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MOTIVATIONAL DRIVERS FOR MINI-GASTRIC BYPASS SURGERY: PERSPECTIVES FROM EGYPTIAN INDIVIDUALS

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Abstract

Background: Obesity is a serious public health concern that significantly reduces life expectancy and impairs quality of life. Until now, bariatric surgery is the most effective and long-lasting treatment both for managing of obesity and curing associated comorbidities. Mini-gastric bypass (MGB) is a common, simple, safe, reversible and effective procedure for treating morbid obesity. As yet, there is limited qualitative research that focuses on motivation of obese individuals to undergo MGB in Egypt. Such data is valuable for capturing patients' perspectives. Therefore, the aim of the current study was to explore the motivational drivers that influence Egyptian individuals to undergo mini-gastric bypass surgery with a focus on understanding their personal, cultural and health-related perspectives. Methods: An interpretative phenomenological descriptive qualitative design was adopted using a purposive maximum variation sampling. Data were collected through four tools: (a) a Personal and Medical Background Data Form, (b) a semi-structured, face-to-face, open-ended interview guide, (c) voice recorder and (d) descriptive field notes. The data collection process extended over ten months until data saturation was attained. In total, 45 interviews were conducted, yielding 31 hours of recorded material. Data were analyzed using Colaizzi's (1978) phenomenological method and trustworthiness was ensured through rigorous qualitative research standards. Results: Twenty participants were included in the study, most of whom were female (55%). Prior to surgery, 90% had morbid obesity, with a mean BMI of 52 ± 9. Analysis revealed six, core and overlapping themes capturing the triggering motivators; they are: (1) deteriorated health status, (2) discontent with appearance and clothing constraints, (3) restricted physical ability and mobility, (4) loss of control over eating, (5) psychosocial distress and stigmatization and (6) despair following repeated failed weight-loss attempts. Conclusion: The motivators for undergoing mini-gastric bypass surgery among Egyptian individuals were multifactorial, with health issues, particularly associated co-morbidities as diabetes, hypertension…etc., pain and fatigue, emerging as the dominant drivers, reinforced by psychosocial distress, loss of control over eating and repeated failed weight-loss attempts, which ultimately led them to view surgery as the only option for restoring health and quality of life.

Keywords: Obesity, Mini-Gastric Bypass Surgery, Motivation.

INTRODUCTION

Obesity is a serious public global health concern that significantly impairs quality of life and reduces life expectancy, as it is strongly associated with a range of comorbid conditions, including type 2 diabetes mellitus (T2DM), cardiovascular diseases, obstructive sleep apnea, musculoskeletal disorders and certain malignancies [1], [2]. According to the World Health Organization (WHO), obesity accounts for approximately 4.7 million premature deaths annually and is ranked as the fifth leading non-

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communicable preventable cause of death [3]. Egypt is among the countries most affected by this global epidemic, ranking 18th worldwide in obesity prevalence. National epidemiological data indicate an upward trend in obesity rates, with the 100 Million Health Survey (2019) reporting that approximately 40% of the Egyptian population is affected. This represents a notable increase from the 36% prevalence reported by the WHO in 2017, underscoring the accelerating burden of obesity in Egypt [4].

Management options for obesity vary from medical and dietary interventions to surgical procedures. Among these, bariatric surgery remains the most effective intervention for individuals with morbid obesity, as it promotes significant weight reduction, improvement in obesity-related comorbidities and enhanced quality of life in patients with severe obesity (BMI ≥ 35) [4], [5].

Mini-gastric bypass (MGB) is currently the third most commonly performed bariatric and metabolic surgery worldwide, offering several advantages including technical simplicity, ease of revision or reversal and effective weight loss outcomes comparable to other procedures [6], [7], [8].

Motivation plays a crucial role in patients' decisions to undergo bariatric surgery, as it reflects both their immediate intentions and long-term expectations. Understanding these motivations is essential in a patient-centered approach, which focuses on the individual's background, concerns, and goals [9].

