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“Why am I gaining this weight back?”: Relapse Experiences of Individuals Living with Obesity in Türkiye

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Research Article

Keywords: Obesity, relapse, qualitative research, biopsychosocial approach, social work

Posted Date: May 20th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9575303/v1

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Additional Declarations: No competing interests reported.

Abstract

Obesity relapse is often explained through behavioural and biomedical models, with limited attention to how it is experienced within broader social contexts. This qualitative study explores relapse experiences among individuals living with obesity in Türkiye from a biopsychosocial perspective. Semi-structured in-depth interviews were conducted with 13 adults who had previously lost and regained weight, and the data were analysed using reflexive thematic analysis. The findings show that relapse cannot be reduced to an individual failure of willpower, but should be understood as a dynamic and multi-layered process shaped by the interaction of biological predispositions, emotional regulation practices including emotional, binge-like, and night eating patterns, and adverse life events, together with social conditions such as family food practices, obesogenic environments, and weight stigma. Participants also linked relapse to broader contextual factors, including the COVID-19 pandemic. This study contributes to the literature by demonstrating that obesity relapse is not merely an individual behavioural outcome, but a socially shaped and contextually embedded experience. The findings highlight the need to move beyond individualised interventions towards more context-sensitive and non-stigmatising approaches in health and social work practice.

Introduction

Obesity is not only a medical condition but also a multidimensional phenomenon that poses a significant global public health challenge, with profound social and psychosocial implications. The World Health Organization (WHO) identifies obesity as one of the ten most critical diseases and recognises it as a global epidemic requiring urgent action (WHO, 2024). Defined as excessive fat accumulation to a degree that threatens health, obesity is commonly measured using the Body Mass Index (BMI) (Turkish Society of Endocrinology and Metabolism, 2019). Current data indicate that 2.5 billion adults worldwide are overweight and 890 million are obese, and projections suggest that if current trends persist, half of the world's population may be overweight or obese by 2035 (Ministry of Health of the Republic of Türkiye, 2024). In Türkiye, according to 2022 data from the Turkish Statistical Institute (TURKSTAT), the obesity rate among individuals aged 15 and older is 20.2% (TURKSTAT, 2023). Across Europe, rising obesity rates are closely linked to widening health inequalities, making obesity a key concern not only for public health but also for social work, particularly in relation to social exclusion, stigma, and unequal access to resources.

Obesity results from the interaction of numerous factors, including insufficient physical activity, unhealthy eating habits, genetic predisposition, stress, obesogenic environments, and sedentary lifestyles (Eliadis, 2006; Giammattei et al., 2003; Hojjat & Hojjat, 2021; Karaçil & Şanlıer, 2014). These multidimensional determinants play a critical role not only in the onset of obesity but also in the sustainability of treatment. Despite various approaches such as diet, exercise, behavioural modification, and surgical interventions, many individuals struggle to maintain weight loss and subsequently experience weight regain, commonly referred to as relapse. The literature suggests that individuals with obesity frequently regain weight within the first year following treatment and, within two to five years, often return to or exceed their initial BMI levels (Anderson et al., 2001; Weiss et al., 2007)

Research has shown that, similar to the causes of obesity itself, the causes of relapse cannot be adequately reduced solely to individual willpower but are shaped by the interaction of biological, psychological, and social factors. Biologically, a reduction in metabolic rate following weight loss, changes in appetite-regulating hormones, and heightened hunger facilitate weight regain (Bray et al., 2017; Martins et al., 2020). Psychologically, stress, emotional eating, unrealistic weight goals, depression, ineffective coping strategies, and low self-esteem increase the risk of relapse, particularly when individuals are navigating ongoing life pressures (Sainsbury et al., 2019; Yau & Potenza, 2013; Ohsiek & Williams, 2011). Socially, obesogenic environments, limited social support, and structural stressors further hinder sustained weight control (Karaçil & Şanlıer, 2014). These interrelated domains point to the limitations of individualised explanations of relapse and highlight the need for approaches that situate weight regain within broader social and structural contexts.

