

Individuals' Active Actions in Reconstructing Psychosocial Balance Following Bariatric Surgery: A Qualitative Study

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ABSTRACT

Bariatric surgery, in addition to its physical consequences, is accompanied by extensive psychological and social changes in individuals' lives. Following surgery, many individuals encounter new challenges related to their bodies, eating behaviors, emotions, and social relationships. The present study aimed to explain individuals' active actions in reconstructing psychosocial balance following bariatric surgery. This qualitative study was conducted using grounded theory based on the systematic approach proposed by Strauss and Corbin (2015). The participants consisted of 40 individuals who had undergone bariatric surgery, including sleeve gastrectomy or gastric bypass, at least six months before participation. Sampling was initially purposive and subsequently theoretical and continued until theoretical saturation was achieved. Data were collected through semi-structured interviews and observations and were analyzed concurrently with data collection. The data analysis revealed that life following bariatric surgery involves a complex and fluctuating process of reconstructing psychosocial balance. The study's core category was identified as "active actions for reconstructing psychosocial balance." This category comprised nine subcategories: adaptation to the new body, management of unhealthy eating behaviors and development of positive alternative behaviors, body image management, emotion regulation, management of social interactions, self-advocacy, weight and body monitoring, development of substitute addictive behaviors, and meaning-making of the experience. These actions indicate that individuals actively attempt to adapt to their new bodies, regulate their emotions, manage their social relationships, and redefine their lived experiences following surgery. The findings demonstrated that reconstructing psychosocial balance after bariatric surgery is an active, dynamic, and multidimensional process shaped through a combination of individual and social actions. Attention to these active actions may play an important role in designing psychological interventions and supportive programs intended to improve individuals' adjustment following bariatric surgery.

Key words: bariatric surgery, psychosocial balance, grounded theory, lived experience, postoperative adjustment

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Introduction

Obesity is a chronic, multifactorial, and relapsing condition resulting from complex interactions among biological predispositions, behavioral patterns, psychological processes, socioeconomic circumstances, environmental exposures, and cultural influences. Its significance extends far beyond increased body weight because it is associated with substantial metabolic, cardiovascular, musculoskeletal, reproductive, and psychosocial consequences. The global expansion of obesity has transformed it into one of the most pressing public health challenges of contemporary societies, imposing considerable burdens on individuals, families,

healthcare systems, and national economies. Epidemiological evidence indicates that the prevalence of obesity has increased across diverse age groups and geographical regions, while changes in food environments, urbanization, sedentary lifestyles, socioeconomic inequalities, and genetic susceptibility have contributed to the persistence of this trend (1). Accordingly, international health policies increasingly emphasize a life-course approach to obesity prevention and management, integrating population-level interventions with accessible, multidisciplinary treatment for individuals already living with obesity (2).

Although obesity is conventionally identified through anthropometric indices such as body mass index, its clinical and psychosocial manifestations are heterogeneous. Individuals with similar levels of body mass may differ substantially in metabolic status, functional capacity, psychological health, social participation, and quality of life. The concept of metabolically healthy obesity illustrates this heterogeneity by demonstrating that some individuals with obesity may temporarily lack major metabolic abnormalities, although they may remain vulnerable to future health complications and psychosocial impairment (3). Therefore, obesity should not be understood solely as an excess accumulation of adipose tissue. It is also a lived condition that may shape self-perception, emotional experiences, interpersonal relationships, social identity, and engagement with everyday environments. Weight-related stigma, repeated unsuccessful attempts at weight loss, restrictive dieting, body dissatisfaction, and negative social evaluations may progressively influence individuals' psychological well-being and their sense of agency.

The relationship between obesity and psychological distress is reciprocal and multidimensional. Obesity may increase vulnerability to depressive symptoms through biological mechanisms, functional limitations, social discrimination, and dissatisfaction with body image, whereas depression may contribute to weight gain through changes in appetite, sleep, motivation, physical activity, and self-care. Longitudinal evidence has confirmed a bidirectional association between obesity and depression, suggesting that each condition may increase the risk of developing the other over time (4). In addition, individuals seeking bariatric surgery may exhibit anxiety, depressive symptoms, emotional eating, impaired self-esteem, interpersonal difficulties, and unrealistic expectations regarding the psychological effects of weight loss. Research on the psychological profiles of bariatric surgery candidates has shown that individuals referred for surgery may present with clinically relevant emotional and behavioral vulnerabilities that require assessment before and after the procedure (5). These findings reinforce the importance of conceptualizing bariatric treatment as a process requiring psychological preparation, postoperative follow-up, and sustained behavioral support rather than as an exclusively surgical intervention.