This understanding supports realistic expectations, encourages lasting behavior change, and improves surgical outcomes [10, 11]. Wellness Motivation Theory (WMT) views motivation as a dynamic, goal-oriented process shaped by personal meaning, readiness for change, and social context [12].

To date, limited qualitative research has examined the motivations of obese individuals undergoing MGB, particularly within culturally specific contexts such as Egypt. Existing studies have largely focused on surgical outcomes, complications and nutritional deficiencies, overlooking the multifaceted motivators that drive patients to pursue surgery [13].

Exploring these motivators within an Egyptian cultural framework provides valuable insights for practitioners to better support patients' complex needs during both the preoperative decision-making and postoperative adjustment phases. Hence, the aim of the current study was to explore the motivational drivers that influence Egyptian individuals to undergo MGB surgery, with a focus on understanding their personal, cultural and health-related perspectives.

To fulfill this aim, the central research question was formulated as: *What motivates Egyptian individuals to undergo MGB surgery?* In addition, probing questions were used to deepen understanding, such as: Please describe your life before the surgery; Tell me about your expectations before the surgery; How did you ultimately come to the decision to have it; and how did you prepare for the surgery?

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METHODS

Design

A phenomenological, interpretative, descriptive qualitative research approach was utilized to explore in-depth the motivational drivers that motivate Egyptian individuals who suffer from obesity to decide to undergo mini-gastric bypass surgery.

Setting

The interviews were conducted across a diverse range of settings in Cairo, Egypt, encompassing governmental outpatient clinics, private bariatric centers, social clubs and workplaces. These locations were deliberately selected to ensure participants' comfort, foster trust and encourage open and honest sharing of their experiences.

Participants

A purposive maximum variation sampling approach was used to recruit Egyptian individuals with obesity that had undergone MGB surgery within the past five years. Eligibility criteria included: age ≥18 years, BMI >35 kg/m² at the time of surgery, no postoperative complications, fluency in Arabic, being raised in Egypt and willingness to share experiences.

A total of 23 participants were recruited. Three participants were excluded for not attending a second interview, resulting in a **final sample size of 20**. Sampling ended when data saturation was reached [14].

Data Collection Tools

Data were collected using a Personal and Medical Background Data Form and a semi-structured face-to-face interview guide, both developed by the researcher, to capture demographic and clinical information (e.g., age, gender, marital status, comorbidities and BMI) and to explore participants' motivations, expectations and decision-making related to surgery. A voice recorder and descriptive field notes were also used to document contextual details.

Procedure

Once official approval was obtained, eligible participants were approached individually. An initial meeting was held to break the ice between the participant and the researcher, explain ethical considerations and obtain informed consent. Participants provided their contact details to facilitate coordination of interview schedules and follow-up communication.

To establish trust, the researcher tailored interview questions to each participant's situation, using probing techniques while avoiding premature interpretation of responses.

Questions were simplified when necessary and participants were given ample time to share their experiences. They were encouraged to seek clarification or stop the interview if they felt emotionally or physically overwhelmed.

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The first interviews took approximately 45 to 60 minutes began with rapport-building and collection of personal and medical background information, followed by open-ended questions about motivations and expectations before surgery.

While the second interviews clarified or expanded on previous responses, addressed remaining topics such as motivators, surgical effects and satisfaction with outcomes and allowed for member checking. On the other hand, five participants required a brief third interview either face-to-face or by phone. In total, 45 interviews were conducted, amounting to 31 hours.

Each interview concluded with expressions of gratitude and reassurance of confidentiality. No session exceeded 60 minutes. Interviews were transcribed within 24 hours and notes taken during sessions were incorporated into the transcripts.

Data collection and analysis were conducted concurrently; each transcript was analyzed soon after completion, allowing emerging themes to inform subsequent interviews. The analysis followed Colaizzi's method, with transcription, coding and interpretation occurring in parallel until data saturation was reached.

