

T.C.

YEDİTEPE UNIVERSITY

INSTITUTE OF HEALTH SCIENCES

DEPARTMENT OF NUTRITION AND DIETETICS

**EVALUATION OF TEACHERS' FAT PHOBIA
LEVELS AND HEALTHY LIFESTYLE
BEHAVIORS**

MASTER OF SCIENCE THESIS

TANSU TUĞCU

İstanbul-2022

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SUPERVISOR

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This thesis has been deemed by the jury in accordance with the relevant articles of Yeditepe University Graduate Education and Examinations Regulation and has been approved by Administrative Board of Institute with decision dated and numbered

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DECLARATION

I declare that this thesis is my own work and it contains no material previously published or written by another person nor material which has been accepted for the award of any other degree except where due acknowledgment has been made in the text.

01.08.2022
Tansu TUĞCU



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LIST OF SYMBOLS AND ABBREVIATIONS

BMI:	Body Mass Index
CDC:	Centers for Disease Control
DSM- IV:	Diagnostic and Statistical Manual of Mental Disorders
HPLPS II:	Health Promoting Lifestyle Profile Scale
NCSS:	Number Cruncher Statistical System
NHANES:	National Health and Nutrition Examination Survey
IDF:	International Diabetes Foundation
WHO:	World Health Organization



ABSTRACT

Tansu Tuğcu, Evaluation of Teachers' Fat Phobia Levels and Healthy Lifestyle Behaviors. Yeditepe University Institute of Health Sciences, Department of Nutrition and Dietetics, MSc Thesis, İstanbul, 2022.

This research was carried out with 136 teachers between October 2021 and November 2021 on teachers teaching students aged 7-17 in a private educational institution, in order to evaluate teachers' fat phobic attitudes and healthy lifestyle behaviors. The study was carried out on 121 female and 15 male participants, aged between 18-57, who gave education in Bursa Private Emine Örnek Educational Institutions after the ethics committee approval. An online questionnaire including sociodemographic information, height and weight, fat-phobia scale, and healthy lifestyle behaviors scale was applied to the participants. 91.9% of the teachers were found to be fat phobic. The total scores of healthy lifestyle behaviors and the scores of the fat phobic teachers in the interpersonal relationships and stress management sub-dimensions of this scale were found to be statistically significantly lower ($p < 0.05$). Considering that interpersonal relationships and stress management behaviors have an impact on the development of fat phobia, it has been concluded that teachers should receive more training in this area and that it is possible to raise children and adolescents in a non-fat phobic environment.

Keywords: Fat phobia, Weight bias, Healthy Lifestyle, Teachers

ÖZET

Tansu Tuğcu, Öğretmenlerin Kilofobi Düzeyleri ile Sağlıklı Yaşam Biçimi Davranışlarının değerlendirilmesi Yeditepe Üniversitesi Sağlık Bilimleri Enstitüsü, Beslenme ve Diyetetik Anabilim Dalı Yüksek Lisans Tezi, İstanbul, 2022.

Bu araştırma özel bir eğitim kurumunda 7-17 yaş aralığındaki öğrencilere eğitim veren öğretmenler üzerinde, öğretmenlerin kilofobik tutumlarını ve sağlıklı yaşam biçimi davranışlarını değerlendirmek amacıyla Ekim 2021- Kasım 2021 tarihleri arasında 136 öğretmen ile gerçekleştirilmiştir. Çalışma etik kurul izni sonrası Bursa Özel Emine Örnek Eğitim Kurumlarında eğitim veren 18-57 yaş aralığında 121'i kadın, 15'i erkek katılımcı üzerinde yürütülmüştür. Katılımcılara sosyodemografik bilgileri, boy ve kiloları, kilofobi ölçeği ve sağlıklı yaşam biçimi davranışları ölçeği içeren online anket uygulanmıştır. Öğretmenlerin %91,9'u kilofobik çıkmıştır. Kilofobik öğretmenlerin, sağlıklı yaşam biçimi davranışları toplam skorları ve bu ölçeğin kişiler arası ilişkiler ve stres yönetimi alt boyutlarından aldıkları puanlar istatistiksel olarak anlamlı şekilde düşük bulunmuştur ($p < 0.05$). Kişiler arası ilişkiler ve stres yönetimi davranışlarının kilofobinin gelişmesinde etkisi olduğu göz önünde bulundurulursa öğretmenlerin bu alanda daha fazla eğitim almaları gerektiği ve bu sayede çocuk ve adölesanları kilofobik olmayan bir ortamda yetiştirmenin mümkün olduğu sonucuna ulaşılmıştır.

Anahtar Kelimeler: Kilofobi, Kilo önyargısı, Sağlıklı Yaşam Biçimi, Öğretmenler

1. INTRODUCTION AND PURPOSE

Obesity, defined by the World Health Organization (WHO) as an increase in body fat, has become a common public health problem worldwide (1). In addition to physical and metabolic disorders, obesity causes some psychiatric and social problems (2).

Furthermore, the physiological and psychological problems caused by obesity, and the problems caused by social aspects are not adequately emphasized. Obesity should also be investigated socially due to the severely biased, discriminatory, and stigmatizing behavior of community members. Especially in western societies, in spite of being thin is admired, individuals with obesity are excluded from society and exposed to various negative labels (3,4). The negative attitudes exhibited by society towards individuals with high body weight have been demonstrated by many studies (5,6,7).

Considering that obesity is increasing day by day in the light of national and international scientific studies, it is a fact that negative attitudes towards people with higher body weight will increase. These negative attitudes towards overweight or people with obesity are defined as “Fatphobia” and precautions are taken to reduce and eliminate the individuals' fatphobia levels by emphasizing many types of research (6,7,8).

According to WHO's statement, the causes of 70-80% of deaths in developed countries and 40-50% of deaths in underdeveloped countries are diseases that occur depending on lifestyle (9). In order to improve health, it is important to know these risk factors and to protect individuals from these risk factors from childhood (10).

This study is planned to be carried out with the aim of evaluating the comparison of the fatphobia levels and Health-Promoting Lifestyle Profile Scale of teachers who are working at a private middle and high school. With this study, a conclusion will be revealed whether teachers have any bias or attitude toward individuals with obesity, especially students, by collecting many independent variables such as the Body Mass Index (BMI) of these teachers, age, gender, branch, marital status, year of the profession, and which level of students they are educated. If the study is carried out successfully, it is thought that it will be a pioneer in fatphobia, especially in the field of education.

This study is a cross-sectional descriptive study aimed at determining the fatphobia levels of teachers working in Emine Örnek private middle and high school, and revealing whether this level differs according to Body Mass Index, branch, and duration of the study and Health-Promoting Lifestyle Profile Scale score.

2. GENERAL INFORMATION

2.1. Definition and Prevalence of Obesity

Obesity is a health problem characterized by an increase in adipose tissue in the body, caused by one or more metabolic, environmental, psychological, or behavioral reasons (11). It was accepted as an epidemic disease by World Health Organisation (WHO) in 2008 and its prevalence in the world has reached enormous numbers in recent years (12). Individuals with a body mass index (BMI) of 30 and above according to the worldwide accepted limit values are obese. In addition to this classification, abdominal obesity can also be classified according to waist circumference. According to the International Diabetes Foundation (IDF); a Waist circumference of 80 cm or more in women and 94 cm in men is considered a risk group for obesity (13). Centers for Disease Control 2000 (CDC) Based on the Body Mass Index (BMI) percentiles for childhood and adolescence, range 85-95% of the percentile chart as overweight and 95% define them as obese (14). Globally, overweight and obesity is a major public health concern, and there are more overweight or obese than underweight adults. In 2016, 39% of men and 40% of women aged 18 and over, accounting for nearly 2 billion adults, were overweight, and 11% of men and 15% of women, more than half a billion, were obese worldwide. Both overweight and obesity have shown a marked increase over the past four decades (15). The 2005-2006 National Health and Nutrition Examination Survey (NHANES) published that 32.7% of people over the age of 18 in the USA were overweight, 34.3% were obese, and 5.92% were morbidly obese. Due to these reports, it is reported for the first time that the adult obesity population of the USA is more than the overweight adult population (16). In a study conducted in Australia, It was determined that 3.71 million people, corresponding to 17.5% of the population, were obese, revealing that 23.5% of the total adult population and 10.6% of the child population were obese (17). According to Soto's report; obesity has become a worldwide health problem and is also seen with high intensity in Mexico. The prevalence of obesity in Anglo-American children is much higher, particularly in southeastern Mexico. He also stated that the burden of diseases caused by obesity in Mexico had increased significantly in the last 15 years (18). Obesity is among the top 5 causes of death worldwide (19). What enables us to characterize obesity as one of the most important health problems in the world is that it affects not only adults but also children and adolescents (20). Childhood obesity rates vary among countries; its prevalence has increased over the past 40 years. Since 1980, obesity among children has doubled in more than 70 countries and has approximately tripled in some

developing countries (21,22). Recent studies estimate that 80% of the 20-year-old population will be overweight or obese by 2020 (21). The prevalence of obesity in children in Turkey varies between 1.6% (Elazığ) and 8.4% (Antalya Urban), and 7.8% (Bursa). According to a compilation study (Kocaeli, Bursa, Düzce) in the western region of our country, the prevalence of obesity is around 7%. On the other hand, it is between 2-3% in similar studies in the eastern region. This situation is related to the prevalence of the lifestyle that causes obesity in western provinces. In general, it can be said that the prevalence of obesity in our country is similar to the countries in the European region (23).

2.2. Psychological Effects of Obesity

Obesity is a highly visible disease that anyone can evaluate and comment on someone's weight status. People with obesity are thought to be extremely responsible for their condition. The scientific literature consistently shows that overweight people are biased and consequently discriminated against in three key areas of life: education, employment, and health care (7). In 1985, the National Institutes of Health published a report highlighting the importance of the psychological burden of obesity (24).

A study conducted in the United States found that adolescents with obesity had the following risks: A 60% higher risk of being diagnosed with anxiety or depression. A 40% greater risk of having feelings of worthlessness. A 40% greater risk of parental concerns about their child's self-esteem. A 70% greater risk of being told by a healthcare provider that they have behavioral problems. A 30% greater risk of being withdrawn (25). Nonobese children have stated that they would prefer to be friends with a child with a physical disability, such as a missing limb or blindness, than a child with obesity (26). Children with obesity are more likely to suffer from negative or decreased self-esteem or self-image, increased anxiety, sad affect, and symptoms of depression (27). One study found that 42% of children with obesity, met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for a mood disorder and 40% for an anxiety disorder (28). Individuals with obesity often experience low quality of social life or insecurity about their image. This causes them to experience an increased risk of depression, guilt, suicidal thoughts, psychiatric disorders, and body image disorders. In addition, the cortisol hormone, which rises due to stress, affects metabolism, just like in Cushing's Syndrome (29). It is thought that the daily discrimination of individuals with obesity is perceived as a chronic stress factor by the body and may create this effect. Therefore, it

is thought that such discrimination or prejudices increase the severity of obesity much more (30). In scenarios where obesity develops since childhood, these children may be at higher risk for depression and body image disorders as adults (31).