For individuals with severe obesity who have not achieved sufficient or durable weight reduction through nonsurgical treatments, metabolic and bariatric surgery is considered one of the most effective interventions for substantial and sustained weight loss. Procedures such as sleeve gastrectomy and gastric bypass alter gastrointestinal anatomy and physiology, influence appetite-regulating mechanisms, restrict food intake, and produce major changes in weight and obesity-related medical conditions. A landmark systematic review and meta-analysis demonstrated that bariatric surgery is associated with considerable weight loss and improvement or resolution of several obesity-related comorbidities, including type 2 diabetes, hypertension, dyslipidemia, and obstructive sleep apnea (6). These outcomes have contributed to the increasing use of bariatric surgery and to its recognition as a major component of comprehensive obesity treatment.

Nevertheless, the success of bariatric surgery cannot be evaluated exclusively through kilograms lost, body mass index reduction, or remission of metabolic disorders. The procedure initiates an extensive transformation that may affect eating behavior, body experience, emotional regulation, family roles, intimate relationships, occupational functioning, social visibility, and personal identity. Psychological outcomes may improve for many patients following surgery, particularly through enhanced mobility, improved health, reduced weight-related limitations, and greater confidence. However, such improvements are not universal, uniform, or necessarily permanent. A randomized clinical trial involving patients with obesity and type 2 diabetes found that bariatric surgery may be associated with changes in psychological health, yet psychological adjustment remains influenced by individual differences and broader postoperative experiences (7). Therefore, the period following surgery should be viewed as a psychologically consequential transition during which individuals must actively reorganize multiple aspects of their lives.

Postoperative psychological adjustment is particularly complex because surgery modifies the body more rapidly than individuals may be able to reconstruct their self-concepts, habits, and social relationships. The person may experience dramatic weight loss while continuing to perceive the self through the lens of the previous body. Positive reactions from others may increase self-confidence but may also create discomfort, mistrust, or uncertainty regarding whether social acceptance is directed toward the person or the transformed appearance. At the same time, individuals may encounter new concerns related to loose skin, scarring, hair loss, changes in facial appearance, altered sexuality, or dissatisfaction with specific body areas. Psychological issues associated with bariatric surgery consequently include body image disturbance, expectations of transformation, disordered eating, mood symptoms, adherence difficulties, and challenges in maintaining behavioral change (8). These issues indicate that postoperative adaptation involves far more than becoming accustomed to a smaller stomach or a reduced number on the scale.

Body-related changes following substantial weight loss may generate contradictory emotional experiences. Individuals may simultaneously feel pride in their achievements and distress regarding excess skin or altered body proportions. Some may pursue reconstructive procedures to bring their external appearance into closer alignment with their desired body image. Evidence suggests that post-bariatric abdominoplasty may be associated with improvements in psychological well-being among formerly obese patients, indicating that the management of excess skin and body dissatisfaction may represent an important component of postoperative adjustment (9). However, reconstructive surgery is not accessible, desirable, or sufficient for every individual. Consequently, many patients must develop psychological and behavioral strategies to accept, conceal, modify, monitor, or reinterpret their changed bodies.

Eating behavior represents another central domain of adjustment. Bariatric surgery imposes physiological limitations on food quantity and may produce discomfort, nausea, vomiting, or other adverse reactions when eating recommendations are not followed. Patients must learn to consume smaller portions, eat more slowly, prioritize nutritional quality, use supplements, and respond appropriately to new hunger and satiety signals. Yet the cognitive and emotional meanings previously attached to food may not disappear after surgery. Food may have functioned as a source of comfort, reward, emotional avoidance, social connection, or regulation of distress. When the physiological capacity for eating is sharply reduced, individuals may need to identify alternative strategies for managing emotions and daily pressures. Qualitative research with women following bariatric surgery has raised the critical question of what replaces obesity and obesity-related behaviors when

the body changes but underlying psychological needs remain present (10). This issue is especially important because some individuals may replace compulsive eating with alcohol use, smoking, excessive work, compulsive shopping, or other potentially maladaptive behaviors.

The success of bariatric surgery is also related to emotional health. Anxiety and depression may influence treatment adherence, eating behavior, perceived outcomes, and satisfaction with the procedure. Research examining sleeve gastrectomy has indicated that anxiety and depressive symptoms are relevant to the evaluation of surgical success, suggesting that postoperative outcomes should be assessed through both physical and psychological indicators (11). Individuals who expect surgery to automatically resolve longstanding emotional difficulties may experience disappointment when distress persists despite weight loss. Conversely, patients who develop realistic expectations, effective coping strategies, and flexible self-regulation may be better positioned to manage postoperative challenges. Psychological adaptation therefore involves repeated efforts to regulate anxiety, tolerate frustration, respond to food-related urges, manage fear of weight regain, and maintain engagement with health-related behaviors.

Resilience may function as an important psychological resource in this process. Bariatric patients differ in their capacities to recover from setbacks, adapt to rapid changes, tolerate uncertainty, and sustain behavioral commitments. Higher resilience has been associated with better psychological health among individuals undergoing bariatric surgery, highlighting the importance of personal strengths in postoperative adaptation (12). Nevertheless, resilience should not be interpreted as a fixed personality trait or as an individual responsibility detached from social circumstances. It may be strengthened or weakened by family support, healthcare relationships, financial resources, social acceptance, prior experiences, and access to psychological services. Thus, postoperative adjustment emerges through an interaction between individual actions and the relational and structural contexts in which those actions occur.