Rigor of Data

Rigor in qualitative research ensures confidence in the study's findings and is established through credibility, transferability, dependability and confirmability [15, 16]. Credibility, the equivalent of internal validity, was maintained in this study through strategies such as triangulation of transcripts and field notes, investigator collaboration, member checking and peer debriefing.

Purposive sampling with maximum variation further enhanced credibility, while deviant case analysis added depth to the findings. Transferability was addressed by providing thick, detailed descriptions of participants' backgrounds, research settings and data collection procedures, allowing readers to judge the applicability of findings in other contexts. Whereas, dependability, which reflects consistency over time, was ensured through peer debriefing, bracketing to minimize researcher bias, repeated transcript reviews and expert validation of themes and subthemes [17]. These measures strengthened the stability and reliability of the research process.

Confirmability focused on ensuring that findings were shaped by participants' voices rather than researcher bias. Reflexive journaling, peer debriefing and member checking were used to safeguard objectivity for example, an audit trail documented each decision, while detailed descriptions and direct quotations-maintained transparency between the raw data and the themes [18, 19, 20]. Together, these strategies reinforced the overall trustworthiness and rigor of the study.

Content Analyses

Data were analyzed using Colaizzi's (1978) phenomenological method, which is considered one of the rigorous and robust methods used in qualitative research that ensures the credibility and transferability of the study results [21]. Data analysis begins right after the first interview; therefore, data collection and analysis go hand in hand.

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RESULTS

Personal Data

Table 1 outlines the demographic characteristics of the 20 study participants. Females represented the majority (55%) and half (50%) were aged 40–<60 years, with a mean age of 39.05 ± 10.66.

Most participants were married (60%), resided in urban areas (65%) and had attained university-level education or higher. In addition, 70% were employed in various occupations and 60% reported having sufficient income for daily living.

Table 1: ***Frequency and percentage distribution of Personal Data among the study participants (N=20).***

Variable	Category	N	%
Age in years	20- <40	9	45
	40- <60	10	50
	>60	1	5
	X±SD	10.6547 ±39.05	
Gender	Male	9	45
	Female	11	55
Marital status	Single	4	20
	Married	12	60
	Divorced	3	15
	Widow	1	5
Place of residence	Urban	13	65
	Rural	7	35
Level of education	Can't read or write	1	5
	Basic education	2	10
	Vocational education	4	20
	University student	2	10
	University graduates or higher	11	55
Employment status	Employed	14	70
	Non-employed	6	30
Occupation	businessman	4	28.57
	Teacher	3	21.43
	Secretary	3	21.43
	others	4	28.57
Income	Sufficient	12	60
	Insufficient	8	40

As shown in Table 2, the time since surgery ranged from less than one year to over five years, with 40% of participants between one- and three-years' post-surgery. Obesity onset was reported during childhood in 80% of participants and prior to surgery, 90% had

The Medical Background Data

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Table 2: ***Frequency and Percentage Distribution of Medical Background data of the Study Participants (N= 20).***

Variable	Category	N	%
The time that has passed since the surgery	Less than 1 year 1 year- < 3 years 3 year- ≤ 5years X± SD in months	7 8 5 15.8632 ±22.2	35 40 25
The onset of obesity	Birth/ early childhood Teenage Early adulthood	16 3 1	80 15 5
BMI* before surgery (kg/m²)	35.0-39.9 (Class II Obesity) Above 40 (Morbid obesity) X± SD	2 18 52±9.0082	10 90
BMI during collection (kg/ m²)	18.5- 24.9 (Normal) 25.0-29.9 (Overweight) 30.0-34.9 (Class I Obesity) 35.0-39.9 (Class II Obesity) Above 40 (Morbid obesity) X± SD	3 4 6 5 2 32.885±6.2404	15 20 30 25 10
Family history	Yes No	18 2	90 10
Obesity related comorbidities	Yes No	17 3	85 15
The comorbidities**	Type II diabetes Hypertension Dyslipidemia Osteoarthritis Breathing problems Cardiac problem Others	12 10 8 10 5 2 7	70.59 58.82 47.06 58.82 29.42 11.76 41.18

* BMI (Body mass index)

**The total is different from the number of the participants, as the same participants may have more than comorbidity at the same time.

morbid obesity (mean BMI 52 ± 9). A positive family history of obesity was reported by 90%, while T2DM (70.6%) and hypertension (58.8%) were the most common comorbidities.