2.3.The Concept of Phobia and Attitude

The etymology of the word phobia is based on the Greek word "phobos", which means escape, panic, fear, and terror. Although the words fear and phobia are used interchangeably, they have different meanings. Horror; is the feeling of anxiety aroused by the thought of serious danger, while a phobia is an unrealistic feeling that emerges as a result of a certain level of pressure. Phobias describe feelings and reactions related to places, situations, objects, and functions, which can be seen in intensity disproportionate to the stimulus shown as the cause, and where the individual cannot prevent avoidance behaviors despite knowing that this exaggerated anxiety response is irrational. In other words, a phobia is an intense fear of a situation or object that does not actually pose a danger. Individuals with a phobia may not only avoid an object or situation but also avoid situations that will remind them of that object or situation (32,33,34).

It can be said that fears and phobias are genetic; people with a specific phobia in their parents have similar phobias, and the discourses of other people and the effect of the environment are effective in the emergence of the phobia (33).

In the psychology literature, it is seen that attitude is defined with different words. For example, Wicker defined attitude by stating that it is a mental and neural readiness, it is organized through experience, and it has a directing effect on individuals' reactions to things and situations they are related to (35). Krech and Champbell defined attitude as a continuous organization of motivational, emotional, perceptual, and cognitive processes related to one's individual world (36). After the 1970s, the attitude was reduced to the words like and dislike.

The attitude was defined as a psychological predisposition showing the degree of liking and disliking when evaluating it (36).

Eiser lists the characteristics of attitude as follows:

- Attitudes are subjective experiences based on inferences that people make from their observations.

- Attitudes are experiences towards some subject or object. That is, attitudes should not be considered merely as emotional reactions. Instead, it should be considered as part of the experience with a topic.
- Attitudes are experiences with an appraisal dimension towards a subject or object. If we have an attitude towards an object, we not only experience it, but we also, to some extent, include our own evaluations.
- Attitudes include judgments made as a result of interpretation.
- Attitudes are expressed through language. Although attitudes can be expressed non-verbally with expressions, verbal expressions have a deeper content.
- Expressing attitudes is a product of intelligence. When other people report their attitudes, we can understand why they act that way and how they feel.
- Attitudes enable communication. Expressions of attitudes are made for others to understand; that is, it is a social act.
- Different individuals may have different approaches to their attitudes. Opinions and attitudes towards an object or subject may differ from person to person.
- Individuals with different attitudes towards an object or concept also differ in their beliefs about whether that object or concept is right or wrong.
- If there are inconsistencies between a person's verbally expressed attitudes and social behaviors, it becomes difficult to understand what this person wants to express, so it can be said that attitudes are related to social behaviors (37).

2.4.Fat Phobia

Fat phobia is the pathological fear of gaining weight, being fat or obese, and having a negative attitude or prejudice towards overweight or individuals with obesity (38). Although many studies have been carried out on this subject and different terms have been used to define fat phobia, it is generally preferred to use the term fat phobia instead of expressing it as prejudice, discrimination, negative attitude, belief, or thought (16). Individuals with fat phobia are generally labeling individuals with obesity as; lazy, weak-willed, unattractive, poor self-control, slow, frail, inactive, selfish, food-loving, out of shape, overeating, anxious, low self-esteem, disorganized, unsuccessful, unmotivated, worthless, lacking in self-confidence, emotional and having body image issues (35). For example, in the study of Puhl et al., it was determined that people with fatphobia think that obesity is related to one's own will, and they hold individuals with obesity responsible

for this situation and engage in more stigmatizing behaviors (36). A similar study revealed that intern health professionals who were overweight themselves understood the reality of being obese better and were not prejudiced (39).

Weight bias has been shown to have major effects on the quality of life of children and adolescents. Exposure to weight bias has been associated with many negative emotional consequences, including depression, anxiety, dislike of one's own body, and increased suicidal thoughts in some individuals. In addition, it has been found that children's bonds with their peers and social environment, academic performance, physical health, and participation in physical activities are negatively affected. Furthermore, it has been reported that this may cause behavioral disorders such as overeating, diet pills, or laxative use (37). Children with obesity may struggle with mood disorders, anxiety, and depression 2.5 times more than their normal-weight peers who do not face fatphobia (40). Studies have shown that fatphobic behaviors among children emerge in early childhood, and children between the ages of 5-10 tend to want to be friends with children in the ideal weight range instead of overweight or children with obesity. It has even been found that even preschool-aged babies are exposed to more negative adjectives than overweight babies (41). In a study of 2516 adolescents, the rate of unhealthy eating behavior for adolescent boys who were teased because of their weight was 27.5%, while this rate was 19.3% for boys who were not mocked. While the rate of unhealthy eating behavior among adolescent women who were teased because of their weight was 18.2%, this rate was 11% among adolescent women who were not mocked (42). In the study of Puhl, Luedicke, and Heuer in two schools, 28% of students in one school and 38% of students in the other school stated that they were teased because of their weight. According to a study conducted in 2013, it was revealed that fatphobic attitudes have effects on children and adults that can lead to psychological disorders, social isolation, academic failure, economic difficulties, and ultimately increased weight gain and disrupted eating habits (43,44). As a result of a study conducted on high school students, it was reported that students exposed to such negative attitudes and behaviors avoided physical activity and going to the gym and also increased their calorie intake (45). According to a recent study, 2/3 of girls and 1/4 of boys reported being bullied by their peers because of their weight. This rate is approximately 60% in children with a high BMI (46). Similarly, in a study of 50 adolescent girls with obesity, all but 2 reported that they had been subjected to nicknames, teasing, or ridicule (47,48).

In the study of Rich et al., it was shown that children show fatphobic attitudes at an early age, and their teachers are effective in this. In a study conducted on teachers and parents in Mexico in 2008, it was revealed that participants with a normal BMI and who thought that self-control was unimportant in losing weight had more negative attitudes towards children with obesity (49). Positive traits such as having more friends or being happy are more appropriate for children with an ideal BMI range, but being more unhealthy and unhappy seems appropriate for children with obesity (50).

In addition, the fatphobic attitude of the children among themselves is also remarkable. In the study by Latner and Stunkard, 6 different drawings were presented to 5th and 6th-grade children. The children ranked 6 drawings of healthy children with or without obesity, various disabilities, and how much they liked each drawing. As a result of the study, it was shown that the children liked the child with obesity's drawing in the last place. Girls liked children with obesity's drawing less than boys. In 2003, children rated healthy children's drawing much higher than the 1961 version of the same study. In 2003, the difference between the scores of a child with obesity and healthy children was 40.8% higher than in 1961 (51). Therefore, it is certain that overweight and children with obesity are exposed to fatphobia by their peers, and this negative attitude will continue throughout their childhood (52).

Children with obesity and overweight children are often less accepted by their peers as playmates and are socially excluded (53). Considering the increasing prevalence of childhood obesity, it is inevitable that this weight-based discrimination and negative behaviors between overweight and children with obesity will increase (54). It was observed that children who reported being bullied by their peers because of their weight had less commitment to school and less willingness to go to school. Since school is perceived as a stressful environment by children with obesity, a decrease in school and course performance is expected. In a study by Puhl, it was reported that children with obesity who reported being exposed to weight discrimination had lower school grades than their peers who were in the ideal BMI range (55). According to a more recent study, children aged 9-11 years were found to be highly fat phobic. This attitude is particularly worrying, considering that one-third of children are in the obese category. In addition, it is suggested that children who are exposed to such stigmatization at this age may show a behavior pattern that leads to unhealthy nutrition in the future (46). It is highly expected and common for the individual to experience pubertal and socio-emotional changes during early adolescence. When social pressure is placed on the adolescent to be thin, the

individual may be expected to obsess over their weight or be ridiculed by their peers (54). It is also the period when children and adolescents have strong desires and expectations for approval from their peers. Being exposed to fatphobia during this period when their social identities are determined makes them very vulnerable. Since this situation has very dangerous consequences for the emotional and social development of the adolescent, its effects become a very important issue (56,57).

The effects of weight phobia increase as age increases in children and adolescents. In a study conducted by Canning on 2000 high school students, when the university applications of high school students were examined, it was seen that the university entrance rate of overweight students with high BMI values was lower despite having the same success (58). According to a study conducted by Grilo on 40 adult women with obesity; it was observed that women who were exposed to fat phobia during childhood or adolescence exhibited more body image disorders, anxiety, binge eating behavior, or unhealthy weight control behaviors as adults (59). This is because obesity in younger age groups is more degrading than in other age groups, and individuals are exposed to more negative and discriminatory attitudes. And people exposed to these negative attitudes at a young age will carry traces of them throughout their lives (60,61).

2.5. Healthy Lifestyle Concept

The whole of the actions that an individual does voluntarily or involuntarily is called behavior, and the whole of actions that he does in the name of health and uses to improve his health is called health behavior. Lifestyle is the set of habits that an individual makes routinely. Lifestyle can sometimes affect the individual positively and sometimes negatively (62). While the individual's being controlled in his behaviors for his own health, arranging his activities accordingly, protecting himself from disease creates a healthy lifestyle, trying to maintain his well-being throughout his life ensures its continuity (63).

2.5.1. Healthy Lifestyle Behaviors

Healthy lifestyle behaviors are activities that people believe and practice to be good to improve their health, minimize diseases, or prevent diseases (64). Improvement of health is not intended to prevent any disease or disorder but to further improve the general health and well-being of the individual (65).

Healthy lifestyle behavior consists of conscious actions aimed at effectively protecting the health of people and others. Since people do not have information about the negativities or healthy options they may face, they may engage in attitudes and actions that deteriorate their health (66). Healthy lifestyle behaviors vary according to the demographic and social status of the individual. While the mortality rate due to lifestyle is 70-80% in developed countries, it is 40-50% in developing countries (67). School is where children spend most of their time and receive their primary education; therefore, school and teachers can influence children's behavior regarding food choices and physical activity (68).