From a social work perspective, obesity is approached not merely as a biological health condition but as a societal issue shaped by environmental, economic, and cultural determinants. The biopsychosocial model emphasises that stress, emotional eating, food culture, economic pressures, and discrimination have significant effects on health behaviours (Bischoff et al., 2017; Bolton & Gillet, 2019). However, contemporary social work literature increasingly argues that the biopsychosocial model should be extended through critical perspectives that address structural inequalities, power relations, and weight stigma. This perspective highlights the limitations of interventions that focus exclusively on individual behaviour change and underscores the need to address broader social contexts and structural inequalities. In European social work debates, this shift is reflected in growing attention to the social determinants of health, anti-oppressive practice, and the critique of individualised health discourses.

Within this framework, social work contributes to the prevention of obesity relapse through early intervention, empowerment, and the strengthening of social support networks at the individual, family, and community levels (Shinan-Altman, 2017; Sorensen & Krings, 2023; Wood et al., 2020). Yet, despite these developments, qualitative research that explores how relapse is experienced and interpreted by individuals themselves—particularly in relation to structural and cultural contexts—remains limited. This gap is especially evident in the context of Türkiye.

Rather than focusing on the dominant question of "How do I lose this weight?", this study reframes the problem by asking, "Why am I gaining this weight back?". By foregrounding lived experience, the study moves beyond behavioural explanations and seeks to understand relapse as a socially and structurally embedded process. This perspective enables relapse to be understood as a dynamic process shaped by biological, psychological, and social conditions. In doing so, the study contributes to European social work debates by offering empirically grounded insights into how structural inequalities, stigma, and everyday practices shape relapse experiences.

Despite a growing body of research, obesity relapse continues to be predominantly explained through individual behavioural factors such as self-control, lifestyle choices, and adherence to treatment. However, this perspective offers limited insight into how relapse is experienced and interpreted by individuals within broader social and everyday contexts. In particular, framing relapse as an individual failure risks obscuring the role of social inequalities and weight stigma in shaping weight regain.

This study addresses this gap by exploring how individuals living with obesity experience and make sense of relapse within a biopsychosocial framework. By foregrounding individuals' lived experiences, the study conceptualises relapse not merely as an individual behavioural outcome, but as a socially shaped and contextually embedded process. It highlights how emotional regulation practices, social environments, and everyday constraints interact in shaping relapse over time, and points to the limitations of individualised approaches to obesity.

Accordingly, the study aims to explore the relapse processes of individuals living with obesity within a biopsychosocial framework and to develop practice-oriented recommendations for social work.

Materials and methods

Research Model

This study employed a qualitative research design, drawing on a narrative approach, to explore obesity relapse within a biopsychosocial framework. While the study was informed by a narrative sensibility, the primary analytical strategy was reflexive thematic analysis. The data reported in this article draw on the qualitative component of a broader mixed-methods doctoral study; however, the present analysis focuses exclusively on the qualitative data. A qualitative approach was particularly appropriate for capturing participants' subjective and lived experiences of weight loss and relapse, as well as the meanings they attributed to these processes within their social and cultural contexts.

This approach is consistent with a reflexive understanding of thematic analysis, which acknowledges the researcher's interpretive role and views meaning as co-constructed through engagement with the data.

Participants

The study sample consisted of 13 adults recruited through purposive sampling. Inclusion criteria were being 18 years of age or older, residing in Ankara, having a body mass index (BMI) ≥ 30 kg/m², having previously lost weight, and subsequently regaining weight. Participants ranged in age from 23 to 72 years (M = 42.5), and the majority were women (9 women, 4 men). Obesity classifications included Class I (38.5%), Class II (23.1%), and Class III (38.5%).

On average, participants had previously lost 16.38 ± 7.37 kg and had maintained this weight loss for approximately 16 months. Four participants regained all of the weight they had lost, while nine regained more than their initial weight loss. Detailed participant characteristics are presented in Table 1.