The Identified Main Themes Describing Motivational Drivers for Undergoing the Surgery (N=20)

Based on the content analysis of the current study six overlapping themes were identified including, (a) deteriorated health status, (b) discontent with appearance and clothing constraints, (c) restricted physical ability and mobility, (d) loss of control over eating, (e) psychosocial distress and stigmatization, and (f) despair over repeated failed weight loss attempts. The content analysis revealed that all participants identified multiple motivators, physical, psychological, and social, for undergoing surgery.

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Regarding the first theme*, deteriorated health status*, all participants, except participant 7, reported deteriorating health as the primary motivator for surgery. Most experienced multiple comorbidities, with diabetes and its complications being the most frequently cited, as noted by participants 1, 4, 6, 8, 11–16, 19 and 20. Pain and joint stiffness, including back pain and difficulty climbing stairs, were reported by participants 2, 4–6, 9–11, 16, 17, 19 and 20.

While cardiovascular and metabolic concerns, such as high blood pressure, elevated cholesterol and heart disease, were highlighted by participants 2, 4, 6, 10, 11, 13, 14, 16 and 20. Nevertheless, breathing and sleep disorders, including snoring, sleep apnea, shortness of breath and night-time choking, were reported by participants 5, 9, 10, 18 and 20.

These health concerns and fear of obesity-related complications were collectively identified as major motivators for undergoing bariatric surgery. Several participants (1, 3, 5, 9, 17, 18) reported that their decision stemmed from growing fear of further health deterioration. As Participant 4 explained, *"I made the decision to save my life from diabetes and its complications and high blood pressure, high cholesterol and triglycerides levels, in addition to bone and joint problems besides, marital problems and esophageal reflux."* Similarly, participant 20 described suffering from *"asthma and shortness of breath, especially during night to a degree that for about five years I'd been sleeping on the couch."* For others, the urgency was reinforced by severe or life-threatening experiences. Participant 19 recounted, *"A pain entered my leg and stayed in it for about three days. I didn't feel it, and my back was hurting."* In a similar vein, participant 10 recalled their physician's warning: *"The cardiologist told me that you will die suddenly if you didn't lose weight, in addition to the persistent high blood pressure and joint problems."*

The second theme, *Discontent with Appearance and Clothing Constraints*, was reported by 15 participants. For many, the burden of excess weight was experienced as both a physical and emotional strain that deeply affected their self-perception. Participants 14 and 16, for instance, described feeling overwhelmed by their body size, as one explained, *"I wasn't happy with my appearance at all. I was carrying a heavy burden on my shoulders. I wanted to get rid of the extra weight."* Similarly, participant 7 stated, *"I wasn't satisfied with my appearance. I have always been imprisoned in a fat body. I felt different from other girls and didn't dress well."*

In addition to the emotional weight of obesity, participants expressed pronounced dissatisfaction with their appearance and the limitations it imposed on clothing choices. Many participants, both male and female, reported frustration and distress about their inability to find clothes that fit properly or reflected their identity. Participant 2, for example, linked dissatisfaction to femininity and social comparison, stating, *"My femininity was hidden; I couldn't wear boots or women's shoes like girls. My foot size was 44."* Participant 6 vividly illustrated this sense of restriction, saying, *"I was imprisoned in a jalabiya,"* highlighting how body size constrained both physical comfort and self-expression. Similarly, participants 4, 8, 9, 11, and 17 described perceiving their appearance as unattractive and struggling to find suitable clothing even in stores that sold plus sizes,

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often resorting to dark colors. Male participant 4 reported, *"My appearance was ugly. My clothes were messy. I didn't buy clothes because I couldn't find what I wanted, even in big clothing stores, and they had to be dark colors."*