Interpersonal relationships are among the most consequential contexts of postoperative change. Weight loss may alter family routines, shared eating practices, marital dynamics, sexual relationships, friendships, and patterns of social participation. Increased self-confidence and autonomy may strengthen some relationships while creating tension in others. Family members or partners may feel threatened by changes in appearance, independence, or social attention. Patients may also encounter intrusive questions, criticism, envy, assumptions that surgery was an “easy solution,” or pressure to justify their decision. A qualitative study of patients’ interpersonal experiences following bariatric surgery showed that surgery may transform social relationships in ways that include both support and conflict (13). Consequently, individuals may engage in selective disclosure, boundary setting, distancing from unsupportive relationships, and active pursuit of alternative sources of support.

A recent narrative review has further emphasized that metabolic and bariatric surgery has broad implications for psychosocial and relational health, including changes in mood, self-esteem, body image, sexuality, social functioning, and intimate relationships (14). These outcomes are not independent domains but interconnected dimensions of the individual’s post-surgical life. For example, dissatisfaction with loose skin may influence sexual intimacy; fear of judgment may affect social participation; emotional distress may trigger maladaptive eating or substitute behaviors; and inadequate family support may weaken adherence to postoperative recommendations. Therefore, psychosocial balance following bariatric surgery should be

understood as a dynamic condition that individuals continually reconstruct rather than as a stable outcome automatically produced by weight loss.

The concept of cognitive adaptation offers a useful framework for understanding how individuals respond to major and potentially threatening life events. According to this perspective, adjustment involves efforts to establish meaning, regain a sense of mastery, and restore self-esteem through cognitive and behavioral processes (15). Bariatric surgery may be experienced as both an opportunity and a threat: it offers the possibility of improved health and social functioning while simultaneously disrupting familiar bodily sensations, eating practices, identities, and relationships. Patients may therefore attempt to interpret their suffering, justify the costs of treatment, redefine personal goals, monitor progress, and construct narratives that make the postoperative experience meaningful. Such meaning-making can contribute to renewed agency, although it may also be accompanied by fear of failure, self-criticism, or concern about renewed social judgment.

Qualitative evidence suggests that the meanings attributed to postoperative changes develop over time and are shaped by interactions among bodily transformation, social responses, emotional experiences, and personal interpretations. Grounded theory research has shown that people assign diverse meanings to the changes occurring after bariatric surgery and that these meanings influence how they understand and manage their new lives (16). This perspective moves beyond a simple distinction between successful and unsuccessful outcomes. An individual may achieve substantial weight loss while experiencing body dissatisfaction, relational conflict, or addictive substitution, whereas another individual may experience slower physical change but develop greater self-acceptance and emotional stability. Understanding postoperative adaptation therefore requires attention to the actions through which individuals respond to challenges, preserve gains, manage risks, and reconstruct everyday life.

Despite the growing literature on psychological outcomes after bariatric surgery, several gaps remain. Quantitative studies have provided valuable evidence regarding depression, anxiety, resilience, body image, quality of life, and weight-related outcomes, but they may not fully capture how these dimensions interact within everyday experience. Moreover, much of the literature focuses on whether psychological symptoms improve or deteriorate rather than on what individuals actively do to manage the transformation. The active role of patients may include adapting meals to reduced capacity, controlling food-related preoccupation, developing alternative activities, regulating emotions, managing disclosure, defending personal decisions, monitoring weight, coping with substitute addictive tendencies, and attributing meaning to suffering and change. These actions may be adaptive, maladaptive, or ambivalent, and their significance can only be understood in relation to the contexts in which they occur.

A process-oriented qualitative approach is particularly appropriate for investigating these active actions because psychosocial reconstruction unfolds through time, interaction, interpretation, and behavioral experimentation. Grounded theory enables researchers to move beyond thematic description by identifying categories and explaining relationships among conditions, actions or interactions, and consequences. The systematic procedures of constant comparison, theoretical sampling, coding, memo writing, and conceptual integration support the development of an explanatory account grounded in participants' experiences (17). Applying this approach to life after bariatric surgery may clarify how individuals actively respond to bodily

restrictions, psychological pressures, relational changes, and threats to identity, as well as how these actions contribute to the reconstruction or disruption of psychosocial balance.

Accordingly, the aim of the present study was to explain individuals' active actions in reconstructing psychosocial balance following bariatric surgery.