Table 1
Socio-demographic Characteristics of Participants

Alias	Gender	Age	Education Level	Marital Status	Number of Children	BMI	Highest Lifetime Weight (kg)	Maximum Weight Lost (kg)	Duration of Weight Maintenance	Weight Regain Status
Fırat	Male	39	Bachelor's	Married	1	38.2 (Class II)	128	28	8 months	More than the weight I lost
Dicle	Female	26	Postgraduate	Single	-	39.2 (Class II)	96	15	18 months	More than the weight I lost
Tuna	Female	40	Associate degree	Married	-	44.0 (Class III)	125	15	1 month	More than the weight I lost
Arda	Female	58	Postgraduate	Single	-	32.4 (Class I)	97	20	84 months	All of the weight I lost
Ren	Female	23	Bachelor's	Single	-	33.6 (Class I)	95	10	1months	All of the weight I lost
Nil	Female	37	Postgraduate	Single	-	36.5 (Class II)	89	13	6 months	More than the weight I lost
Gediz	Male	47	High school	Married	2	41.5 (Class III)	120	10	1 months	All of the weight I lost
Amazon	Male	47	High school	Married	2	34.4 (Class I)	105	10	12 months	More than the weight I lost
Nilüfer	Female	33	Secondary school	Married	2	32.2 (Class I)	95	8	3 months	All of the weight I lost
Asi	Female	43	Bachelor's	Married	2	31.2 (Class I)	85	20	3 months	More than the weight I lost
Meriç	Female	50	High school	Married	1	41.02 (Class III)	118	24	6 months	More than the weight I lost
Menderes	Male	72	Primary school	Married	4	42.2 (Class III)	136	30	48 months	More than the weight I lost

Alias	Gender	Age	Education Level	Marital Status	Number of Children	BMI	Highest Lifetime Weight (kg)	Maximum Weight Lost (kg)	Duration of Weight Maintenance	Weight Regain Status
Aras	Female	39	Primary school	Married	2	43.3 (Class III)	118	10	18 months	More than the weight I lost

The sample size was guided by the concept of information power, whereby the adequacy of the sample was determined based on the study aim, sample specificity, and the richness of the data, rather than relying on a predefined notion of saturation.

Data Collection Tools and Procedure

Data were collected through in-depth semi-structured interviews and field notes. Semi-structured interviews enabled an in-depth exploration of participants' experiences of obesity relapse and the biological, psychological, and social factors shaping these experiences. The interview guide included questions addressing key life events, weight loss and regain trajectories, emotional responses, and social and environmental influences.

Field notes were recorded during and after the interviews to document contextual observations, emotional expressions, and non-verbal cues, and were used as supplementary data during the analysis process.

Data collection took place between January and June 2024. A total of 13 interviews were conducted, including ten face-to-face and three online interviews. Interviews lasted an average of 64 minutes and were audio-recorded with participants' informed consent before being transcribed verbatim. To ensure confidentiality, only pseudonyms and gender (F, M) were used in the presentation of findings, and BMI values were reported only in aggregate form.

Data Analysis

Data were analysed using reflexive thematic analysis, following Braun and Clarke's six-phase approach (Braun& Clarke, 2019). While the study was informed by a narrative sensibility, particularly in attending to how participants constructed and made sense of their experiences over time, the primary analytic strategy was thematic rather than narrative analysis.

The analysis involved repeated reading of the transcripts to develop familiarity with the data, the generation of initial codes, and the development and refinement of themes through an iterative and interpretive process. In line with a reflexive approach, themes were not treated as pre-existing entities emerging directly from the data, but as analytic patterns developed through the researcher's active engagement with participants' accounts.

The analysis was primarily inductive, while interpretation was informed by a biopsychosocial framework to explore the interconnections between biological, psychological, and social dimensions of relapse. MAXQDA 2020 was used to support data organisation and management throughout the analytical process.

Reflexivity and Trustworthiness

Reflexivity was integrated throughout the research process. The researchers critically reflected on how their academic backgrounds, assumptions, and prior engagement with the topic of obesity might shape data interpretation. Reflexive notes were maintained to examine underlying assumptions and potential biases, thereby supporting an analytic process in which participants' experiences and perspectives remained central. Researcher reflexivity was considered an integral part of the analytical process. The researcher's assumptions and academic positioning in relation to obesity were critically reflected upon throughout the study, and reflexive notes were maintained to make visible how these perspectives may have shaped data interpretation.