The third theme is *Restricted Physical Ability and Mobility.* The current study uncovered that 16 participants experienced extreme fatigue, weakness and a profound lack of energy which affected their daily lives and ability to perform basic activities to the point that some of them were unable to take care of themselves or even change their position. For example, participant # 5 (male, 40 years) narrated that: "*I felt like I was helpless, my legs couldn't carry me, and I couldn't make any effort. I was resting twice in 100-meters".* Physical limitations were also reflected in the statements of participant 9 (male, 23 years), who said that he could not put on clothes and bend down to wear shoes. On the other hand, participants 12, 13 and 14, described life as a "torment," marked by an inability to move or exert any effort. Participant 20 (male, 40 years) shared his struggle mentioned that: "*I wasn't able to play with my daughter for even ten minutes. Life was very, very difficult".*

The fourth theme, *Loss of Control over Eating*, was reported by 17 participants and represented a central psychosocial factor contributing to their decision to undergo MGB surgery. This theme reflected participants' perceptions of a diminished ability to regulate their eating behaviors, often described as a compulsive or addictive relationship with food. Many participants characterized their eating as driven by emotional rather than physiological needs, associating food consumption with comfort, stress relief, and emotional gratification. For example, Participants 10 and 18, for example, similarly stated, *"I love food to the point of addiction; my whole life is about food. When I'm happy, I eat; when I'm upset, I eat."*

Loss of control was particularly evident in relation to sweets, which were frequently described as irresistible and habit-forming. Participants recounted maladaptive behaviors such as overeating large quantities of food, experiencing persistent hunger, and concealing their eating habits from family members, illustrating the internal conflict between the desire to lose weight and the compulsive urge to eat. For instance, participants 2 and 14 reported, *"I ate a lot. I could not live without sweets. I used to lie to my family and tell them that I was on a diet and then ate behind them. Eating was a pleasure for me."* Similarly, participant 5 articulated that: *"I was eating in huge quantities and I always feel hunger and unable to control myself"*.

The fifth theme, *Psychosocial Distress and Stigmatization*, emerged as a significant motivator for undergoing bariatric surgery among the majority of participants. Eighteen participants described profound emotional suffering associated with obesity, including feelings of hopelessness, social rejection, diminished self-confidence and internalized shame. These experiences often culminated in a sense of psychological paralysis and loss of identity. Participant 4 articulated this despair poignantly, stating, *"I was dead… I was about to buy a grave,"* capturing the depth of emotional exhaustion that characterized many participants' experiences. Several participants reported social withdrawal as a consequence of perceived and actual stigmatization. Participants 6, 11, and 13 expressed

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that their self-confidence was extremely low, describing themselves as constantly upset, emotionally shattered, and socially isolated. They noted that people often avoided them, leading them to leave their homes only when absolutely necessary. Participant 11 elaborated on how people bullied her by saying, *"You are like a calf, and we are going to slaughter you."*

Participants 8 and 10 used metaphorical language to describe their emotional state, referring to themselves as *"dead persons disguised in the body of a living person."* Participant 8 further explained, *"We were buried in obesity. My self-confidence was very low,"* and shared that she was often teased, even by close friends, who made fun of how she looked with comments such as, *"You can't bring teddy bears in this place."* These accounts reflect how obesity extended beyond physical limitations to encompass profound psychosocial suffering.

Obesity also disrupted important life events and relationships. Participant 7 described the emotional trauma of having her engagement called off because of her weight, while participant 18, a 29-year-old woman, shared, *"My psychological state was very bad. I felt that I was slowly dying, and that my life had stopped and would not move forward unless I changed it."* Similarly, participant 20, a 40-year-old man, highlighted experiences of public humiliation, noting, *"Strange looks from people were killing me. Microbus drivers would refuse to give me a ride and would say, 'You alone need a car."*

While, the sixth theme was *Repeated Unsuccessful Weight Loss Attempts*, all participants shared a deep sense of frustration and hopelessness after trying many methods to lose weight without lasting success. They described experimenting with strict diets, exercise programs, herbal remedies, medications and even medical procedures such as liposuction or stomach balloons, yet the results were always temporary.

