resentment, anger, shame, etc...) being affected at the speeches that extra kilos are mentioned: Most of the patients expressed that they feel upset by the speeches that people near them do about their extra kilos. Some of them differently said they feel anger.

Married, 36 year-old woman with a sad expression: "… whoever sees me say 'ayy how fat have you been? You have been too bad' …Previously I was weak…" (…upset, her voice tone reduced when she remembered the past) (patient number: 3)

3.4 Respect, being listened: 27 year-old accountant woman patient mentioned that in order her sayings have influence, being well cared is also required, thus she needs to lose weight.

"… of course, you have to look after yourself in order people listen to you…" (Patient number: 7)

3.5 Self-Confidence at job, the possibility to find job: Some of the patients stated that they think physical appearance has the primary importance for being more successful in job environment and for having better job opportunities.

The 25 year-old woman patient who studies graduate degree, states that physical appearance is very important for finding a job about her profession, and she will be able to find a job more easily if she loses weight.

"….at first your self-confidence will be refreshed, due to my professions requisite there is not many job opportunities I hesitate to apply to private sector, being well educated is very important too but for example when you apply to be a secretary appearance is very important, I will have my confidence refreshed, I will say 'I managed to do this, I will be able to do the other one also', as you have energy to do something you will have much more, when you began to lose weight you are able to talk these topics between people around you… " (patient number: 21)

3.6 Self-confidence in social relationships: While the 25 year-old woman patient who studies higher education stated that her self-confidence will refreshed if she loses weight, she said thus she wants to lose weight and she seemed hopeful and decisive…

"…At first the self-confidence that you have will refreshed…" (She was observed hopeful and decisive) (Patient number:21)

3.7 Social Isolation: The 52 year-old woman patient stated the reason for not getting outside the home as:

"…. I feel like isolated…" (Patient number: 9)

3.8. Problems of the selection of clothing: Most of the patients added that they had difficulty in the selection of clothing due to their weight problems. The majority of patients expressed that they experienced difficulties when choosing a dress "make them very sad".

One of our patient, who was 25 year-old single woman, emphasized the importance of choice clothes in society in order to feel better. She told us that she takes a challenge in selection because of her weight, she has limitations and this situation makes her upset. She voiced the request of reaching select clothes what she wants by losing weight.

"… Of course, first and foremost health is important but in order to feel better apparel is more important in society. In a store you want to wear something which makes you feel better. For example I had dressed men's section for many years, due to here is a small town, finding cloth was difficult. Previously always I had to dress up in men shelves. In my childhood I didn't wear any pants. I wore my first pant in high school. I couldn't do these things and those remained inside of me. I want to wear clothes which I will feel better…" (Patient number: 21)

4.Beliefs of the obese individuals to treatment

4.1. On making the change of lifestyle: The majority of the patients said that they cannot continue their efforts in weight loss. The vast majority of these patients told that the successful experience of loss weight stay half because they can't make this thing permanent due to various reasons. Some of the patients said that they can't continue because of "it doesn't meet their lifestyle", at least part of them "it can't provide", a little part of them "they couldn't continue due to economic reasons", some of them "their psychology affected by negative experiences". 44 year old male patient told that he had experiences which resulting in positive, however he gain weight again because he couldn't make his diet changes permanent.

".. The fact that I tried to diet two times and this try was concluded positive, but I couldn't change my eating style so my weight has increased again over time." (Patient number: 6)

4.2. Conformity,applicability and sustainability to diet program: Most of the patients stated that the consulted a dietician before in order to lose weight. While a small number of these people told that they could keep up with dietary advices, others told they could not keep up with the advices. Most of the patients told that besides consulting a dietician, they tried to develop different ways of losing weight. Some patients told that they had not consulted a dietician before. These patients said they tried to diet on their own, with the information they saw on television or internet, or tried to improve their physical movements.