Methods and Materials

The present study aimed to explain individuals' active actions in reconstructing psychosocial balance following bariatric surgery and was conducted using a qualitative approach and grounded theory methodology. Because psychosocial adjustment following bariatric surgery is a process-oriented, multidimensional phenomenon influenced by individual and social contexts, a qualitative method facilitated an in-depth understanding of participants' lived experiences, subjective meanings, and agentic strategies. The systematic grounded theory approach developed by Strauss and Corbin (2015) was employed because the purpose of the study was not merely to describe individuals' experiences but also to identify concepts, categories, and relationships among them in order to explain the process through which psychosocial balance is reconstructed following bariatric surgery.

The participants were individuals who had undergone bariatric surgery, including sleeve gastrectomy or gastric bypass, at least six months before participating in the study. This time interval was selected because postoperative adjustment is a gradual process, and the passage of time enables individuals to experience, reflect upon, and achieve a degree of stability in relation to physical, psychological, and social changes. The inclusion criteria were being older than 18 years, having a history of bariatric surgery, having undergone surgery at least six months previously, and providing informed consent to participate. The exclusion criteria included the presence of acute physical or psychological problems that prevented participation in the interview, withdrawal from further participation, and failure to complete the interview.

Sampling was conducted in two stages. In the first stage, purposive sampling was used to select participants who had direct experience relevant to the phenomenon under investigation. Subsequently, theoretical sampling was employed concurrently with data analysis. This meant that the selection of subsequent participants was guided by the emerging concepts and categories so that different dimensions of the phenomenon could be clarified and the categories could be further developed. The sampling process continued until theoretical saturation was reached. A total of 40 individuals participated in the study, including 29 women and 11 men. The participants ranged in age from 21 to 55 years, and their mean age was approximately 35 years.

Data were collected through semi-structured interviews and researcher observations. The interviews were conducted individually and primarily face to face. When an in-person interview was not feasible, the interview was conducted by telephone. Interview locations were selected according to participants' circumstances and included healthcare centers, physicians' offices, or another location preferred by the participant. Each interview lasted between 45 and 90 minutes. The interview guide included open-ended questions concerning participants' experiences of life before surgery, postoperative changes, body image, social relationships, received support, and adjustment strategies. As the data analysis progressed, the questions were revised and made more focused in accordance with the emerging concepts. With participants' consent, all interviews were audio-recorded and subsequently transcribed verbatim. In addition to the

interviews, the researcher recorded observations concerning participants' tone of voice, pauses, facial expressions, emotional reactions, and nonverbal cues in the form of field notes.

Data analysis was conducted concurrently with data collection and followed the stages proposed by Strauss and Corbin (2015). Initially, the interview transcripts were read line by line, and preliminary concepts were extracted. Similar concepts were then compared and organized into subcategories and main categories. Subsequently, the relationships among the categories were examined in terms of conditions, actions/interactions, and consequences. Finally, the categories were integrated into a coherent conceptual explanation of the process of reconstructing psychosocial balance following bariatric surgery. Throughout the analytical process, constant comparison, analytical questioning, memo writing, repeated return to the data, and the mapping of conceptual relationships were used to enhance theoretical sensitivity and analytical coherence.

To comply with ethical principles, the purpose of the study was explained to the participants before the interviews, and informed consent was obtained for both participation in the study and audio-recording of the interviews. Confidentiality of information, the use of identification codes instead of participants' real names, and the right to withdraw from the study at any stage were guaranteed.

To enhance the credibility and dependability of the findings, strategies such as prolonged engagement with the data, repeated review of the interviews, constant comparison of the data, documentation of analytical memos, and member checking of selected interpretations with several participants were employed. In addition, the coding process and development of the categories were reviewed and revised in consultation with the supervisors and academic advisors to strengthen the conceptual coherence and analytical accuracy of the findings.

Findings and Results

The analysis of the interview data demonstrated that the experience of living following bariatric surgery was not limited to weight loss or physical changes. Rather, it involved a complex, fluctuating, and multilayered process of reconstructing psychosocial balance. Following surgery, participants were required to readjust to their new bodies, eating patterns, emotions, social relationships, and the meaning of their lived experiences. The most prominent aspect of this process was individuals' active and intentional actions to adapt and restore balance. These actions were continuously developed in response to the physical, psychological, and social changes associated with surgery. Based on the data analysis, the core category of this section was identified as "active actions for reconstructing psychosocial balance," which consisted of nine subcategories.

Table 1. Core Category of Active Actions for Reconstructing Psychosocial Balance

Core Category	Subcategories	Concepts
Active actions for reconstructing psychosocial balance	Adaptation to the new body	Adapting to smaller food portions; adjusting meals to the body's new capacity; changing previous unhealthy eating patterns; relative adherence to postoperative treatment instructions, including taking supplements and protein powder
Active actions for reconstructing psychosocial balance	Management of unhealthy eating behaviors and development of positive alternative behaviors	Relative control of mental cravings and persistent preoccupation with food; adopting new and creative strategies for eating; eliminating tobacco and alcohol use; developing new behaviors such as exercising, reading books, and watching films
Active actions for reconstructing psychosocial balance	Body image management	Accepting loose skin; becoming less sensitive to others' attention; receiving dermal fillers and botulinum toxin injections; undergoing abdominal and breast surgery; undergoing hair transplantation