For instance, participants 2 and 5 similarly disclosed, *"Oh, I tried everything, and nothing helped to achieve what you dream of. I did diet, mezsotherapy, cavitation, herbs and medicines."* Participants 4, 10, 11, and 19 also expressed the same sense of defeat, stating, *"I did everything and it all failed; the operation was the last decision. Oh, we've been trying our whole lives but nothing works."*

Participant 4 added, *"Even I had liposuction,"* while participant 10 mentioned, *"And I made a stomach balloon."* Participant 11 captured the collective feeling of exhaustion and resignation, stating, *"The decision to operate was the final and last decision... even laser had no effect."* Likewise, participant 19 noted, *"I tried almost everything except herbs, which I am afraid of."*

DISCUSSION

Triggering Motivators captures the multifaceted factors driving participants to choose MGB surgery, encompassing physical, psychological and social dimensions. Through the lens of WMT, these motivators illustrate how personal meaning, goal-directed processes and social resources interact to shape readiness for change. Participants in the current qualitative study described severe physical limitations, psychosocial distress and repeated failures with other weight loss regimens as critical tipping points that lowered

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self-efficacy and intensified the desire for transformation. These combined factors catalyzed surgery as a decisive step toward reclaiming health and identity.

A dominant theme was deterioration of health, reported by nearly all participants, often involving comorbidities such as diabetes, hypertension, dyslipidemia, joint problems and sleep apnea. Participants perceived obesity as life-threatening rather than beautifying, expressing urgency with statements like “I took the decision to save my life” or “the cardiologist told me I would die suddenly.” From a WMT perspective, worsening physical health created a discrepancy between current functioning and desired wellness, triggering goal-directed action. In fact, the decision to undergo the surgery reflected a deliberate effort to restore health, autonomy and future potential.

Recent literature indicates that individuals undergoing MGB are primarily motivated by the cumulative burden of chronic illness, escalating health risks, and concerns about longevity [9, 10, 11, 22, 23] therefore, bariatric surgery was understood as an essential means to safeguard health and extend life expectancy. Participants also reported dissatisfaction with appearance and clothing limitations, a burden shared by both men and women. Frustration arose from the inability to find clothes that fit or reflected personal identity, with women noting lost femininity and men restricted to traditional loose garments.

Many avoided shopping or chose dark colors, reinforcing a sense of social exclusion and psychological constraint. WMT frames this dissatisfaction as a potent internal motivator, intersecting with social pressures to amplify readiness for change. For participants, MGB represented a deliberate step toward aligning external appearance with internal self-image, restoring personal agency, self-expression and psychosocial integration these findings are in line with the findings of [29, 31].

Severe physical limitations emerged as a dominant motivator for participants to undergo MGB surgery. Many described profound fatigue and difficulty performing routine tasks such as walking, climbing stairs, or dressing independently, leading to increased reliance on others and lower of self-worth. Recent studies report similar findings, highlighting that physical limitation; functional impairment and escalating discomfort often precipitate surgical decisions [23, 24, 25, 30]. From a WMT perspective, declining physical capacity disrupts wellness and activates goal-directed motivation to restore independence, social and occupational functionality.

A universal finding was participants’ struggle with uncontrolled eating, particularly sweets and calorie-dense foods, often described as addictive. Despite repeated dieting attempts, participants experienced ongoing internal conflict between cravings and self-restraint. This aligns with recent evidence identifying emotional eating and food addiction as barriers to weight loss in MGB patients [25, 26]. Wellness Motivation Theory interprets these patterns as disrupted behavioral regulation; whilst, MGB provides physiological and motivational support to restore self-regulation and facilitate adaptive behavioral change.