Trustworthiness was enhanced through the triangulation of interview data and field notes, the use of rich and context-sensitive descriptions, and the transparent documentation of analytic decisions, in line with established qualitative research standards.

Ethical Considerations

Ethical approval

was obtained from a university-based Non-Interventional Clinical Research Ethics Committee (details blinded for peer review). Institutional permission was granted, and all participants provided written informed consent prior to participation. Confidentiality was ensured through the use of pseudonyms, and all data were stored securely and used solely for research purposes.

Results

The findings presented in this section aim to make visible how relapse is experienced and interpreted by participants. Participants' narratives indicate that relapse is lived not as an abrupt rupture or a singular moment of failure, but as an experience that accumulates and deepens over time. Participants described relapse not as a single moment of "losing control," but as a gradual and cumulative process shaped by the interaction of embodied predispositions, emotional regulation practices, and social environments. Throughout the interviews, participants frequently returned to the question of "why the weight comes back," articulating relapse through meanings such as inevitability, exhaustion, and disrupted coping.

Narratives aimed at making sense of this process demonstrate that participants approached weight regain not merely as an event they experienced, but as an ongoing experience that was repeatedly reflected upon and questioned. Participants reported encountering these questions at multiple points across their lives and offered extensive reflections on how they understood weight regain following initial weight loss. Over time, these repeated reflections evolved into a sustained process of self-evaluation. For example, Arda (F) described this process as a persistent form of self-questioning, often asking herself, "Why am I like this?". She further emphasised that weight gain should not be understood solely as an individual issue, stating, "This is not only the problem of Turkish women; it is a global issue."

Theme 1: Embodied predispositions and "destiny" narratives

Participants' narratives suggest that obesity relapse was not only explained through biological predispositions, but also constructed through meanings of inevitability and "destiny". Dicle (F) expressed this perception by stating, *"Everyone in the family is obese. My mother's side, my father's side… I don't know anyone who is not."* Similarly, Fırat (M) explained, *"Whatever the family's fate is, the child experiences the same."* These accounts illustrate that genetic transmission was not perceived merely as a physiological risk factor but as an unchangeable life condition. These accounts suggest that biological explanations not only describe the condition, but also shape how participants make sense of relapse. Such explanations often lead participants to perceive weight regain as inevitable, thereby weakening their sense of control over this process.

Being overweight since childhood was also frequently mentioned among the biological factors. Tuna (F) expressed this situation with the words: *"I was always bigger than my peers."* Nilüfer (F), referring to her youth, said: *"I was chubby. At the ages of 13, 14, even 15, suitors would constantly come to ask for us. We are already big and chubby by nature."* Such narratives indicate that obesity was internalised as part of personal identity from an early age, extending beyond bodily weight to influence how participants understood themselves and their life trajectories. In this sense, early weight experiences appeared to shape not only bodily trajectories but also enduring self-perceptions, contributing to a narrative continuity between past and present experiences of relapse.

Importantly, these biological explanations were closely intertwined with social meanings. Framing obesity relapse as "destiny" appeared to overshadow individual efforts and contributed to feelings of resignation. Framing obesity relapse as "destiny" appeared to overshadow individual efforts and functioned as a powerful narrative that shaped expectations about change. This narrative not only reduced motivation but also contributed to emotional distress, creating a context in which coping mechanisms such as emotional eating became more prominent. For many participants, this perception reduced motivation, intensified emotional distress, and created a context in which psychological coping strategies, such as emotional eating, became more prominent.

Theme 2: Emotion regulation, exhaustion, and the relapse cycle

Participants' narratives suggest that psychological processes played a central role in shaping relapse, particularly through patterns of emotional regulation and cumulative emotional exhaustion. Emotional eating emerged as the most frequently reported coping

strategy, particularly in response to stress, sadness, loneliness, and disappointment. Gediz (M) described this pattern by stating, "*It usually happens more when I am unhappy. When I am sad or preoccupied, I eat more. When I am unhappy, I say to myself that food will make me feel better psychologically"* Tuna (F) similarly noted, "*When I was sad, eating made me feel happy. I was taking my anger out on food."* These accounts demonstrate that eating functioned as a form of emotional regulation, yet one that provided only short-term relief.