Active actions for reconstructing psychosocial balance	Emotion regulation	Controlling anger; managing anxiety; identifying emotional triggers
Active actions for reconstructing psychosocial balance	Management of social interactions	Selective disclosure; limiting disclosure of the surgical experience to selected individuals
Active actions for reconstructing psychosocial balance	Self-advocacy	Disregarding others' judgments about the surgery; establishing boundaries in response to negative comments from others; resisting additional surgical procedures; identifying alternative sources of support when support from one's spouse or family is unavailable
Active actions for reconstructing psychosocial balance	Weight and body monitoring	Self-monitoring; monitoring changes in weight and the body
Active actions for reconstructing psychosocial balance	Development of substitute addictive behaviors	Excessive alcohol consumption as a substitute for eating; increased cigarette smoking; addiction to work or household cleaning
Active actions for reconstructing psychosocial balance	Meaning-making of the experience	Accepting suffering; engaging in positive self-talk; changing beliefs and patterns of thinking; developing new motivations; fear of failure and being judged again; continuously reminding oneself of the psychological and financial costs incurred; attributing meaning to pain and difficulties

1. Adaptation to the New Body

One of the participants' earliest active actions involved attempting to adapt to their new bodies following surgery. This adjustment was not limited to accepting the reduced capacity of the stomach. It also included adapting to smaller food portions, organizing meals in accordance with the body's new capacity, changing previous eating patterns, and showing relative adherence to treatment recommendations such as taking supplements and protein powder. In practice, participants attempted to understand their transformed bodies and align their daily behaviors with their bodies' new limitations and needs. This process represented an essential component of reconstructing their psychosocial balance.

2. Management of Unhealthy Eating Behaviors and Development of Positive Alternative Behaviors

The findings indicated that participants consciously attempted to control harmful eating behaviors and replace them with more positive behaviors in order to prevent a return to their previous unhealthy patterns. This transformation was not merely a dietary modification; rather, it represented a redefinition of the individual's relationship with food. Participants attempted to control emotional eating, overeating, and previous unhealthy eating habits and to establish more regular and mindful eating patterns in their daily lives.

3. Body Image Management

Following surgery, individuals' bodies underwent noticeable changes, which affected how they perceived and experienced themselves. Consequently, body image management emerged as an important active action. Participants attempted to redefine their relationships with their changed bodies, develop greater satisfaction with their appearance, and cope with their previous body-related sensitivities. In many cases, this process was accompanied by fluctuations because the new body could simultaneously represent a source of hope, pride, concern, and instability.

4. Emotion Regulation

Part of the reconstruction of psychosocial balance was related to individuals' ability to regulate their emotions. Participants employed strategies to manage their emotional states when confronting anxiety, disappointment, food-related temptations, or concerns about the future. Emotion regulation helped them

avoid returning to previous maladaptive patterns when facing postoperative difficulties and enabled them to achieve greater psychological stability.

5. Management of Social Interactions

Following surgery, social relationships and other people's reactions constituted an important component of individuals' lived experiences. Participants were therefore required to manage their social interactions by adjusting their behavior and social presence in response to the attention, judgments, or expectations of others. Some participants attempted to distance themselves from stressful situations, some redefined particular social interactions, and others strengthened their social adjustment by maintaining supportive relationships. This action represented an aspect of reconstructing the individual's position within their network of social relationships.

6. Self-Advocacy

The findings indicated that participants sometimes engaged in self-advocacy in response to external pressures, social judgments, and misconceptions regarding their bodies or surgical procedures. Such advocacy could take the form of establishing boundaries with others, resisting unwanted interference, or emphasizing their right to make decisions concerning their bodies and lives. In this context, self-advocacy was not merely a passive response but constituted part of the reconstruction of personal agency and dignity.

7. Weight and Body Monitoring

Continuous monitoring of weight and physical condition was one of the most frequently reported behaviors among participants. To ensure the success of the surgery, prevent weight regain, and evaluate the progression of changes, participants regularly monitored their weight and bodily indicators. In addition to its regulatory function, this continuous monitoring also served a psychological function because it allowed individuals to observe their progress and develop a greater sense of control over the adjustment process.

8. Development of Substitute Addictive Behaviors

During the process of reconstructing their lives following surgery, some participants encountered the risk of replacing one addictive behavior with another. This finding demonstrates that the adjustment process is not always smooth or linear and that individuals may transition from one unhealthy pattern to another. Recognizing this phenomenon as part of participants' lived experiences was therefore important because it indicated that reconstructing psychosocial balance requires continuous care and attention to the deeper dimensions of behavior.

9. Meaning-Making of the Experience

The final subcategory was meaning-making of the experience. To understand what they had undergone, participants attempted to place the surgical experience and its consequences within a comprehensible and meaningful framework. This process of meaning-making helped them organize the suffering, limitations, and achievements associated with surgery within their lives and identify a new direction for continuing their lives. Meaning-making was therefore a process of reinterpreting the experience that contributed to the relative stabilization of psychosocial balance.