Most participants voiced profound psychosocial distress and stigmatization, including social rejection, bullying, low self-confidence and social withdrawal. Actually, some reported disrupted life events, such as broken engagements or strained relationships.

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Recent qualitative studies indicate that stigma and isolation are key motivators for MGB, driving individuals to reclaim self-worth and social acceptance [24, 27, 30]. WMT emphasizes the role of social contextual influences, with stigma acting as an external force motivating decisive health behavior change. Participants universally reported despair following repeated failures with diets, exercise, medications and interventions like liposuction or gastric balloons. These failures eroded self-efficacy and reinforced surgery as a “last resort” [28]. Through the lens of WMT, this represents adaptive motivational reorientation, where internal cognitive processes (e.g., reduced self-competence) and external factors (e.g., stigma, health decline) converge to create readiness for transformative health behavior change. MGB thus functions as both a physiological and psychological step toward regaining control over health and identity.

CONCLUSION AND RECOMMENDATIONS

Conclusion

In summary, the study provides further insight into motivation to undergo MGB among Egyptian individuals reflects a complex and multifaceted phenomenon. The decision is rarely based on medical indications alone rather arises from the interplay of health-related suffering, psychosocial pressures and personal aspirations. Surgery was perceived not only as a medical solution but also as a means to regain identity, autonomy, and quality of life. The findings demonstrate that deteriorating physical health, psychosocial distress, loss of control over eating, restricted mobility and repeated failed attempts at weight loss collectively shaped participants’ readiness for surgery.

This choice emerged as the culmination of sustained physical, emotional and social challenges rather than an impulsive act. Within the Egyptian cultural context, motivators were further intensified by pressure in form of social stigmatization and appearance-related pressures, particularly among women. Interpreted through Fleury’s Wellness Motivation Theory, these motivators illustrate how personal meaning, goal-directed processes, and social influences dynamically interact to foster transformative health behavior change.

Implications

- Preoperative assessment should be patient-centered, addressing physical comorbidities, psychosocial well-being, emotional eating, and previous weight loss experiences to guide individualized care.
- Psychological and behavioral support programs should be integrated to manage compulsive eating, stigma-related distress, and body image concerns, improving postoperative adherence and long-term outcomes.
- Care should be culturally sensitive, acknowledging social and appearance-related pressures to enhance communication and support.
- Multidisciplinary follow-up involving medical, nutritional, and psychological monitoring is essential to sustain behavioral change, improve quality of life, and reinforce autonomy and self-efficacy.

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Recommendations

- It would be beneficial for future research to adopt a longitudinal, unbiased, quantitative and large-scale design to provide a deeper understanding of long-term outcomes and variations in patients' post-surgical experiences.
- I t is recommended that future studies develop and assess standardized pre-surgical education programs that integrate lifestyle modification and mental health components.
- Further research is recommended to examine patient-centered, multidisciplinary approaches that ensure individualized, continuous, and holistic pre-surgical support.

Limitations

- The limitations of the study are as follows:
- The unique, context-specific nature of qualitative research limits replication and validation across different settings.
- The small, non-random sample from a single region in Egypt restricts the generalizability of findings.
- Researcher interpretation may introduce subjectivity, as different analysts might derive varying conclusions.
- Despite achieving data saturation, some motivations for surgery may not have been captured.
- Recall bias may have occurred among participants whose surgeries were conducted long before the interviews.

Abbreviations

MGB	Mini-gastric bypass
WHO	World Health Organization
BMI	Body mass index
T2DM	type 2 diabetes mellitus
WMT	Wellness Motivation Theory

Declarations

Ethical Considerations

This study was part of a Doctorate thesis, approved by the Research Ethics Committee of Faculty of Nursing, Cairo University (ethics code: RHDIRB2019041701). In addition, a written informed consent was obtained from all participants after explaining the nature, purpose and significance of the study. It was emphasized also that participation in the study is entirely voluntary and they have the right to withdraw from the study at any point without penalty.

Availability of data and materials

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Competing Interests

The authors declare that they have no competing interests.

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