2.5.2.Components of Healthy Lifestyle

It is reported that six factors have a significant effect on healthy lifestyle behaviors or activities (69). These can be listed as follows;

- Health Responsibility
- Self-Realization (Spiritual Development)
- Exercise and Physical Activity
- Interpersonal Relationship
- Stress Management
- Nutrition

2.5.2.1.Health Responsibility

According to Steinbooks, health responsibility is for individuals to exhibit behaviors such as weight control, exercise, and avoiding smoking in order to protect and maintain health, to have health checks on time, to feel better by applying the recommendations of physicians, and to create less health expenses (70). The protective measures taken by the individual for the purpose of protecting her own health, her attitudes and behaviors towards her health, and her interest in health care are under the individual's own health responsibility (71). It is thought that a person who is trying to improve her health also realizes her responsibilities (70).

Health responsibility behaviors are affected by many factors such as cultural habits, health literacy level, health inequality, mental capacity, and social media. It is assumed that individuals are free to choose healthy living behaviors. However, these responsibilities are under the influence of many internal and external factors such as the

actions of individuals, their voluntariness, and what they hear from different people. In terms of individual health responsibility, it is recommended to consider especially internal effects (72).

In general, it has been reported that there are two types of health responsibilities; role and causal responsibility. While role responsibility explains the autonomous decision-making of individuals, the responsibility for causation emphasizes the determination of the choices that occur based on behavior (73).

2.5.2.2. Self Realization

In 2007, self-actualization was defined as an innate human need or tendency to actively use all of her abilities and qualities to develop and realize her potential, and exist in every human being (74). Self-actualization is being exactly what a person can be and want to be. In some individuals, this may take the form of a desire to be a wonderful parent; in another, it may manifest itself as a desire for perfection in athletic abilities, as a painting or an invention (75).

Developing appropriate long-term goals and setting activities accordingly helps one achieve self-actualization (76). The spiritual development of the individual is defined as the "unifying force" that affects his soul and body. In this context, the individual can express himself and please himself in line with his abilities (77). Social environment and family relations are among the factors that affect the spiritual development of the individual (78).

2.5.2.3. Exercise and Physical Activity

It is the concept of fitness that people exercise their muscular functions with their characteristic natural abilities on the way to happiness and health. Fitness is also described as the state of the body to perform physical activities without distress or injury (79).

Exercising is known to provide many benefits. The most important of these are listed as providing muscle strength, joint range, flexibility, coordination, and weight control at all ages, while the other benefits can be expressed as making people feel better, improving personal control, and increasing socialization. It is also known that regular physical activity has many positive effects on cardiovascular, musculoskeletal, metabolic, hormonal systems, and psychological functions (80,81).

2.5.2.4. Interpersonal Relationship

The term interpersonal relations, which covers all kinds of communication that cause the individual to interact with others, includes the elements of emotion, thought, behavior, and reciprocity (82). Fiske and Taylor reported that in the study of interpersonal relations on the scale of social psychology approaches, the individual is evaluated both as a phenomenon in terms of processes within himself and as an interpersonal phenomenon in terms of social networks. In other words, the person states that he or she is seen as an influencing and affected factor (83).

The mother-child, husband-wife, and teacher-student relationships that individuals establish throughout their lives, as well as the relationships of friends, relatives, and colleagues, help us to understand interpersonal relationship support. For society to be happy and productive, these support systems must continue successfully. A person's personality and behaviors are shaped by these relationships (84).

Every social structure, Along with its own social network, cultural and historical background, it affects the perception of the other in the relationship as well as the self-perception of the individual, thus enabling interpersonal relations to take shape. The individual is affected in a normative way, such as conforming to gain the approval of the group or community to which she belongs, not being excluded, or remaining in conflict. At the same time, it gains a social identity by being influenced by the sharing of useful and compulsory information as a reflection of the harmony shown. Thus, according to the social model where there is life, the individual can adjust herself and take shape in relationships (85).

2.5.2.5. Stress Management

In cases where coping skills are not used appropriately, the process of perceiving possible situations in the internal and external environments as a threat, war, or danger is called stress (86). Stress can always be experienced while working, thinking, writing, or reading a book; it is not just caused by anxiety and worry. The individual can be exposed to stress while resting. Because the heart pumps blood in the resting state, the brain works, the lungs are filled with air, bodily functions work continuously even in inactivity, the mind is active when awake, and things are constantly being thought about (87).

Since people's reactions when exposed to various stressors will vary according to their socio-demographic characteristics, The methods of coping with stress will differ

accordingly. Getting away from stress sources, various relaxation techniques, exercises, socializing and physical activities help in coping with stress (88).

Not paying attention to one's self-care and not prioritizing their health indicates that the person is under stress. Behaviors similar to these also affect health negatively, making the body vulnerable to possible diseases (89).

2.5.2.6.Nutrition

Nutrition is the activities carried out to maintain vital functions and make life happy, as well as consuming the nutrients that the individual needs for growth and development. The right to food is included in the National Human Rights documents (90). Nutrition is essential for growth, survival, and proper maintenance of health. For individuals and society to live happily, peacefully, and in prosperity, it is indispensable to acquire appropriate and high-quality dietary habits (91).

Bozhüyük et al. grouped a healthy and balanced diet under four main headings: getting from every food group, getting every nutrient needed by the body according to need, consuming different foods, and avoiding unhealthy foods (76).

Nutrition includes the main factors such as the number of meals, the types of foods that people consume in main and snack meals and their portions, the way they provide nutrients, their cooking habits, as well as whether individuals eat slowly or quickly, chewing times, tired, sad or happy. While it is a process that covers many details, such as food consumption preferences and consuming hot or cold foods. In addition to these, it is known that details such as education levels, income levels, nutritional knowledge, the environment, and traditions of individuals also affect their eating habits (92).

It is known that chronic diseases are seen at a high rate in unbalanced and malnourished societies, and in addition to this, the emerging infectious diseases increase, and these diseases that are exposed can result in death even though they are severe (93). Communities and individuals need to become conscious in order to protect and maintain their health. For this reason, it is very important for people and institutions that can be effective on the health of societies, provide education and direct them, and have sufficient knowledge about nutrition (94).

3. MATERIAL AND METHODS

This study was conducted in Bursa Private Emine Örnek Educational Institutions, and the ethics committee approval of the study was received from Yeditepe University Non-Interventional Clinical Research Ethics Committee on 13.08.2021.

The sample of the study consists of 200 teachers who give education to the age range of 7-17 in Bursa Private Emine Örnek Educational Institutions. In this study, in which the data were collected between 01.10.2021 and 30.11.2021, 137 teachers out of a total of 200 volunteered to participate in the study. One of the 137 teachers was excluded from the study because they dropped out during our study. Thus, our total number of volunteers became 136. 89% (n=121) of the participants were women and 11% (n=15) were men. The ages of the individuals ranged from 18 to 57 years, with an average of 37.31 ± 8.47 years.

Teachers' fat phobia levels were determined by the Fat phobia Scale developed by Rabinson, Bacon, and O'Reilly, abbreviated and revised by Bacon et al., and adapted into Turkish by Koçak et al.(5,38). It consists of 14 pairs of adjectives used to describe overweight people presented in the form of a list, and the grading of the items is made according to the 5-point rating system. Numbers close to 5 characterize a high-fat phobic attitude, and numbers close to 1 characterize a low-fat phobic attitude. Evaluation in the fat phobia scale is made by dividing the total score from 14 items by 14. According to the score obtained; 2.5 and below means neutral or positive fatphobia; 2.5-3.6 corresponds to low negative fat phobia; A score of 3.6-4.4 means moderate negative fat phobia, and finally 4.4 and above mean high negative fatphobia. The Test-Retest analysis result of the short form of the scale adapted by Koçak et al. was found to be 0.82 (95).

The Healthy Lifestyle Behaviors Scale-II used in the study was designed by Walker, Sechrist, and Pender in 1987; In 1996, Walker was adapted by Hill Polerecky and renamed HLBS II (96,97). The validity and reliability research of the scale in Turkey was conducted by Bahar et al. in 2008 (98). While measuring the health-promoting behaviors of the person related to a healthy lifestyle, the overall score of the scale gives the healthy lifestyle behaviors score. The scale consists of 52 items and six subgroups (health responsibility, physical activity, nutrition, spiritual development, interpersonal relationship, and stress management). With all the items of the Health Promoting Lifestyle Profile Scale (HPLPS II) being positive, the marking is a 4-point Likert type. A score of 1 is given for the "never" answer, 2 for the "sometimes" answer, 3 for the "often"

answer, and 4 for the "regularly" answer. The lowest total score on the scale is 52, and the highest score is 208. The Cronbach's alpha coefficient of the scale is ninety-two. BMI values were calculated with the height and weight data entered by the participants, and BMI values of 18.5 kg/m² and below were evaluated as underweight; While BMIs between 18.5-24.9 kg/m² are considered normal; Those between 25.0-29.9 kg/m² were considered overweight, those who were 30 kg/m² and above were considered obese (96). In the online surveys, the participants were provided with their own smartphones. The first part of this online questionnaire created with onlineanketler.com has questioned whether the participant's participation in the study was voluntary and whether non-volunteers were excluded from the study sample. Afterward, in the second part of the questionnaire, demographic questions such as sex, age, marital status, level of education to students, branch, years of occupation, height, weight, health status rating, and whether they have children were directed to the 136 volunteer participants. Fat phobia and healthy living behaviors scales were applied in the third and fourth parts of the questionnaire. NCSS (Number Cruncher Statistical System) 2007 (Kaysville, Utah, USA) program was used for statistical analysis. Descriptive statistical methods (mean, standard deviation, median, frequency, percentage, minimum, maximum) were used while evaluating the study data. The conformity of the quantitative data to the normal distribution was tested with the Shapiro-Wilk test and graphical examinations. Independent groups t-test was used for comparisons between two groups of normally distributed quantitative variables. Repeated measures analysis of variance was used for within-group comparisons of normally distributed quantitative variables, and Bonferroni-corrected pairwise evaluations were used for pairwise comparisons. Fisher's Exact Test and Fisher-Freeman-Halton exact test were used to compare qualitative data. Pearson correlation analysis and Spearman correlation analysis were used to evaluating the relationships between quantitative variables. Statistical significance was accepted as $p < 0.05$.

4. RESULTS

The study was conducted between 01.10.2021 and 30.11.2021 in Bursa Private Emine Örnek Educational Institutions with a total of 136 participants, 89% (n=121) women and 11% (n=15) men. The ages of the individuals ranged from 18 to 57 years, with an average of 37.31 ± 8.47 years.

71.3% (n=97) of the participants are married.

When the class levels of the students that the participants were teaching were examined, the distribution was as follows: 22.1% of them were in kindergarten (n=30), 30.9% of them were in primary, and 17.6% were in middle school and 33.8% were high school level students.