Overall, the findings demonstrated that individuals following bariatric surgery are not merely passive recipients of treatment-related changes. Rather, they participate in an active and continuous process of reconstructing their psychosocial balance. This reconstruction occurs through adaptation to the new body, modification of eating behaviors, body image management, emotion regulation, management of social

relationships, self-advocacy, monitoring of weight and the body, avoidance of replacing one addictive behavior with another, and meaning-making of the lived experience. Participants' active actions were therefore not merely reactions to the consequences of surgery but also represented part of their efforts to reconstruct their identity, agency, and the everyday organization of life following bariatric surgery.

Discussion and Conclusion

The present study aimed to explain individuals' active actions in reconstructing psychosocial balance following bariatric surgery. The findings showed that adaptation after bariatric surgery was not a passive consequence of weight loss or anatomical change but an active, dynamic, and multidimensional process involving continuous behavioral, emotional, cognitive, bodily, and interpersonal efforts. The core category, "active actions for reconstructing psychosocial balance," comprised nine interrelated subcategories: adaptation to the new body, management of unhealthy eating behaviors and development of positive alternative behaviors, body image management, emotion regulation, management of social interactions, self-advocacy, weight and body monitoring, development of substitute addictive behaviors, and meaning-making of the experience. Together, these findings indicate that individuals actively participate in reorganizing their daily lives, identities, relationships, and psychological responses following surgery. This interpretation is consistent with the view that bariatric surgery produces broad psychosocial and relational consequences extending beyond weight reduction and metabolic improvement (8, 14).

The first subcategory, adaptation to the new body, reflected participants' efforts to adjust to reduced food capacity, reorganize meal patterns, change previous dietary habits, and follow postoperative recommendations regarding supplements and protein intake. This finding demonstrates that the body after surgery is not immediately experienced as familiar or fully manageable. Rather, individuals must gradually learn the limits, signals, and nutritional needs of the transformed body. Bariatric surgery produces substantial anatomical and physiological modifications, and although it is effective in reducing weight and obesity-related medical complications, its outcomes depend partly on sustained postoperative behavioral adaptation (6). The participants' active efforts to coordinate everyday eating with their new bodily capacities suggest that physical recovery and psychosocial adjustment are closely interconnected. The body becomes a new environment that must be interpreted, monitored, and incorporated into daily routines.

This finding may also be understood in relation to the heterogeneity of obesity and its outcomes. Obesity is not merely a uniform metabolic condition, and individuals differ considerably in their clinical profiles, behavioral histories, and psychological responses (3). Consequently, adjustment to the postoperative body may differ according to previous eating habits, expectations, medical conditions, and available support. Participants' relative adherence to treatment recommendations also indicates that adaptation is not necessarily complete or consistent. Individuals may alternate between compliance and resistance, mastery and confusion, or confidence and uncertainty. This fluctuating pattern supports the present study's broader conclusion that reconstructing psychosocial balance is a nonlinear process rather than a single postoperative achievement.

The second subcategory involved the management of unhealthy eating behaviors and the development of positive alternatives. Participants attempted to reduce food-related preoccupation, control cravings, modify the manner in which they ate, discontinue tobacco or alcohol use in some cases, and introduce alternative

activities such as exercise, reading, or watching films. These findings suggest that bariatric surgery changes the physical possibility of eating but does not automatically eliminate the psychological functions previously served by food. Emotional eating, reward-seeking, boredom reduction, and avoidance of distress may persist even when food intake is physically restricted. Earlier qualitative research similarly questioned what might replace obesity-related patterns after surgery and showed that psychological needs may continue even after substantial physical transformation (10). Thus, the development of positive alternative behaviors may represent an attempt to replace food-based coping with more adaptive forms of self-regulation.

The importance of such behavioral reconstruction is further supported by evidence showing that psychological difficulties are common among individuals seeking bariatric surgery. Anxiety, depressive symptoms, low self-esteem, and maladaptive eating patterns may exist before surgery and influence postoperative adjustment (5). The participants' attempts to redirect attention toward exercise, reading, and other activities may therefore be interpreted as efforts to establish new sources of pleasure, mastery, and emotional relief. These actions also demonstrate personal agency. Rather than relying exclusively on the restrictive effects of surgery, participants attempted to construct everyday behavioral structures that could support long-term adaptation.

Body image management emerged as another major component of reconstructing psychosocial balance. Participants reported accepting loose skin, reducing their sensitivity to others' attention, and using cosmetic or reconstructive procedures such as botulinum toxin injections, dermal fillers, abdominal or breast surgery, and hair transplantation. These findings illustrate the ambivalent nature of postoperative bodily transformation. Weight loss may improve mobility, health, and satisfaction with appearance, while simultaneously creating new sources of dissatisfaction such as excess skin, altered facial features, or hair loss. Body image therefore does not necessarily improve in direct proportion to weight loss. Instead, it must be renegotiated through psychological acceptance, social comparison, concealment, cosmetic intervention, or reconstructive surgery.