A 31 years old housewife told that she had not consulted a dietician and tried to diet on her own but could not succeed. It was observed that the motivation of conformity and sustaining the diet of the patient is insufficient.

"… I could not keep dieting; I gave up because I think "anyway… it is nonsense. Is a slice of bread which makes me getting weight?" (Patient number: 4) (she seems to be unhappy and anxious because of this)

A 32 years old housewife told that she could not afford the food advised by the doctor all the time and get difficulty economically.

"… I consulted a dietician, could not apply the diet, and could not buy the list…" "If I buy one of the stuff, I cannot buy another" (Patient number: 15)

4.3. Facilities and limitations for exercise: Most of the patients stated that exercise is useful and necessary. They said that they could not find enough time to exercise because of intensive work/house program.

A small number of the patients said that they do exercise only when they apply a diet program.

A small number of the patients mentioned the lack of physical facility to do exercise. Most of the patients told that physical facilities for exercise are adequate and accessible yet they do not do for various reasons.

A 40 years old woman patient said that she had many facilities to exercise however she only made exercise while she applied a diet.

"… yes I do exercise, I have a treadmill in my home; I do it when I am on diet; for example I have a 45 minutes way to work, I walk there; but when I am on diet…" (Patient number: 12)

A 27 years old patient, an accountant, told that he was busy because of his workload and had no time and strength for sport:

"Everybody is working, coming home tired and cannot say anyone 'Come on! Let's go walking' There is a high workload and we are stuck into computer. I am leaving work at 7, it is nearly 8-8.30 arriving home; feeding, washing up and etc. takes time and at the end I really got tired and overdone. My eyes are searching for sleep" (Patient number: 7)

4.4. Professional support: Most of the patients told that they were in the effort of losing weight on their own without consulting a dietician. Most of them told they applied to a dietician after their own efforts while a small number of them think there would no need for consulting professional support to lose weight.

A 31 years old patient, housewife, told that she did not get a professional support and her own efforts ended because of giving up quickly.

"… I made diet on my own but I could not keep going because I gave up…"(Patient number: 4) A 52 years old patient, housewife, did not take any professional support and tried to find a solution on his own; reading and following from the media. Yet, she got weight again after losing.

"…I tried some diets which I saw on television or read on journals, and I could lose 3-5 kilos. However I feel weary when I lose weight so I begin to eat again…" (Patient number: 9)

27 years old another woman said, unlike other patients, that there would be no certainly need a doctor help to lose weight.

"… there is no need precisely for the doctor; one knows where the problem is: "fail to act"…" (Patient number: 7)

4.5. Motivation: Although most of the patents told their causes of not keeping their exercises with the word "motivation", they stated that their motivation was decreased and lost within the time as understood from the speeches "I gave up, I could not keep going, I gave up because of any support from my family/friends".

A 40 years old woman mentioned the cause why she could not continue dietary program, she complained about motivation:

"…Only I can't keeping that motivation…" (Patient number: 12)

5. Effects of obesity on quality of life

5.1. Decrease of physical capacity: Most of the patients were suffering from limitation of movement because of arthralgia due to her weights.

Arthralgia and limitation of movement cause a vicious circle.

Our doctor patient, 29 years old complained about limitation of movement because of overweight:

"… When I feel that weight make me feel weary and limits me while doing my works, and even when I am tired after having rest, I thought it as a health problem…" (Patient number: 26)

5.2. Mental and emotional well-being: Obesity has been an obstacle in most of the patients against mental and emotional well-being. It was observed that this caused the lack of self-confidence and sovereignty of pessimism and sorrow. Most of the patients thought that they got less respect and not paid attention by the neighborhood.

A 37 years old woman told that it will be much easier to reach her targets when she lost weight:

"I am dreaming of it; I am getting divorced now and when I apply somewhere in order to find a job for my children… I do not want to hear something negative when I need something to wear in a shop…" (Patient number: 24).