Emotional eating was not limited to negative feelings; positive emotions were also reported to trigger eating behaviors. Ren (F) summarized this pattern by saying, *"Whether I am happy or sad, it doesn't matter, we eat"*. Asi (F) emphasized that eating was also associated with joy: *"I like eating when I am happy. But I eat with pleasure. I am more mindful of what I eat when I'm happy, not eating unconsciously."*. These findings suggest that emotional eating was not merely an immediate coping response, but functioned as a cyclical process that reinforced relapse over time.

Another prominent theme was night eating and uncontrolled snacking. Participants stated that they could not control their urge to eat during the night. Meriç (F) described this with pleasure: *"My face blossoms when I eat at night"*. Gediz (M) portrayed the intensity of this behavior: *"Even if I am full, I go to the kitchen. It's as if something tells me to go and look. I can't sleep without checking the fridge… At 1, 2, or 3 a.m. I must check what is there. Otherwise, I can't sleep."*. Tuna (F) added that secrecy and shame accompanied this habit: *"I was eating at night so that no one would see me"*. The intensity and uncontrollable nature of night eating indicate that this pattern was experienced not simply as a habit, but as a compulsive form of behaviour.

Eating speed, portion size, and hedonic eating also emerged as key psychological factors. Tuna (F) noted, *"I was finishing my meal in three minutes… I was the one who could eat three stuffed wraps in a row. While my mother was full with a small toast, I could only be satisfied with three toasts."* Ren (F) admitted, *"I always eat a second plate"*. Arda (F) expressed eating as a source of pleasure: *"Eating is probably a pleasure. Pleasure, happiness, that's what I think it is"*. Similarly, Amazon (M) associated eating with daily satisfaction: *"If I don't eat dessert, I don't count that day as a day"*.

Finally, negative life events and transitional periods emerged as significant psychological triggers of relapse. Tuna (F) pointed to marital betrayal: *"He cheated on me… these kilos didn't come for nothing"*. Ren (F) underlined the impact of health problems and emotional disappointment: *"I had a car accident… psychologically I was devastated; I gained a lot at that time. And during that period, I was in a relationship that ended with betrayal. That also triggered me a lot"*. Dicle (F) noted role transitions as vulnerable periods: *"I think I gain weight during transitions. Graduation, for example, is a very serious turning point in people's lives. Responsibilities increase. Once you gain weight, it keeps adding up. It turns into a yo-yo cycle"*. Asi (F) stated, *"I got married. Then in five or six months, I gained 20 kilos"*. These accounts demonstrate how life events and transitional phases created fragile grounds for relapse. These accounts indicate that relapse was shaped not only by individual choices, but also by the embodied and behavioural consequences of emotionally challenging life experiences.

Psychological coping patterns were further shaped by social contexts. Work schedules, family food practices, and weight-related comments from others often amplified stress and limited opportunities for sustained self-care, thereby reinforcing relapse over time. Overall, these findings indicate that relapse can be understood as a cyclical process sustained by emotional regulation practices and cumulative emotional exhaustion. Within this process, eating functioned not only as a physiological necessity, but also as a means of coping with emotional distress.

Theme 3: Obesogenic contexts, family food cultures, and social pressure

Participants' narratives suggest that obesity relapse was not merely influenced by individual choices, but was actively shaped and reinforced by the social environments and cultural contexts in which they lived. Working conditions, family-based eating cultures, social pressures, and the COVID-19 pandemic emerged as key social contexts that triggered weight gain. These accounts demonstrate that obesity relapse is embedded in social conditions that cannot be adequately explained at the individual level.

The influence of environmental conditions was particularly evident in relation to shift work. Amazon (M) expressed this situation: *"Since we work in a shopping mall, what can you eat here? If you want to go out to eat, it's all fast food."* Similarly, Gediz (M) explained how eating late after shifts made weight gain inevitable: *"We go home at 10 or 11 p.m. We sit down for dinner. When you eat, you inevitably eat bread. When you eat bread, half an hour or an hour later you go to bed… What happens? When you sleep, what you ate turns directly into fat… No movement, nothing. It comes back to us as fat, as weight."* Participants evaluated the eating practices imposed by the work environment as contributing both to unhealthy diets and to reduced opportunities for physical activity. These findings

suggest that working conditions not only facilitated unhealthy eating practices, but also constrained opportunities for healthy living, thereby structurally reproducing conditions that contribute to relapse.