The finding is consistent with evidence indicating that post-bariatric body-contouring procedures may improve psychological well-being among formerly obese individuals (9). Nevertheless, the present findings show that body image management extends beyond additional surgery. Participants also attempted to become less vulnerable to the gaze and judgment of others. This suggests that body image is both an internal psychological representation and a socially mediated experience. Individuals must reconcile how they see themselves with how they believe others perceive them. This interpretation is compatible with previous discussions of body dissatisfaction, identity change, and psychosocial expectations after bariatric surgery (8).

Emotion regulation was also central to participants' adaptation. They described controlling anger, managing anxiety, and identifying emotional triggers. These actions indicate that postoperative adjustment requires emotional awareness and the capacity to respond to distress without returning to previous maladaptive eating patterns. Anxiety about complications, fear of weight regain, disappointment regarding the pace or extent of change, and uncertainty about social reactions may all challenge psychological stability. Previous research has shown that anxiety and depression are relevant to evaluations of surgical success and may affect adherence, satisfaction, and perceived outcomes (11). Likewise, although bariatric surgery can

contribute to improved psychological health, the benefits are not uniform and may depend on individual and contextual factors (7).

The participants' emotion-regulation efforts may also reflect resilience as an active capacity rather than a fixed trait. Resilience among bariatric surgery patients has been associated with better psychological health and more adaptive responses to stress (12). In the present study, controlling anger, recognizing emotional triggers, and managing anxiety represented practical manifestations of this capacity. However, these findings also indicate that resilience is built through repeated actions. Participants actively experimented with ways to tolerate discomfort, prevent emotional escalation, and preserve their postoperative progress.

Management of social interactions constituted another prominent subcategory. Participants selectively disclosed their surgical experiences and limited disclosure to trusted individuals. This finding indicates that the social environment may be both supportive and threatening. Individuals may receive encouragement and practical assistance, but they may also encounter stigma, intrusive questioning, envy, criticism, or assumptions that surgery is an effortless method of weight loss. Selective disclosure can therefore function as a protective strategy through which individuals control access to personal information and reduce exposure to judgment. Previous qualitative findings have shown that bariatric surgery may substantially change interpersonal relationships, producing both increased support and relational strain (13). The broader literature similarly identifies changes in intimacy, family roles, social participation, and relational health as important postoperative outcomes (14).

Closely connected to this finding was self-advocacy. Participants attempted to disregard negative judgments, establish boundaries in response to critical comments, resist pressure to undergo additional procedures, and seek alternative support when spouses or family members were unsupportive. These actions demonstrate that postoperative adjustment involves reconstructing personal agency. Individuals were not only adapting to bodily change but also renegotiating their right to make decisions about their bodies and lives. This finding is particularly important because obesity is often accompanied by social stigma and reduced autonomy in healthcare and interpersonal contexts. After surgery, participants' self-advocacy may represent an effort to reclaim dignity and control.

The importance of agency can be understood through cognitive adaptation theory, which proposes that adjustment to threatening or disruptive events involves restoring meaning, mastery, and self-esteem (15). The participants' boundary setting and resistance to external pressure can be interpreted as efforts to regain mastery over an experience that had transformed their bodies and social identities. Rather than allowing others' judgments to define the meaning of surgery, they attempted to construct their own evaluations and decisions. This process may support psychological stabilization by reinforcing autonomy and personal legitimacy.

Weight and body monitoring was another frequently reported action. Participants regularly tracked weight changes and bodily indicators in order to evaluate progress, prevent weight regain, and maintain control. Such monitoring may be adaptive when it supports adherence, early identification of problems, and realistic evaluation of change. It may also provide psychological reassurance by making progress visible. However, excessive monitoring may become anxiety-driven and contribute to preoccupation with weight or fear of failure. The dual nature of this behavior reflects the broader complexity of postoperative adaptation. Monitoring may simultaneously strengthen control and increase vulnerability to distress.

This finding should be considered within the broader context of obesity as a chronic and relapsing condition requiring long-term management (1). International recommendations similarly emphasize continued monitoring, multidisciplinary care, and long-term support across the life course (2). Therefore, participants' self-monitoring represents both an individual strategy and a response to the chronic nature of obesity. Nevertheless, the psychological meaning of monitoring should be assessed carefully because the same behavior may reflect adaptive self-care in one individual and compulsive fear in another.

One of the most clinically significant findings was the development of substitute addictive behaviors. Some participants reported excessive alcohol consumption, increased cigarette smoking, work addiction, or compulsive household cleaning as alternatives to eating. This finding confirms that restricting food intake does not necessarily resolve the emotional, compulsive, or reward-related processes underlying previous behavior. When eating is no longer available as the primary coping strategy, other behaviors may assume similar psychological functions. Earlier qualitative research has similarly indicated that new forms of behavior may replace obesity-related coping after surgery (10). The emergence of substitute behaviors demonstrates that successful adaptation cannot be judged solely by weight outcomes.