Branch distribution of the participants are, 2.2% (n=3) Physical Education, 1.5% (n=2) Information Technologies, 11.8% Foreign Language, 2.9% (n=4) Philosophy, 4.4% (n=6) Science, 1.5% (n=2) Visual Arts, 8.1% (n=11) Mathematics, 8.1% of (n=11) are teachers of vocational knowledge, 1.5% (n=2) Music, 11.8% (n=16) Pre-School Education, 8.1% (n=11) Special Education, 6.6% (n=9) PCG, 23.5% (n=32) Primary school Teaching, 1.5% (n=2) Social Studies, 2.2% (n=3) Technology and Design, % 4.4 of them (n=6) are Turkish Language and Literature.

The profession years of the teachers participating in the research ranged from 1 to 36 years, with an average of 13.95 ± 8.28 years. The height of the participants varied between 1.5 m and 1.9 m, and the average height was determined as 1.66 ± 0.07 m. The weight of the teachers participating in the study ranged from 40 to 106 kg, and the average weight was determined as 67.23 ± 11.56 kg. The BMI values of the participants in the study ranged from 16 to 34 kg/m^2 , and the average BMI value was found to be $23.90 \pm 3.54 \text{ kg/m}^2$. 5.1% (n=7) of the participants were underweight, 56.6% (n=77) were normal weight, 29.4% (n=40) were overweight, 8.8% (n=12) is obese.

The participant's scores for rating their own health status ranged from 1 to 10, and the average score was determined as 7.57 ± 1.61 . 64% (n=87) of the participants have children (Table 4.1).

Table 4.1 Distribution of Descriptive Features

		n	(%)
Sex	Women	121	(89.0)
	Men	15	(11.0)
Marital status	Single	39	(28.7)
	Married	97	(71.3)
*Grade Level	Kindergarten	30	(22.1)
	Primary school	42	(30.9)
	Middle school	24	(17.6)
	High school	46	(33.8)
Branch	Physical education	3	(2.2)
	Information technologies	2	(1.5)
	Foreign language	16	(11.8)
	Philosophy	4	(2.9)
	Science	6	(4.4)
	Visual arts	2	(1.5)
	Mathematics	11	(8.1)
	Vocational knowledge	11	(8.1)
	Music	2	(1.5)
	Pre-school education	16	(11.8)
	Special education	11	(8.1)
	Psychological counseling and guidance service	9	(6.6)
	Primary school teacher	32	(23.5)
	Social studies	2	(1.5)
	Technology design	3	(2.2)
	Turkish language and literature	6	(4.4)
Presence of children	Having no children	49	(36.0)
	Having children	87	(64.0)
BMI	Underweight	7	5.1
	Normal	77	56.6
	Overweight	40	29.4
	Obese	12	8.8
		<i>Mean±SD</i>	<i>Range (min-max)</i>
Age		37.31± 8.47	18-57
Grading own health status		7.57±1.61	1-10
BMI		23.90±3.54	16-34

*More than one option is marked.

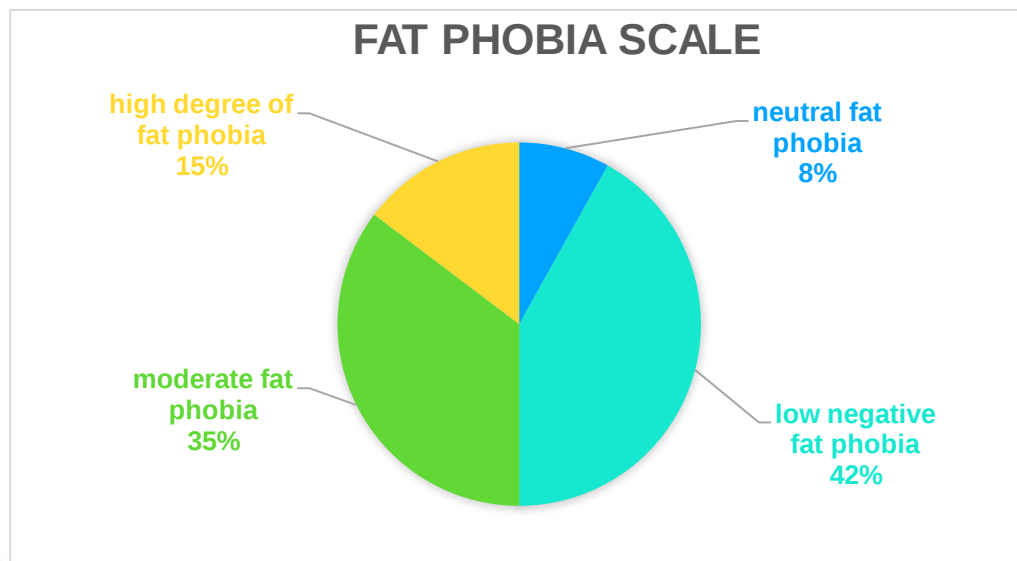


Figure 4.1 Distribution of participants' fat phobia levels

Neutral fat phobia in 8.1% (n=11), low negative fat phobia in 41.9% (n=57), moderate negative fat phobia in 35.3% (n=48), 14.7% (n=20) had a high degree of fat phobia. (Figure 4.1).

As the distribution of responses given to Fat Phobia Scale's 14 different adjective pairs seen in Table 4.2. the most chosen ones to adjective pairs between 1-5 points are as follows; in industrious/lazy option 57 of participants marked 3 point, in has willpower/no willpower option 43 of participants marked 5 point, in attractive/unattractive option 49 of participants selected 1 point, in good self-control/poor self-control option 41 of participants marked 2 point, in fast/slow option 46 of participants chose 1 point, in having endurance/no endurance option 43 of participants selected 3 point, in active/inactive option 51 of participants selected 1 point, in strong/weak option 54 of participants chose 3 point, in self-sacrificing/self-indulgent option 74 of participants marked 3 point, in dislikes food/likes food option 88 of them selected 1 point, in shapely/shapeless option 44 of them selected 3 point, in undereats/overeats option 79 of participants marked 1 point, in secure/insecure option 50 of them selected 3 point and finally, in high self-control/low self-control option 52 of them marked 3 point. (Table 4.2).

On the other hand; the least chosen ones to adjective pairs between 1-5 points are as follows; in industrious/lazy option 14 of participants marked 2 point, in has willpower/no willpower option 9 of participants marked 2 point, in attractive/unattractive option 7 of participants selected 5 point, in good self-control/poor self-control option 8

of participants marked 5 point, in fast/slow option 10 of participants chose 5 point, in having endurance/no endurance option 14 of participants selected 5 point, in active/inactive option 8 of participants selected 5 point, in strong/weak option 13 of participants chose 1 point, in self-sacrificing/self-indulgent option 8 of participants marked 5 point, in dislikes food/likes food option 6 of them selected 4 point, in shapely/shapeless option 11 of them selected 1 point, in undereats/overeats option 4 of participants marked 4 point and 4 of participants marked 5 point, in secure/insecure option 11 of them selected 1 point and finally, in high self-control/low self-control option 13 of them marked 1 point. (Table 4.2).

Table 4.2 Distribution of Responses to Fat Phobia Scale Questions

	5	4	3	2	1	
	n (%)	n (%)	n (%)	n (%)	n (%)	
Lazy	27(19.9)	22(16.2)	57(41.9)	14(10.3)	16 (11.8)	Industrious
No will power	43(31.6)	38(27.9)	35(25.7)	9 (6.6)	11 (8.1)	Has will power
Attractive	7 (5.1)	10 (7.4)	35(25.7)	35(25.7)	49 (36.0)	Unattractive
Good self-control	8 (5.9)	15(11.0)	34(25.0)	41(30.1)	38 (27.9)	Poor self-control
Fast	10 (7.4)	12 (8.8)	29(21.3)	39(28.7)	46 (33.8)	Slow
Having Endurance	14(10.3)	16(11.8)	43(31.6)	36(26.5)	27 (19.9)	Having no endurance
Active	8 (5.9)	10 (7.4)	24(17.6)	43(31.6)	51 (37.5)	Inactive
Weak	27(19.9)	25(18.4)	54(39.7)	17(12.5)	13 (9.6)	Strong
Self-indulgent	8 (5.9)	11 (8.1)	74(54.4)	17(12.5)	26 (19.1)	Self-sacrificing
Dislikes food	8 (5.9)	6 (4.4)	10 (7.4)	24(17.6)	88 (64.7)	Likes food
Shapeless	38(27.9)	24(17.6)	44(32.4)	19(14.0)	11 (8.1)	Shapely
Undereats	4 (2.9)	4 (2.9)	22(16.2)	27(19.9)	79 (58.1)	Overeats
Insecure	31(22.8)	28(20.6)	50(36.8)	16(11.8)	11 (8.1)	Secure
Low self-esteem	31(22.8)	25(18.4)	52(38.2)	15(11.0)	13 (9.6)	High self-esteem

91.9% (n=125) of the participants in the study have fat phobia. (Table 4.3).

The total scores of the participants in the Fat Phobia Scale ranged from 1.6 to 5 points, and the average score was determined as 3.57 ± 0.72 .

Neutral fat phobia in 8.1% (n=11), low negative fat phobia in 41.9% (n=57), moderate negative fat phobia in 35.3% (n=48), 14.7% (n=20) had a high degree of fat phobia. 91.9% (n=125) of the participants in the study have fat phobia.

The Cronbach's alpha value for the total of the fat phobia Scale was found to be 0.868; accordingly, our scale is highly reliable. (Table 4.3).

Table 4.2 Distribution of Fat Phobia Scale Scores and Groups

	Fat Phobia Scale Total Score
Number of questions	14
Mean±SD	3.57±0.72
Min-Max	1.6-5
Fat Phobia Scale Groups	n (%)
neutral fat phobia ($\leq 2,5$ points)	11 (8.1)
low negative fat phobia (2,5-3,6 points)	57 (41.9)
moderate negative fat phobia (3,4-4,4 points)	48 (35.3)
high degree of fat phobia ($\geq 4,4$ points)	20 (14.7)
Presence of fat phobia	
Fat phobia	11 (8.1)
No fat phobia	125 (91.9)

The distribution of the answers given by the participants to the Health Promoting Lifestyle Profile Scale questions is shown in Table 4.4.