Family-based food cultures and normative beliefs around eating also played a central role in shaping relapse. Participants frequently referred to the lasting influence of family eating habits, such as the expression, *"We are people who eat pasta with bread."* Fırat (M) emphasized the family's influence: *"Parents are important in a child's life, upbringing, and nutrition. If the child is overweight, I think it's from the family. Either genetic or nutritional. Is the family attentive? How much does the family feed the child healthily? After all, the family raises us. Whatever my mother served, we ate it."* Similarly, Ren (F) explained how the childhood habit of "finishing the last bite on the plate, otherwise it will cry behind you" continued into adulthood: *"Even if it was food I didn't like, I thought it had to be finished, even if I vomited afterward. There were many times I vomited. But still, I finished it."* These accounts illustrate how eating behaviours learned within the family environment became internalised and transformed into enduring habits that complicated weight control. In this context, eating practices learned within the family functioned not only as individual habits, but as socially transmitted patterns that contributed to the persistence of relapse.

Social pressure and weight-related stigma also emerged as significant sources of stress, often producing effects opposite to those intended. Nil (F) expressed this paradox: *"Trying to lose weight because of someone else's guidance affects a person differently. How does it affect? I am overweight, and on top of that, my manager guided me. Then I had to be successful in this. That creates pressure."* Tuna (F) also stated that constant "lose weight" remarks from her family drove her into psychological collapse and caused her to gain even more weight: *"Hearing it constantly from your own family. I already collapsed psychologically. Because of their pressure, I started to gain even more. I became more stressed."* These findings indicate that weight stigma did not merely produce psychological distress, but also operated as a source of stress that paradoxically contributed to relapse.

Finally, sedentary lifestyles and the pandemic emerged as highly visible social factors shaping relapse. Nil (F) said: *"A sedentary life. Work is already like that. We always work sitting in front of the computer."* Gediz (M) added: *"After dinner, I don't move at all."* Tuna (F) said: *"During the days we sat at home, with pastries and pies, I didn't move at all. I was sitting like a rock."* Participants also emphasised that curfews, restrictions, and uncertainty during the pandemic intensified emotional eating and reduced everyday routines. Dicle (F) summarized the effect of this period: *"I think during the pandemic it really got out of control. At home, it was eat, eat, and only eat. It was such a period. I attribute it to that a little."* The pandemic made existing structural vulnerabilities more visible, further illustrating that relapse is not solely an individual process, but a contextually shaped one.

Together, these accounts illustrate relapse as a biopsychosocial spiral in which embodied vulnerability, emotional coping practices, and obesogenic social contexts mutually reinforced one another over time, rather than as an individual failure of willpower. Overall, these findings suggest that relapse cannot be explained solely through individual behaviour, but is continuously produced through the interaction of social, cultural, and structural conditions.

Discussion

This study demonstrates that obesity relapse is a complex biopsychosocial process shaped by the interaction of biological, psychological, and social factors. Rather than reflecting individual failure, relapse emerges through the convergence of cumulative vulnerabilities and structural conditions over time.

Biological predispositions, meaning- making, and perceived inevitability

The findings suggest that genetic predisposition and family history play a significant role in how relapse is experienced and interpreted by individuals living with obesity. Participants' references to obesity as a "family destiny" indicate that genetic inheritance was understood not only as a physiological condition but also as a socially and culturally meaningful explanation that framed weight regain as inevitable. Existing research similarly highlights the role of genetic variation in regulating weight loss and weight regain (Loos et al., 2021; Nicklas et al., 2001) and the increased risk associated with family history (Semerci, 2004). However, this study extends the literature by illustrating how genetic explanations are actively woven into participants' meaning-making processes, shaping expectations, motivation, and perceived agency in relation to relapse. This finding extends existing research by demonstrating that genetic predisposition is not only a biological risk factor but also socially interpreted and internalised as a form of constrained agency, shaping how individuals understand their capacity for change.