DISCUSSION

Obesity is a worldwide health problem of growing prevalence. The number of studies on the diseases that are caused by obesity and the causes of odesity is increasing every year. Also, the dynamics that are effective in development of obesity process are the subjectcs of researchs. Large number of qualitative studies have been done abroad, on the subject of how and why individuals face with the problem of obesity, and what can be done for the solution of the problem. In our country, quantitative studies on the subject are performed in large number, in opposite to the qualitative study, that is hardly found in national publications.

Obesity, has become both economical and social problem that counties try to solve. In our country, as well, obesity incidence is getting increasing both in adulthood and childhood. Due to the growing prevalence of obesity it become a public health emergency subject that need effective solutions. Obesity is a multifactorial occasion, and is complex both in understanding the formation of it and in process of solution. For this reason, it will not be sufficient to assess obesity issue In a single aspect, either in terms of development or the solution. So we believe that it will be more usefull to deal with obesity by utilizing both quantitative and qualitative datas. Based on this idea, this study was planned to approach to obesity from a different point.

1.Obese people' aspect of obesity: Sophie Lewis and his colleagues have carried out a qualitative study of obesity in Australia in 2009, most of the obese individuals contained in their study, thought that obesity would lead to health problems in later years. These patients also so "fear" and "worry" have expressed(22). Similarly in our study, the vast majority of the patients included in the study, believes that excess weight may adversely affect their health and "I'm worried ", "fear", "worried " stated that such expressions. In our study, the vast majority of patients who expressed their feelings in this way are concerned that they have witnessed obese individuals' distress. And also they thought that if they couldn't loose weight, they would face similar problems over the years.

If family physicians can learn their patients' thoughts and feelings about being obese as close to first consultant doctors; they will recognize their aspect of obesity clearly. Thus co-operation could be made easier and existing concerns could be troubleshooted. The patient who has difficulty in transferring her problem to the other person is less likely to obtain accurate results from the diagnosis and treatment(27).

2.Awareness level of obese people: According to findings of Epstein and Ogden's qualitative study on obesity in England in 2005; doctors, expressed that obese patients are not aware of the seriousness of their current situation. When they talk with patients, they noticed that they are awareness about diet and they don't know how their diet should be. They gave one patients' words as an example "But I only eat lettuce"(23). Similarly some of our patients had no idea on the eligibility of the contents of the diets. Even a very small percentage compared to other individuals in their house and mentioned that they ate very little, but could not understand why they loose less weight. In addition one of our patients, couldn't understand the possible changes in diet program.

Before starting treatment, if family physicians notice whether their patients are aware of the severity of obesity and where the deficiency in their diet and daily activities, family physicians can increase the awareness by telling them the truth. Thus, it can be ensured to realize thyself whatever is missing or wrong and compliance with treatment could be increased.

3.Obesity self-confidence relationship: Thomas SL. and his colleagues in Australia in 2008, in their qualitative study, most of the patients participating in the study think that obese individuals reflected as a 'criminal' especially by the media(24). Also in many studies it has been revealed that prejudiced approach to obese people is very high(28-30). In our study our participants mentioned that criteria needed to see loved and appreciated in society is "being slim". This situation affects their self-confidence.

In Rebecca M. Puhl and her colleagues' qualitative study, most of participants expressed that they are not satisfied with the criticism and jokes made about their excessive weight(26). In our study similarly most of our participants was quite unhappy with negative verbal criticism, jokes, fun and a small part of them was quite unhappy with some disagreeable insults. Although majority of our

patients sorrowed because of this situation, only a small part of them expressed that they uneased with this attitude and approach. Small proportion of patients regretted that some people imply their excess weight with their non- verbal behaviors or sometimes they insinuated. As well as, in our study, small proportion of patients expressed clearly that the problem of weight may be caused by or accompanied by psychological problems. Besides when the majority of patients with obesity talked about their experiences, body language was thought to be adversely affected psychologies due to observation during interviews. So that a question appeared "Is an adverse effect on the psychology which obesity induced or obesity adversely affected psychologies?" which we thought for our most participants.