This finding is also relevant to the established reciprocal relationship between obesity and psychological distress. Depression and obesity may reinforce one another through behavioral, biological, and social mechanisms (4). If emotional distress remains untreated after surgery, individuals may search for alternative methods of mood regulation or avoidance. Substitute addictive behaviors may therefore represent attempts to manage unresolved anxiety, depression, emptiness, or interpersonal conflict. This interpretation highlights the necessity of long-term psychological assessment rather than assuming that weight loss will eliminate underlying vulnerabilities.

The final subcategory, meaning-making of the experience, included acceptance of suffering, positive self-talk, changes in beliefs, development of new motivations, fear of failure or renewed judgment, reminders of the financial and psychological costs of surgery, and attributing meaning to pain and difficulty. This finding demonstrates that participants sought to integrate surgery into a coherent personal narrative. Meaning-making enabled them to interpret sacrifice, discomfort, and behavioral restriction as part of a larger process of transformation. According to cognitive adaptation theory, establishing meaning is a central mechanism through which individuals adjust to disruptive and threatening experiences (15). In the present study, meaning-making supported persistence by transforming hardship into evidence of commitment, survival, or personal growth.

This result is also consistent with grounded theory research showing that individuals attribute diverse meanings to postoperative changes and that these meanings shape their behavioral and emotional responses (16). Some meanings may be empowering, such as viewing surgery as a second opportunity for life, whereas others may increase pressure, such as interpreting any weight regain as failure. Thus, meaning-making is not inherently positive; its adaptive value depends on whether the resulting interpretation promotes flexibility, self-compassion, and realistic engagement or intensifies fear and self-criticism.

Overall, the findings indicate that reconstructing psychosocial balance after bariatric surgery involves continuous movement among adaptation, control, resistance, vulnerability, and reinterpretation. Individuals actively restructure eating practices, regulate emotions, manage bodies and relationships, defend autonomy, monitor progress, confront substitute behaviors, and create meaning. This

multidimensional process supports the use of grounded theory because it captures relationships among conditions, actions, interactions, and consequences rather than reducing postoperative life to isolated psychological variables (17). The findings also extend previous literature by showing that psychosocial adjustment is created through concrete actions in everyday life. While bariatric surgery may improve physical health and reduce obesity-related complications (6), long-term well-being depends on how individuals integrate these changes into their identities, behaviors, and social environments.

This study had several limitations. The findings were based on the experiences of 40 participants and were therefore shaped by their particular sociocultural, relational, and healthcare contexts. Although purposive and theoretical sampling supported conceptual variation, the findings are not intended for statistical generalization. Differences in surgical procedure, time elapsed since surgery, socioeconomic status, access to reconstructive surgery, and psychological treatment may also have influenced participants' experiences. In addition, some data were obtained through telephone interviews, which may have limited observation of nonverbal responses. The study relied primarily on participants' retrospective accounts and may therefore have been affected by memory limitations, selective disclosure, or social desirability. Finally, the perspectives of spouses, family members, surgeons, dietitians, and mental health professionals were not included.

Future studies should examine the process of psychosocial reconstruction longitudinally from the preoperative period through several years after surgery. Comparing individuals who undergo different surgical procedures may clarify whether bodily adjustment, eating behavior, and psychological challenges vary according to the type of operation. Further research should investigate substitute addictive behaviors in greater depth and distinguish occasional behavioral replacement from clinically significant addiction. Studies involving spouses, family members, and healthcare professionals could provide a more relational understanding of postoperative adaptation. Quantitative research may also develop and test measures based on the nine categories identified in this study. Comparative studies across cultural, socioeconomic, and healthcare contexts would help determine which aspects of psychosocial reconstruction are shared and which are context-specific.

Bariatric care should include structured psychological assessment and support before surgery and throughout long-term follow-up. Interventions should address emotional eating, body image, fear of weight regain, relationship changes, self-advocacy, and the risk of substitute addictive behaviors. Patients should receive practical training in recognizing emotional triggers, developing adaptive alternative behaviors, setting interpersonal boundaries, and monitoring weight without becoming excessively preoccupied. Family education may reduce criticism and improve supportive responses. Multidisciplinary teams should also distinguish physical success from psychosocial adjustment and avoid assuming that substantial weight loss necessarily indicates psychological well-being. Follow-up programs should provide accessible referral pathways for psychotherapy, addiction treatment, nutritional counseling, and reconstructive consultation when needed.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. This article was derived from the first author's doctoral dissertation at the Shiraz Branch, Islamic Azad University, Shiraz, Iran. The study received ethical approval from the Research Ethics Committee of the Shiraz Branch, Islamic Azad University, under the ethics code IR.IAU.SHIRAZ.REC.1404.254.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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