In addition, the findings underscore the lasting influence of childhood obesity on later relapse experiences. Participants' expressions such as "I was always big" reflect how early weight experiences become embedded in personal identity and life narratives. This aligns with previous research linking childhood obesity to long-term health risks and increased mortality in adulthood (Marcus et al., 2022; Young et al., 2012). From a social work perspective, these findings highlight the importance of understanding obesity not merely as a biomedical trajectory, but as a lived experience shaped across the life course, in which early stigma, social labeling, and familial narratives may constrain later possibilities for change.

Notably, women's accounts suggest that body weight also intersects with gendered social expectations, influencing social identity and life trajectories, including early marriage. This finding points to the need for socially and culturally sensitive interventions that address not only weight-related behaviours, but also the broader social meanings attached to bodies, gender, and family roles.

Psychological processes, emotional exhaustion, and relapse cycles

One of the most striking findings of this study is that stress, burnout, and emotional eating play a central role in shaping obesity relapse. Participants' accounts indicate that the repeated cycle of weight loss and weight regain fosters a cumulative sense of failure, reinforcing beliefs about "not being able to succeed" and gradually undermining motivation. Beyond existing literature, the findings suggest that relapse should also be understood as an accumulation of emotional exhaustion produced through repeated cycles of weight loss and regain, rather than as isolated behavioural failure. While existing research similarly highlights the reinforcing relationship between stress, burnout, emotional eating, and relapse (Nevanperä et al., 2012; Sainsbury et al., 2019), the present findings draw attention to emotional exhaustion as a critical, yet often overlooked, dimension of relapse. In this regard, obesity interventions that focus exclusively on behavioural compliance or weight loss outcomes risk neglecting the psychological toll produced by repeated and unsuccessful weight control efforts.

The findings further demonstrate that emotional eating is not limited to negative emotional states, but is also triggered by positive emotions. Participants' narratives suggest that food functions simultaneously as a reward and as a refuge, depending on emotional context. In this sense, emotional eating can be interpreted not merely as an individual coping strategy, but as a socially and structurally mediated response to ongoing stressors. This dual function resonates with existing literature indicating that emotional states such as stress, anxiety, and depression trigger eating behaviours (Ganley, 1989; Kavas et al., 2022), and that emotional eating is associated with continuous weight gain in adulthood (Strien et al., 2012). From a social work perspective, these findings underscore the importance of addressing emotional regulation capacities, rather than focusing solely on dietary restraint.

Night eating, binge eating, and hedonic consumption emerged as additional psychological processes that complicated participants' relapse experiences. For many participants, food became not only a biological necessity but also a source of pleasure, comfort, and emotional security. Previous studies similarly associate night eating syndrome and binge eating with weight gain (Furtado et al., 2023; Ishida et al., 2020), while hedonic eating has been linked to the pursuit of reward and happiness (Ziauddeen et al., 2015). Taken together, these findings highlight the need for obesity interventions to engage more seriously with psychiatric processes and disordered eating patterns, rather than treating relapse solely as a failure of self-control (Yanovski, 2003).

In addition, the findings indicate that life transitions such as graduation, marriage, and pregnancy, as well as negative life events including infidelity and separation, act as significant triggers in relapse processes. Participants' expressions such as "these weights did not come for nothing" illustrate how emotional distress linked to life events becomes embodied through eating and weight gain. Consistent with prior research demonstrating the impact of transition periods on body weight (Dinour et al., 2012; Edmonds et al., 2008), this study suggests that obesity interventions should move beyond generalised treatment models and incorporate psychosocial support and preventive strategies tailored to critical life-course transitions.