Table 4.3 Distribution of Responses to the Questions on The Health Promoting Lifestyle Profile Scale

	Never	Sometimes	Often	Routinely
	n(%)	n(%)	n(%)	n(%)
Discuss my problems and concerns with people close to me.	3 (2.2)	38 (27.9)	72 (52.9)	23 (16.9)
Choose a diet low in fat, saturated fat, and cholesterol.	16 (11.8)	65 (47.8)	30 (22.1)	25 (18.4)
Report any unusual signs or symptoms to a physician or other health professional.	6 (4,4)	62 (45,6)	42 (30,9)	26 (19,1)
Follow a planned exercise program.	44 (32,4)	64 (47,1)	14 (10,3)	14 (10,3)
Get enough sleep.	8 (5,9)	49 (36,0)	48 (35,3)	31 (22,8)
Feel I am growing and changing in positive ways	3 (2,2)	49 (36,0)	59 (43,4)	25 (18,4)

Praise other people easily for their achievements	1 (0,7)	10 (7,4)	64 (47,1)	61 (44,9)
Limit use of sugars and food containing sugar	27 (19,9)	66 (48,5)	29 (21,3)	14 (10,3)
Read or watch TV programs about improving health.	25 (18,4)	75 (55,1)	24 (17,6)	12 (8,8)
Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber).	26 (19,1)	64 (47,1)	26 (19,1)	20 (14,7)
Take some time for relaxation each day.	20 (14,7)	66 (48,5)	24 (17,6)	26 (19,1)
Believe that my life has purpose	6 (4,4)	18 (13,2)	57 (41,9)	55 (40,4)
Maintain meaningful and fulfilling relationships with others.	1 (0,7)	23 (16,9)	65 (47,8)	47 (34,6)
Eat 6-11 servings of bread, cereal, rice and pasta each day	61 (44,9)	44 (32,4)	20 (14,7)	11 (8,1)
Question health professionals in order to understand their instructions.	9 (6,6)	54 (39,7)	56 (41,2)	17 (12,5)
Take part in light to moderate physical activity (such as sustained walking 30-40 minutes 5 or more times a week).	29 (21,3)	57 (41,9)	31 (22,8)	19 (14,0)
Accept those things in my life which I can not change.	12 (8,8)	62 (45,6)	44 (32,4)	18 (13,2)
Look forward to the future.	6 (4,4)	46 (33,8)	44 (32,4)	40 (29,4)
Spend time with close friends.	2 (1,5)	25 (18,4)	62 (45,6)	47 (34,6)
Eat 2-4 servings of fruit each day.	29 (21,3)	62 (45,6)	22 (16,2)	23 (16,9)
Get a second opinion when I question my health care provider's advice.	21 (15,4)	72 (52,9)	29 (21,3)	14 (10,3)
Take part in leisure-time (recreational) physical activities (such as swimming, dancing, bicycling).	33 (24,3)	72 (52,9)	19 (14)	12 (8,8)
I discuss my concerns and problems with people close to me.	23 (16,9)	63 (46,3)	40 (29,4)	10 (7,4)
Concentrate on pleasant thoughts at bedtime.	27 (19,9)	61 (44,9)	30 (22,1)	18 (13,2)
Feel content and at peace with myself	10 (7,4)	48 (35,3)	54 (39,7)	24 (17,6)
Find it easy to show concern, love and warmth to others.	6 (4,4)	63 (46,3)	62 (45,6)	5 (3,7)
Eat 3-5 servings of vegetables each day.	6 (4,4)	24 (17,6)	66 (48,5)	40 (29,4)
Discuss my health concerns with health professionals	25 (18,4)	68 (50,0)	39 (28,7)	4 (2,9)
Do stretching exercises at least 3 times per week.	2 (1,5)	23 (16,9)	66 (48,5)	45 (33,1)
Use specific methods to control my stress.	22 (16,2)	72 (52,9)	37 (27,2)	5 (3,7)
Work toward long-term goals in my life.	17 (12,5)	46 (33,8)	56 (41,2)	17 (12,5)
Touch and am touched by people I care about.	25 (18,4)	60 (44,1)	35 (25,7)	16 (11,8)
Eat 2-3 servings of milk, yogurt or cheese each day.	10 (7,4)	45 (33,1)	55 (40,4)	26 (19,1)
Inspect my body at least monthly for physical changes/danger signs.	11 (8,1)	44 (32,4)	53 (39,0)	28 (20,6)
Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parking car away from destination and walking).	22 (16,2)	61 (44,9)	45 (33,1)	8 (5,9)
Balance time between work and play.	13 (9,6)	42 (30,9)	47 (34,6)	34 (25,0)
Find each day interesting and challenging.	10 (7,4)	46 (33,8)	55 (40,4)	25 (18,4)
Find ways to meet my needs for intimacy.	9 (6,6)	56 (41,2)	45 (33,1)	26 (19,1)
Eat only 2-3 servings from the meat, poultry, fish, dried beans, eggs, and nuts group each day	24 (17,6)	52 (38,2)	45 (33,1)	15 (11,0)
Ask for information from health professionals about how to	42 (30,9)	57 (41,9)	28 (20,6)	9 (6,6)

take good care of myself.				
Check my pulse rate when exercising.	36 (26,5)	57 (41,9)	33 (24,3)	10 (7,4)
Practice relaxation or meditation for 15-20 minutes daily.	20 (14,7)	57 (41,9)	39 (28,7)	20 (14,7)
Am aware of what is important to me in life.	23 (16,9)	51 (37,5)	38 (27,9)	24 (17,6)
Get support from a network of caring people	22 (16,2)	62 (45,6)	28 (20,6)	24 (17,6)
Read labels to identify nutrients, fats, and sodium content in packaged food.	53 (39,0)	62 (45,6)	18 (13,2)	3 (2,2)
Attend educational programs on personal health care.	20 (14,7)	69 (50,7)	43 (31,6)	4 (2,9)
Reach my target heart rate when exercising.	19 (14,0)	49 (36,0)	35 (25,7)	33 (24,3)
Pace myself to prevent tiredness	2 (1,5)	42 (30,9)	56 (41,2)	36 (26,5)
Feel connected with some force greater than myself.	4 (2,9)	51 (37,5)	43 (31,6)	38 (27,9)
Settle conflicts with others through discussion and compromise	21 (15,4)	60 (44,1)	24 (17,6)	31 (22,8)
Eat breakfast.	11 (8,1)	47 (34,6)	54 (39,7)	24 (17,6)
Seek guidance or counseling when necessary.	15 (11,0)	40 (29,4)	47 (34,6)	34 (25,0)
Expose myself to new experiences and challenges.	3 (2,2)	38 (27,9)	72 (52,9)	23 (16,9)

The scores of the participants in the Health Promoting Lifestyle Profile Scale, "Health Responsibilities" subscale ranged from 15 to 32 points, with an average score of 22.27 ± 3.01 ; The scores they got from the "Exercise" subscale ranged from 9 to 29 points, with the mean score being 17.81 ± 3.70 ; The scores they got from the "Nutrition" subscale ranged from 14 to 30 points, with the mean score being 21.18 ± 3.22 ; The scores they received from the "Self-realization" subscale ranged from 15 to 32 points, with an average score of 24.17 ± 3.12 ; The scores they got from the "Interpersonal relationship" subscale ranged from 19 to 34 points, with an average score of 25.72 ± 2.97 ; The scores they received from the "Stress Management" subscale ranged from 15 to 27 points, and the average score was determined as 20.10 ± 2.76 . (Table 4.5).

When the average scores of the participants from the Health Promoting Lifestyle Profile Scale were examined according to the subscale, the average of the scores obtained from the Interpersonal Relationship subscale was found to be the highest at 25.72, and the mean of the scores obtained from the Physical Activity sub-dimension was the lowest with 17.81. (Table 4.5).

The total scores of the participants on the Health Promoting Lifestyle Profile Scale ranged from 109 to 159, with the mean score being 131.25 ± 10.88 . The Cronbach's alpha

value for the Total Health Promoting Lifestyle Profile Scale was found to be 0.676; Accordingly, our scale is quite reliable. (Table 4.5).

Table 4.4 Evaluation of the Subscale of the Health Promoting Lifestyle Profile Scale and the Scale's Internal Consistency

	Number of questions	Mean±SD	Min-Max
Health responsibilities	9	22.27±.01	15-32
Exercise	8	17.81±3.70	9-29
Nutrition	9	21.18±3.22	14-30
Self-realization	9	24.17±3.12	15-32
Interpersonal relationship	9	25.72±2.97	19-34
Stress management	8	20.10±2.76	15-27
Total	52	131.25±10.88	109-159

The scores of the women participating in the study on the Fat phobia Scale range from 1.6 to 5 points, with an average score of 3.59 ± 0.71 , and the scores of the males participating in the study on the Fat phobia Scale range from 1.9 to 4.5 points. It was determined as 3.38 ± 0.74 . (Table 4.6).

The scores of the kindergarten teachers who participated in the study on the Fat phobia Scale ranged from 2.3 to 4.7 points, the average score was 3.47 ± 0.61 , and the scores of the primary school teachers on the Fat phobia Scale ranged from 1.6 to 5 points. The scores of the middle school teachers on the Fat phobia Scale range from 3 to 4.9 points, the average score is 3.81 ± 0.58 , and the scores of the high school teachers on the Fat phobia Scale are between 1.8 and 4 points. It varies between .9 points and the mean score was determined as 3.45 ± 0.77 . (Table 4.6).

The scores of the participants with a BMI in the "underweight" category ranged from 2.3 to 4.4, with an average score of 3.64 ± 0.69 , while the scores of the participants in the "normal weight" category received between 1.6 and 5 points. The average score of the participants in the "overweight" category is between 2.3 and 4.9, the mean score is 3.56 ± 0.77 , and the mean score is 3.64 ± 0.58 . The scores of the participants whose values were in the "obese" category ranged between 1.9 and 4.9, and the average score was determined as 3.37 ± 0.81 . (Table 4.6).

Fat phobia scores do not show a statistically significant difference according to their gender, education level, and BMI levels ($p>0.05$). (Table 4.6).

Table 4.5 Evaluation of Fat Phobia scores according to descriptive features

		Fat phobia scores		p
		Mean±SD	Min-Maks	
Sex	Women	3.59±0.71	1.6-5	^a 0.270
	Men	3.38±0.74	1.9-4.5	
*Grade level	Kindergarten	3.47±0.61	2.3-4.7	^a 0.410
	Primary school	3.60±0.77	1.6-5	^a 0.709
	Middle school	3.81±0.58	3-4.9	^a 0.067
	High school	3.45±0.77	1.8-4.9	^a 0.156
BMI	Underweight	3.64±0.69	3.8 (2.3-4.4)	^b 0.711
	Normal	3.56±0.77	3.6 (1.6-5)	
	Overweight	3.64±0.58	3.7 (2.3-4.9)	
	Obese	3.37±0.81	3.3 (1.9-4.9)	

^aStudent T Test; ^bOneway ANOVA Test; *more than one option ticked

No statistically significant correlation was found between the age and years in the profession and the fat phobia scores of the cases ($p>0.05$). (Table 4.7).