If family physicians understand their patients' psychologies clearly with reasons, both treatment and cooperation with patients will be affected positively. If it is considered that the underlying cause is adversely affected psychology, it can be firstly cooperated with the patient. If family physicians consider that their patients' psychologies were affected after being obese, they can supply psychological support besides obesity treatment. So the rate of successful treatment can be increased. Most of patients' self-esteem was negatively impacted.

4. Beliefs of the obese individuals to treatment: In the Epstein's study it was stated that patients are giving the responsibility to doctors and it was emphasised that this is a wrong belief(23). If patient satisfaction and expectations are met adherence to treatment increases both in hospital and after hospitalization(31). In our study this situation was not clearly defined. But the patients told that if diet and exercise don't work, they believe the doctors and dieticians are responsible. Some expressions that they used ;"I went to dietician but I could not loose weight", "Doctor gave me an exercise program but how can I do it?"

5. Effects of obesity on quality of life: In the study of Lewis and her friends, obese people think that obesity can lead to health problems in the future(22). Also in our study patients stated that if they don't loose weight, health problems will begin and this will affect the quality of life.

CONCLUSION

As a result of the study it was understood that patients have different expectations and needs on loosing weight. According to biopsychosocial approach, family physicians need to define how patients get obese and what will be done specifically. One of our main goals in this study is to raise awareness in both patients and doctors. Regarding this issue, more qualitative studies can be usefull for what can be done for solving this problem with a cooperation of doctors and patients.

Conflict of Interest Statement: The authors declare that they have no conflict of interest.

REFERENCES

1. http://www.who.int/gho/ncd/risk_factors/bmi_text/en/
2. World Health Organization. Obesity: preventing and managing the global epidemic (Report of a WHO Consultation: WHO Technical Report Series 894). Geneva: World Health Organization; 2000.
3. Llewellyn A, Simmonds M, Owen CG, et al. Childhood obesity as a predictor of morbidity in adulthood: a systematic review and meta-analysis. Obes Rev. 2016; 17(1): 56-67.
4. World Health Organization. WHO fact sheet on overweight and obesity. Updated October 2017. http://www.who. int/mediacentre/factsheets/fs311/en/. Erişim tarihi:16/08/2019.
5. Taverno Ross SE, Larson N, Graham DJ, et al. Longitudinal changes in physical activity and sedentary behavior from adolescence to adulthood: comparing U.S.-born and foreign-born populations. J Phys Act Health. 2014;11:519-27.
6. Gordon-Larsen P, Harris KM, Ward DS, et al. Acculturation and overweight-related behaviors among Hispanic immigrants to the US: the National Longitudinal Study of Adolescent Health. Soc Sci Med. 2003;57:2023-34.
7. Kocken PL, Schönbeck Y, Henneman L, et al. Ethnic differences and parental beliefs are important for overweight prevention and management in children: a cross-sectional study in the Netherlands. BMC Public Health. 2012;12:867.
8. Crawford PB, Story M, Wang MC, et al. Ethnic issues in the epidemiology of childhood obesity. Pediatr Clin North Am. 2001;48:855-78.
9. Peña MM, Dixon B, Taveras EM. Are you talking to ME? The importance of ethnicity and culture in childhood obesity prevention and management. Child Obes.2012;8:23-7.
10. Claire Wang Y, Gortmaker SL, Taveras EM. Trends and racial/ethnic disparities in severe obesity among US children and adolescents, 1976-2006. Int J Pediatr Obes. 2011; 6:12-20.
11. Kumanyika SK. Environmental influences on childhood obesity: ethnic and cultural influences in context. Physiol Behav. 2008;94:61-70.
12. Hendley Y, Zhao L, Coverson DL, et al. Differences in weight perception among blacks and whites. J Womens Health (Larchmt). 2011;20:1805-11.
13. Lau PW, Lee A, Ransdell L.Parenting style and cultural influences on overweight children's attraction to physical activity. Obesity (Silver Spring). 2007;15:2293-302.