Social contexts, culturel norms, and structural constraints

The findings demonstrate that obesity relapse cannot be explained solely through individual willpower or behavioural choices. Rather than merely influencing relapse, these findings suggest that social environments actively produce and reproduce conditions that make sustained weight loss difficult. Instead, social contexts such as family environments, cultural practices, economic conditions, and obesogenic settings play a decisive role in shaping relapse. Participants' statements such as "we are people who eat pasta with bread," "finish your plate," or "even if it's fast food, let it be" illustrate how obesity is reinforced through eating norms learned in childhood and sustained through contemporary consumption practices. This finding resonates with existing research highlighting how parental eating habits and family food cultures increase obesity risk (Demir & Bektas, 2017; Kime, 2009). Moreover, the obligation

to consume carbohydrate-heavy diets due to economic constraints further underscores obesity as a socioeconomic issue rather than an individual failure (Bennett et al., 2011; Salmasi & Celidoni, 2017).

Cultural discourses also emerge as powerful mechanisms that legitimise and shape eating behaviours. In the Turkish context, expressions such as “life comes through the throat” or “finish your plate or it will cry after you” function as social codes that regulate food consumption. Similarly, the use of food metaphors to describe the female body reflects the intersection of gender norms and cultural eating practices (Alpyıldız, 2020; Karakeçili & Çetinsöz, 2018). These findings support perspectives that conceptualise obesity as a socially transmitted phenomenon, embedded within shared meanings and everyday practices (Melius, 2013).

Structural conditions further constrain individuals’ capacity to sustain weight loss. Shift work systems, “mega size” options in fast food chains, and obesogenic urban environments were described as factors that normalised unhealthy eating and limited opportunities for physical activity. Previous studies similarly emphasise the role of urban design and food environments in promoting obesity (Lake & Townshend, 2006; Karaçil & Şanlıer, 2014; Nicolaidis, 2019). Participants’ accounts align closely with this literature, illustrating how environmental conditions interact with biological and psychological vulnerabilities to accelerate relapse processes.

Finally, the COVID-19 pandemic emerged as a critical contextual factor that intensified existing vulnerabilities. Participants reported that lockdown measures, physical inactivity, and prolonged periods of carbohydrate-heavy eating at home contributed to rapid weight gain. Consistent with studies indicating that 48–72% of individuals experienced weight gain during the pandemic (Khubchandani et al., 2022; Khan et al., 2022), these findings demonstrate that crisis conditions amplify the social determinants of obesity and make structural influences more visible. The pandemic can therefore be understood as a crisis context that amplified existing structural vulnerabilities and made the social determinants of relapse more visible.

This study has several limitations. First, the relatively small sample size and the context-specific nature of the data (Türkiye) may limit the generalisability of the findings. However, the aim of qualitative research is not to generalise findings, but to develop an in-depth understanding of individuals’ experiences. In addition, the findings are based on participants’ own accounts, which may involve the reinterpretation of past experiences over time. Nevertheless, these accounts provide valuable insights into how relapse is experienced.

Conclusion

This study demonstrates that obesity relapse cannot be adequately understood as an individual behavioural failure, but rather as a dynamic and multi-layered process shaped by the interaction of biological, psychological, and social factors. The findings highlight that relapse is not a discrete event, but a cumulative and self-reinforcing process that unfolds over time within individuals’ lived experiences and social contexts.

By foregrounding individuals’ experiences, this study contributes to the literature by conceptualising relapse not as an individual outcome, but as a socially shaped and contextually embedded process. The findings point to the limitations of interventions that focus solely on behaviour change, and underline the need for more holistic approaches that address emotional regulation, social environments, and structural conditions.

In this regard, social workers have a critical role at both individual and structural levels. Psychosocial support, family-based interventions, and policies aimed at reducing social inequalities are essential for promoting sustainable health outcomes. Future research should build on these findings by employing larger samples and diverse contexts to further explore the complexity of relapse processes.

Declarations

Declaration of Conflicting Interests

The author(s) declare that there is no conflict of interest regarding this study.

Funding Statement

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Clinical trial number

Not applicable.

Consent to participate:

Written informed consent was obtained from all participants prior to participation.

Ethical Statement and Informed Consent

This study was conducted in accordance with the Declaration of Helsinki. The study was initiated after obtaining ethical approval from the Non-Interventional Clinical Research Ethics Committee of Hacettepe University on 07.02.2023 (Approval No: 2023/02-26). Written informed consent was obtained from all participants prior to participation.

Consent to Participate

All participants were informed about the purpose and procedures of the study, and written informed consent was obtained prior to participation.

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