Table 4.6 Evaluation of Fat Phobia scores according to descriptive features

		Fat phobia scores	
		Min-Max	
Age	$r^{\dagger}$	-0,021	
	p	0.804	
Year of profession	$r^{\ddagger}$	-0,012	
	p	0.892	

[†]Pearson correlation analysis; [‡]Spearman analysis

There is no statistically significant difference in fat phobia levels according to the participants' gender, age, education level, years in the profession, and BMI levels ($p>0.05$). (Table 4.8).

Table 4.7 Evaluation of Descriptive Characteristics According to Fat Phobia Levels

		Fat Phobia				
		Neutral (n=11)	Low negative (n=57)	Moderate negative (n=48)	Highly negative (n=20)	p
Sex	Women	10 (8.3)	47 (38.8)	45 (37.2)	19 (15.7)	ª0.268
	Men	1 (6.7)	10 (66.7)	3 (20.0)	1 (6.7)	
Grade level	Kindergarten	2 (6.7)	14 (46.7)	12 (40)	2 (6.7)	ª0.548
	Primary school	4 (9.5)	15 (35.7)	16 (38.1)	7 (16.7)	
	Middle school	0 (0)	10 (41.7)	9 (37.5)	5 (20.8)	
	High school	5 (10.9)	22 (47.8)	12 (26.1)	7 (15.2)	
BMI	Underweight	1 (14.3)	2 (28.6)	3 (42.9)	1 (14.3)	ª0.531
	Normal	6 (7.8)	31 (40.3)	26 (33.8)	14 (18.2)	
	Overweight	2 (5.0)	18 (45.0)	17 (42.5)	3 (7.5)	
	Obese	2 (16.7)	6 (50.0)	2 (16.7)	2 (16.7)	
Mean±SD						
Age		39.64±8.24	37.37±9.19	36.75±8.35	37.20±6.95	ª0.600
Year of profession		17.36±6.27	13.96±9.23	13.33±7.93	13.50±7.23	ª0.317
BMI		23.45±4.68	24.37±3.33	23.65±3.42	23.4±3.83	ª0.531

^aFisher Freeman Halton Test; ^bKruskal Wallis Test; *More than one option ticked

According to their gender, the scores of the participants from the Health Promoting Lifestyle Profile Scale "Health Responsibility", "Exercise", "Nutrition", "Self-Realization", "Interpersonal relationship", "Stress Management" subscales and the Total Health Promoting Lifestyle Profile Scale were statistically does not show a significant difference ($p>0.05$). (Table 4.9).

According to the status of giving education in kindergarten, the scale of Health Promoting Lifestyle Profile Scale, "Health Responsibility", "Exercise", "Nutrition", "Self-Realization", "Interpersonal relationship", "Stress Management" subscales and the

sum of the Health Promoting Lifestyle Profile Scale scores do not differ statistically significantly ($p>0.05$). (Table 4.9).

According to the status of primary school education, the Health Promoting Lifestyle Profile Scale consisted of the subscales of "Health Responsibility", "Exercise", "Nutrition", "Self-Realization", "Interpersonal relationship", "Stress Management" and the sum of the Healthy Lifestyle Behaviors Health Promoting Lifestyle Profile Scale scores do not differ statistically significantly ($p>0.05$). (Table 4.9).

The scores of the middle school teachers participating in the research from the Health Promoting Lifestyle Profile Scale "Health Responsibility", "Physical Activity", "Nutrition", "Interpersonal Relationship", "Stress Management" sub-dimensions and the Total Health Promoting Lifestyle Profile Scale do not show a statistically significant difference ($p>0.05$). (Table 4.9).

The scores of the high school teachers participating in the research from the Health Promoting Lifestyle Profile Scale "Health Responsibility", "Physical Activity", "Nutrition", "Interpersonal Relationship", "Stress Management" sub-dimensions and the Total Health Promoting Lifestyle Profile Scale do not show a statistically significant difference ($p>0.05$). (Table 4.9).

According to BMI levels, the scores of the participants from the Health Promoting Lifestyle Profile Scale "Health Responsibility", "Physical Activity", "Nutrition", "Interpersonal Relationship", "Stress Management" sub-dimensions and the Total Health Promoting Lifestyle Profile Scale do not show a statistically significant difference. ($p>0.05$). (Table 4.9).

Table 4.8 Evaluation of Health Promoting Lifestyle Profile Scale Total Scores According to Descriptive Characteristics

Health Promoting Lifestyle Profile Scale Total				
				Significance
		Mean $\pm$ SD	Min.-Max.	p
Sex	Women	131.53 $\pm$ 10.67	109-159	^b 0.398
	Men	129.00 $\pm$ 12.59	111-150	
Kindergarten	No	131.55 $\pm$ 10.98	109-159	^b 0.551
	Yes	130.20 $\pm$ 10.63	109-158	
Primary school	No	131 $\pm$ 10.52	109-159	^b 0.690
	Yes	131.81 $\pm$ 11.76	109-156	
Middle school	No	130.56 $\pm$ 10.68	109-158	^b 0.112
	Yes	134.46 $\pm$ 11.45	117-159	
High school	No	131.91 $\pm$ 11.47	109-159	^b 0.323
	Yes	129.96 $\pm$ 9.59	112-151	
BMI	Underweight	124.14 $\pm$ 10.09	109-139	^a 0.340
	Normal	132.27 $\pm$ 10.18	110-159	
	Overweight	130.43 $\pm$ 11.50	110-158	
	Obese	131.58 $\pm$ 13.04	109-151	

^aKruskal Wallis Test; ^bStudent T Test; * $p < 0.05$

Between the ages of the participants in the study and the scores they got from the Health Promoting Lifestyle Profile Scale's "Health Responsibility", "Exercise", "Nutrition", "Self-Realization", "Interpersonal relationship", "Stress Management" subscales and the Total score has no statistically significant relationship ($p>0.05$). (Table 4.10).

The years of the study participants in the profession and the scores they got from the Health Promoting Lifestyle Profile Scale's "Health Responsibility", "Exercise", "Nutrition", "Self-Realization", "Interpersonal relationship", "Stress Management" subscales and the Health Promoting Lifestyle Profile Scale total no statistically significant relationship was found between the two ($p>0.05$). (Table 4.10).

The BMI measurements of the participants in the study and the scores they got from the Health Promoting Lifestyle Profile Scale "Health Responsibility", "Exercise", "Nutrition", "Self-Realization", "Interpersonal relationship", "Stress Management" subscales and the Health Promoting Lifestyle Profile Scale total has no statistically significant relationship between them ($p>0.05$). (Table 4.10).

Table 4.9 The Relationship between Age, Year of Profession, BMI, and Health Promoting Lifestyle Profile Scale Scores

	Age		Year of profession		BMI	
	$r^{\ddagger}$	p	$r^{\ddagger}$	p	$r^{\ddagger}$	p
Health responsibilities	0.041	0.640	0.002	0.984	-0.023	0.790
Exercise	0.033	0.700	0.010	0.908	0.070	0.416
Nutrition	0.153	0.076	0.161	0.061	0.076	0.377
Self-realization	0.057	0.509	0.106	0.218	-0.032	0.712
Interpersonal relationship	- 0.039	0.650	-0.027	0.752	-0.144	0.095
Stress management	0.082	0.341	0.089	0.303	-0.034	0.696
Total	0.094	0.274	0.114	0.186	-0.017	0.846

‡ Pearson correlation coefficient; ‡ Spearman correlation coefficient

A statistically significant and weak correlation was found between the scores of the participants on the total Fat phobia Scale and the scores they got from the Health Promoting Lifestyle Profile Scale "Self-realization" subscale ($r=0.209$; $p=0.015$; $p<0.05$). (Table 4.11).

The scores of the teachers participating in the study from the Total Fat phobia Scale and the scores they got from the Health Promoting Lifestyle Profile Scale from the "Health Responsibility", "Exercise", "Nutrition", "Interpersonal relationship", "Stress Management" subscales and the Health Promoting Lifestyle Profile Scale' total score has no statistically significant relationship ($p>0.05$). (Table 4.11).

Table 4.10 The Relationship Between Fat Phobia and Health Promoting Lifestyle Profile Scale Scores

	Fat phobia Total score	
	$r^{\ddagger}$	p
Health responsibilities	-0.030	0.726
Exercise	-0.064	0.457
Nutrition	-0.151	0.079
Self-realization	0.209	0.015*
Interpersonal relationship	0.045	0.605
Stress management	-0.120	0.166
Total	-0.033	0.701

$\ddagger$ Pearson Correlation Coefficient; * $p<0.05$

When the gender distribution of the participants was examined according to the presence of fat phobia, 90.9% of the participants without fat phobia ($n=11$) were women, while 9.1% were men. While 88.8% of the participants with fat phobia ($n=125$) were women, 11.2% were men. (Table 4.12).

When the age distribution of the participants according to the presence of fat phobia was examined, the ages of the participants ($n=11$) without fat phobia ranged from 25 to 56, with a mean age of 39.64 ± 8.24 . The ages of the participants with fat phobia ($n=125$) ranged from 18 to 57, and the mean age was 37.10 ± 8.49 . (Table 4.12).

When the years of occupation of the participants according to the presence of fat phobia were examined, the years of the participants without fat phobia (n=11) ranged between 5 and 26 years, with an average of 17.36 ± 6.27 . The years of the participants with fat phobia (n=125) ranged from 1 to 36, with an average of 13.65 ± 8.39 years. (Table 4.12).

When the BMI values of the participants were examined according to the presence of fat phobia, the BMI values of the participants without fat phobia (n=11) ranged between 18 and 33, with an average of 23.45 ± 4.68 . The BMI values of the participants with fat phobia (n=125) ranged from 16 to 34, and the mean value was found to be 23.94 ± 3.44 . The presence of fat phobia does not show a statistically significant difference according to the gender, age, education level, years in the profession, and BMI levels of the participants ($p > 0.05$). (Table 4.12).