14. Baruffi G, Hardy CJ, Waslien CI, et al. Ethnic differences in the prevalence of overweight among young children in Hawaii. J Am Diet Assoc. 2004;104:1701-7.
15. Kaholokula JK, Townsend CK, Ige A, et al. Sociodemographic, behavioral, and biological variables related to weight loss in native Hawaiians and other Pacific Islanders. Obesity (Silver Spring). 2013;21:196-203.
16. Wang Y, Beydoun MA. The obesity epidemic in the United States--gender, age, socioeconomic, racial/ethnic, and geographic characteristics: a systematic review and meta-regression analysis. Epidemiol Rev. 2007;29:6-28.
17. Taveras EM, Durousseau S, Flores G. Parents' beliefs and practices regarding childhood fever: a study of a multiethnic and socioeconomically diverse sample of parents. Pediatr Emerg Care. 2004;20:579-87.
18. Stern MP, Pugh JA, Gaskill SP, et al. Knowledge, attitudes, and behavior related to obesity and dieting in Mexican Americans and Anglos: the San Antonio Heart Study. Am J Epidemiol. 1982;115:917-28.
19. Shoneye C, Johnson F, Steptoe A, et al. A qualitative analysis of black and white British women's attitudes to weight and weight control. J Hum Nutr Diet. 2011; 24:536-42.
20. Smith LH, Holm L.Social class and body management. A qualitative exploration of differences in perceptions and practices related to health and personal body weight. Appetite. 2010;55:311-8.
21. Morrison Z, Douglas A, Bhopal R, et al. Understanding experiences of participating in a weight loss lifestyle intervention trial: a qualitative evaluation of South Asians at high risk of diabetes. BMJ Open 2014;4:e004736.
22. Lewis S, Thomas SL, Blood RW, et al. Do health beliefs and behaviors differ according to severity of obesity? A qualitative study of Australian adults. Int J Environ Res Public Health 2010;7: 443-59.
23. Epstein L, Ogden J. A qualitative study of GPs' views of treating obesity. British Journal of General Practice 2005; 55: 750-4.
24. Thomas SL, Hyde J, Karunaratne A, et al. Being 'fat' in today's world: a qualitative study of the lived experiences of people with obesity in Australia. Health Expect 2008;11: 321-30.
25. Weaver NF, Hayes L, Unwin NC, et al. "Obesity" and "Clinical Obesity" Men's understandings of obesity and its relation to the risk of diabetes: a qualitative study. BMC Public Health 2008; 8: 311.
26. Puhl RM, Moss-Racusin CA, Schwartz MB, et al. Weight stigmatization and bias reduction: perspectives of overweight and obese adults. Health Educ Res 2008; 23:347-58.
27. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, editors. Analyzing qualitative research. London: Routledge; 1994;173–94.
28. Storch EA, Milsom VA, DeBraganza N, et al. Peer victimization, psychosocial adjustment, and physical activity in overweight and at risk for overweight youth. J Pediatr Psychol, 2007;32(1);80- 9.
29. Soto L, Armendariz-Anguiano AL, Bacardi-Gascon M, et al. Beliefs, attitudes and phobias among Mexican medical and psychology students towards people with obesity. Nutr Hosp 2014; 30(1);37-41.
30. Sarıkaya R, Öztürk H, Afyaon YA, et al. Examining university students' attitudes towards fat phobia. Turkish Journal of Sport and Exercise, 2013;15(2):70-4.
31. Hekimoğlu L, Tekiner AS, Peker GS. Kamuya ait bir eğitim ve araştırma hastanesinde ayaktan ve yatan hasta memnuniyeti. Konuralp Tıp Dergisi 2015;7(1):1-5.