Table 4.11 Evaluation of Descriptive Characteristics According to the Presence of Fat Phobia

		Fat Phobia		P
		No fat phobia (n=11)	Fat phobia (n=125)	
Sex	Women	10 (90.9)	111 (88.8)	^c 1.000
	Men	1 (9.1)	14 (11.2)	
Grade level	Kindergarten	2	28	^c 1.000
	Primary school	4	38	^c 0.738
	Middle school	0	24	^c 0.212
	High school	5	41	^c 0.508
BMI	Underweight	1	6	^a 0.355
	Normal	6	71	
	Overweight	2	38	
	Obese	2	10	
		Mean±SD	Mean±SD	
		Min-Max	Min-Max	
Age		39.64±8.24	37.10±8.49	^b 0.198
		25-56	18-57	
Year of profession		17.36±6.27	13.65±8.39	^b 0.062
		5-26	1-36	
BMI		23.45±4.68	23.94±3.44	^b 0.441
		18-33	16-34	

^aFisher Freeman Halton Test; ^bKruskal Wallis Test; ^cFisher's Exact Test

The scores of those with fat phobia in the "Interpersonal relationship" subscale of the Health Promoting Lifestyle Profile Scale were found to be statistically significantly lower than those who did not ($p=0.039$; $p<0.05$). (Table 4.13).

The scores of those with fat phobia in the "Stress Management" subscale of the Health Promoting Lifestyle Profile Scale were found to be statistically significantly lower than those who did not ($p=0.026$; $p<0.05$). (Table 4.13).

The scores of those with fat phobia from the Total Health Promoting Lifestyle Profile Scale were found to be statistically significantly lower than those who did not ($p=0.045$; $p<0.05$). (Table 4.13).

According to the prevalence of fat phobia, the scores of the participants in the Health Promoting Lifestyle Profile Scale "Health Responsibility", "Exercise", "Nutrition", and "Self-realization" subscales do not show a statistically significant difference ($p>0.05$). (Table 4.13).

Table 4.12 Evaluation of Health Promoting Lifestyle Profile Scale Scores According to the Presence of Fat Phobia

	Fat phobia		p
	No fat phobia(n=11)	Fat phobia(n=125)	
	Mean $\pm$ SD	Mean $\pm$ SD	
Health responsibilities	23.18 $\pm$ 2.89	22.19 $\pm$ 3.02	^b 0.285
Exercise	18.27 $\pm$ 2.90	17.77 $\pm$ 3.77	^b 0.561
Nutrition	22.27 $\pm$ 3.10	21.08 $\pm$ 3.22	^b 0.258
Self-realization	23.73 $\pm$ 1.90	24.21 $\pm$ 3.21	^b 0.647
Interpersonal relationship	27.36 $\pm$ 2.46	25.58 $\pm$ 2.98	^b 0.039*
Stress management	21.73 $\pm$ 1.68	19.96 $\pm$ 2.80	^b 0.026*
Total	136.55 $\pm$ 7.43	130.78 $\pm$ 11.03	^b 0.045*

^bKruskal Wallis Test; * $p<0.05$

5. DISCUSSION AND CONCLUSION

This study was conducted on 136 teachers between 01.10.2021 and 30.11.2021 to evaluate teachers' fat phobia levels and healthy lifestyle behaviors. Results obtained by the data form were analyzed by using NCSS 2007.

136 participants voluntarily agreed to participate in the study, 15 (11%) were male and 121 (89%) were female, the ages of the teachers ranged between 18-57 and the mean age was 37.31 ± 8.47 . This numerical difference between female participants and male participants is related to the fact that the total number of female teachers working at Bursa Private Emine Örnek Educational Institutions is higher than the number of male teachers.

We can say that the literature is divided into two about whether gender or age has an effect on fat phobia. Toprak and Saraç in their study in 2017 revealed that female participants showed more fat phobic attitudes than male participants. The reason for this is that women are more exposed to the pressures of being thin and to fat phobia in society (99). In society, not only adult women but more critically girls are also exposed to fat phobia. In the last 20 years, the ages of girls who are dissatisfied with their bodies and want to be thinner have decreased to 5-6 years old (100). In this way, fat phobic attitudes that start at a young age lead to the formation of children's thoughts and attitudes on body image, and these attitudes continue in primary school, secondary school, high school, and young adult life (101). In a study conducted at the University of Liverpool on 202 participants, it was reported that female participants scored more negatively on overweight individuals than male participants (102). According to a study conducted on 2100 university students at Sakarya University in 2016, the fat phobia scores of female students were found to be statistically significantly higher than the fat phobia scores of male students (13).

Contrary to these findings, in a study conducted with 583 participants at Hacettepe University in 2020 to determine the factors affecting fat phobia, it was determined that there was no significant difference in fat phobia scores according to gender (103). In a similar study conducted at Heidelberg University in 2020, no significant gender-related difference was found in the fat phobia scores of 490 participants (104). In 2 different studies conducted on university students to investigate the fat phobic attitudes of students, no significant difference was found according to gender (42,105). Swift et al. In their study in 2012 examining the fat phobic attitudes of intern health personnel, reported that fat phobia scores showed a significant difference with age and BMI values, but there was no significant relationship with gender (48). Similarly, in a study conducted on health

department students, no statistically significant difference was found between the fat phobia scores of male and female students. In addition, in this study, the fat phobia scores of the students were not statistically significant according to their age (106). In our study, the fat phobia scores of the participants did not show a significant difference according to age and sex, and it is compatible with the majority of the literature. In our study, we think that there is no significant difference in fat phobia according to age and sex and that it is possible for teachers to have pedagogical elements in their education despite age and gender differences.

BMI is another descriptive feature that is thought to be a determinant of fat phobia, apart from age and gender. When the BMI values of the participants in our study were examined, the mean BMI value was found to be 23.90 ± 3.54 kg/m². 5.1% (n=7) of the participants were underweight, 56.6% (n=77) were normal, 29.4% (n=40) were overweight and 8.8% (n=12) were obese. When we look at the mean BMI values of 4 different fat phobia categories in order to investigate the effect of BMI values on the fat phobic attitude, the mean BMI of the participants with neutral fat phobia is 23.45 ± 4.68 , and the mean BMI of the participants with a low negative fat phobia is 24.37 ± 3.33 , the mean BMI of the participants with moderate negative fat phobia was 23.65 ± 3.42 and the mean BMI of the participants with high negative fat phobia was 23.4 ± 3.83 . According to this distribution, the group with the lowest mean BMI is the high negative fat phobic group. However, this difference was not statistically significant.

In parallel with our research, in the research conducted at Sakarya University in 2016 with 2100 participants in order to evaluate the fat phobia levels of university students; It was observed that the level of fat phobia of the participants whose BMI values were in the underweight category was higher than those of the students with normal weight, overweight and obese. In the analyzes performed in this study, it was determined that there was a statistically negative and weakly significant relationship between BMI and fat phobia scores. Accordingly, Çetinkaya reported that as BMI decreases, students become more fat phobic (107). This situation showed us the impression that individuals who try to keep their BMI values within normal ranges by adapting to distorted healthy living habits reflected in social media and communication tools may be more fat phobic. In the online study conducted by Alperin et al. in the USA in 2013, a total of 1176 participants volunteered. In this study, which was founded on the fact that the negative attitude towards overweight people is related to our relationship with our own body, the participants with low BMI levels had higher fat phobia levels than the participants with

normal BMI levels, slightly overweight and obese (108). The fact that the participants with high BMI values in these studies were less fat phobic may be due to their more understanding of overweight and people with obesity and the fact that they did not feel the need to defend their egos against overweight and people with obesity (109).

Contrary to these studies, there is a study of 450 medical students with a mean age of 23.1 ± 2.88 years, the average BMI value was reported as 22.0 ± 2.64 . The BMI value of 84% of the students participating in the study was normal, and the BMI value of about 10% was overweight or obese. Average fat phobia values were found to be higher in overweight individuals than in individuals with normal body weight. Negative biased attitudes towards individuals with obesity were reported to be higher in overweight individuals, and the difference was found to be statistically significant (19).

When the fat phobia values of the participants who voluntarily participated in our study were examined, it was found that the scores ranged between 1.6-5 and the mean fat phobia score was 3.57 ± 0.72 . This score of fat phobia showed that the group we studied was moderate negative fat phobic, as Bacon stated (5). According to our research, 64.7% of the teachers stated that individuals with obesity like to eat, 58.1% of them stated that individuals with obesity overeat, 37.5% of them stated that individuals with obesity are inactive and 36% of them stated that individuals with obesity are not attractive.

A study was conducted in Aydın in 2019 in which a total of 401 high school senior (12.) students, 216 of whom were women (53.9%) and 185 were men (46.1%), participated. The ages of the students ranged from 17 to 19. The aim of the study was to evaluate the social physical anxiety and fat phobia levels of students preparing for the university entrance exam. The mean score of women participating in the study was found to be 2.81, and the mean score of fat phobia for men was found to be 2.77 (110). Different from our study, the fact that students preparing for the university entrance exam were in the low negative fat phobic class in this study, whose average age is younger than our study, can be seen as an effect of the "body positivity movement" that has become widespread today. The body positivity movement is a movement that opposes the invisibility and devaluation of everyone outside of an ideal body idea, which is idealized and bounded by industries such as health, aesthetics, cosmetics, fashion, media, and advertising (111).

In the study conducted in 2016 to compare the negative attitudes and behaviors of 379 registered and student nurses toward overweight people, the average fat phobia of the student nurses was 3.70 ± 0.50 , and the mean fat phobia of the registered nurses was

3.91±0.43. In this study, parallel to our study, the participants are in the moderate negative fat phobia class. In this study conducted on nurses, the mean fat phobia score of registered nurses with more years of profession was found to be statistically significantly higher than nurses who were students (112). In our study, the teachers in the neutral fat phobia group had the highest year of profession mean score, but this was not statistically significant.

According to a descriptive study conducted at Çukurova University in 2010 on 201 young women and 266 young men, the mean female participants' fat phobia score was 3.55±0.69, and the average male participants' fat phobia score was 3.62±0.69. Furthermore, the frequency distributions obtained from the responses given to the items in the fat phobia scale in this study are consistent with our study. The majority of young female and male students reported that individuals with a high body weight were unattractive (n= 165), slow (n= 250), weak (n= 159), inactive (n= 186), self-indulgent (n= 132), likes food (n= 319), their bodies were shapeless (n= 254), and they overeat (n= 281) (42).

In a cross-sectional study conducted on 524 nursing and midwifery students in 2014, the mean value of all participants was 3.02±0.59. The mean fat phobia score of the nursing students was 2.97±0.59, and for the midwifery students was 3.11±0.59. It has been reported that there is a statistically significant difference between the fat phobia attitudes of nursing and midwifery students (106).

Fat phobia has been most researched in the healthcare industry. For example, 1130 students of the University of Nottingham participated in the 2012 study by Swift et al. The prejudices of students studying dietetics, medicine, nursing, and nutrition towards overweight people were investigated. The participants' fat phobia scores ranged from 1.9 to 5, while the mean fat phobia score was reported as 3.8±0.5 (48). Similar to our study, the smallest fat phobia group in the study was determined as the neutral fat phobic group. This made us think that the intensity of fat phobia is still a current problem in different fields of study such as health and education.

As one of the few studies conducted in the field of education; 205 teachers and 80 parents participated in the study conducted by Cruz et al. in the region on the Mexican-US border in 2007. The aim of the study was to determine the attitudes of teachers and parents towards children with obesity. The questionnaire used in the research included 3 separate subheadings; Attitudes about features of the children with obesity, Attitudes related to the care of the child with obesity, and Strong beliefs on the personal

responsibility of obesity. As a result of the study, it was shown that both teachers and parents have a strong negative attitude towards children with obesity. Teachers and parents cited low personal responsibility and low self-control as causes of obesity in children. It was observed that teachers' negative attitudes toward children with obesity were lower than that of parents, but teachers gave more priority to the importance of child's self-control in the prevention of childhood obesity (18). In our study, we found it more appropriate to apply the fat phobia scale to teachers for the first time in Turkey and to make a cross-sectional situation assessment in this area, instead of directly looking at the weight bias attitude shown by teachers and parents to children. In this way, we aimed to find the source of teachers' fat phobic attitudes and to take initiatives to improve this point.

The HPLPS II measures health-promoting behaviors in relation to healthy lifestyles. High scores obtained from this scale indicate that the level of having and developing health-promoting behaviors is high. The lowest score that can be obtained from the scale is 52, and the highest score is 208 (98). In our study, while the age range of 136 volunteer teachers who participated, ranged from 18 to 57, the average score they got from the total HPLPS II scale was 131 ± 10.88 . The lowest score obtained from the scale is 109 and the highest score is 159. In a study conducted in 2017, which was similar to our study in terms of age range and number of participants, an average of 100.45 ± 19.82 points was obtained from the HPLPS II. In this study conducted in Iran, the fact that the participants were selected among type 2 diabetes patients explains the difference in scores (113).

In a similar study conducted in Korea, Bae and Yoon, who think that teachers are role models for students in terms of healthy living habits, applied the HPLPS II scale on 474 teachers with an average age of 42.6 in 2020. The total scale average of the participants, consisting of primary, middle school, and high school teachers, was 130.73 ± 22.81 . This study reveals parallel results with our research (114).

In our study, the average score obtained from the sub-dimension of health responsibility was 22.27 ± 3.01 . In Bae's study, the mean score obtained from the sub-dimension of responsibility for health was 24.62 ± 0.51 . It is an expected result that the scores were close and high since both studies were conducted with adults who could take responsibility for their own health. (114).

The exercise subscale evaluates the level at which individuals do regular exercise and physical activities (115). In our study, the mean score of the exercise sub-dimension

was found to be 17.81 ± 3.70 . The exercise sub-dimension, which has the lowest mean among all sub-dimensions, was found to be 9.4 ± 0.71 in Bae's study and 13.9 ± 4.50 in a study conducted on nurses in Turkey. In parallel with our study, the averages taken from this sub-dimension in these two different studies are the lowest averages (114,116).

Healthy eating habits play a major role in ensuring growth and development, maintaining the body's functions, and developing healthy behaviors. With a good diet, protection can be provided against chronic diseases such as diabetes, hypertension, cardiovascular diseases, and cancer types that may occur in adolescence and continue into adulthood (117). In our study, the mean score obtained from the nutrition sub-dimension was 21.18 ± 3.22 . This is on average higher than the nutritional sub-dimension scores obtained in Bae's and Kirag's studies. Considering that the educational institution we are working with is an institution that gives importance to healthy nutrition, a factor may have affected our result (114,116).

The interpersonal relationship subgroup evaluates the relationship and continuity level of the individual with her family, friends, and close environment (78). In our study, the average score obtained from the sub-dimension of interpersonal relations was 25.72 ± 2.97 . This score is higher than the average scores of the sub-dimension of interpersonal relations in Bae and Kirag's studies. Considering that the psychologists at our school regularly give personal development and approach to adolescents' seminars, we would expect to reach a higher result compared to similar studies (114,116).

Spiritual development is a unifying force that unites the body and spirit and is beyond the individual's self and existence (78). In this study we conducted on teachers, the average score obtained from the self-realization sub-dimension was found to be 24.17 ± 3.12 . The average score obtained from the same sub-dimension in Bae's study on Korean teachers was 11.49 ± 0.59 . In the study conducted on Turkish nurses, the average self-realization sub-dimension score was determined as 25.9 ± 5.00 . It was thought that this big difference could be the cultural difference between Turkey and Korea (114,116).

Stress management is the identification and use of psychological and physical resources to reduce or control tension (78). In our study, the average score obtained from the stress management sub-dimension was 20.10 ± 2.76 . According to Kirag's study, the mean score of the teachers participating in our study in the stress management sub-dimension is much higher than the average scores obtained from the stress management sub-dimension in the other study. The mean scores from these two studies are 17.6 ± 4.38 . It is thought that these differences between the scores may be due to the fact that the

educational institution we work with is not as stressed as the nurses working in the hospital (116).

When the HPLPS II sub-dimensions were evaluated in our study, the highest mean among the behaviors contributing to the development of health were; interpersonal relationships (25.72 ± 2.97), self-realization (24.17 ± 3.12), health responsibility (22.27 ± 3.01), nutrition (21.18 ± 3.22), stress management (20.10 ± 2.76) and the last exercise (17.81 ± 3.70). In our study, in parallel with other studies, the lowest scoring sub-dimension was physical activity. Due to the high course densities and working hours, the physical activities of the teachers may be lower. It is promising that the teachers who participated in our study got a higher score in the interpersonal relations sub-dimension than in the other sub-dimensions.

In our study; The total HPLPS II score obtained according to the variables of age, gender, grade level, BMI, and year of profession was not found statistically significant. As the reason for this result, it was thought that despite all their differences, teachers might show similar healthy living habits because they work in the same institution.

In our study, a statistically significant and weak correlation was found between the "self-realization" sub-dimension of the Health Living Habits Scale and the fat phobia scores. This means that participants who are self-aware are more fat phobic. Although it does not seem logical at first glance, according to the Gestalt approach, which is based on the views of Jung and eastern philosophies, people are born with yin/yang energy. According to this point of view, for a feature to emerge, its opposite must appear at the same time (118).

In our study, the scores of those with fat phobia from the Health Promoting Lifestyle Profile Scale were found to be statistically significantly lower than those without fat phobia. Although this result seems contradictory to the literature at first glance, the Health Promoting Lifestyle Profile Scale not only includes nutrition and exercise but also participants' health responsibility, personal development, interpersonal relations, and stress management sub-dimensions; In other words, it should be taken into account that they are evaluated in terms of all the criteria stipulated by the World Health Organization for a healthy state.

In our study, it was determined that the scores of those with fat phobia in the stress management and interpersonal relations sub-dimensions of the healthy lifestyle behaviors scale were statistically significantly lower than those without fat phobia. In a study

published by Latner et al. in 2014, there is a link between poor interpersonal relationships and prejudice against overweight people (119).

Since our study is the first study to apply the scale of fat phobia and healthy lifestyle behaviors simultaneously to teachers, it has touched upon a point in the literature that has not been illuminated before. As a result of our study, it is thought-provoking that 91.9% of our 136 participants, who were teachers, were found to be fat phobic. The attitudes of the teachers in the schools where children and adolescents who will be the future educators, health professionals, engineers, and adolescents spend most of their time, will be the building blocks of the future attitudes and behaviors of these children. In order for children and adolescents to be successful in their education life, it is essential that they receive education in an environment free from stress and fear of being judged. Each comment and criticism that children and adolescents receive from their peers and elders will affect their life habits and this effect will continue throughout their lives. While these discourses and attitudes have such a critical position in the lives of children and adolescents, the fat phobic attitudes of teachers, whom children take as an example, play a key role. In our study, we focused on radically solving the problem we identified by identifying the core of teachers' fat phobic attitudes. The main problem we found was that teachers who need support in interpersonal relations and stress management exhibit a more fat phobic attitude and in this case, they can create a more stressful educational environment for students.

In order to solve this situation, we think that stress management and interpersonal relations training should be given to teachers. In fact, we plan to carry out these training practically, to reinforce them by teachers and facilitate their implementation. We think that conducting this training under the leadership of a team of dietitians and psychologists will be much more beneficial in terms of defining the right keys to a healthy life and correct behavior patterns.

6. REFERENCES

1. Phillips, C.M. (2016). Metabolically Healthy Obesity: Personalised and Public Health Implications. *Trends in Endocrinology & Metabolism*, 27(4), 189-191.
2. Fruh, M., Nadglowski, J., Heather, R., Davis, L., Crook, D. & Zlomke, K.(2016). Obesity Stigma and Bias. *The Journal for Nurse Practitioners*, 12, 7.
3. Tezcan, B. (2009). Obez bireylerde benlik saygısı, beden algısı ve travmatik geçmiş yaşantılar. Uzmanlık Tezi, T.C. Sağlık Bakanlığı Bakırköy Prof. Dr. Mazhar Osman Ruh Sağlığı ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi.
4. Puhl, R., Wharton, C., & Heuer, C. (2009). Weight Bias among Dietetics Students: Implications for Treatment Practices. *Journal of the American Dietetic Association*, 109(3), 438-444.
5. Bacon, J. G., Scheltema, K. E., Robinson, B. E., "Fat phobia scale revisited: the short form", *Int J Obes Relat Metab Disord.*, 25(2): 252-7, 2001.
6. Teachman, B. A., Gapinski, K. D., Brownell, K. D., Rawlins, M., Jeyaram, S., "Demonstrations Of Implicit Anti-Fat Bias: The Impact Of Providing Causal Information And Evoking Empathy", *Health Psychol.*, 22(1): 68-78, 2003.
7. Puhl, R., Brownell, K. D., "Bias, Discrimination, and Obesity", *Obes Res.*, 9(12): 788-805, 2001
8. O'Brien, K. S., Latner, J. D., Halberstadt, J., Hunter, J. A., Anderson, J., Caputi, P., "Do Antifat Attitudes Predict Antifat Behaviours?", *Obesity (Silver Spring)*. 16 Suppl 2:S87-92, 2008.
9. Dickey RA, Janick JJ. Lifestyle modifications in the prevention and treatment of hypertension, *Endorc Pract* 2001;7:392-399.
10. Ergün A, Erol S. Lise öğrencilerinin sağlıklı yaşam biçimi davranışları. *Hemşirelik Forumu* 2007; Ocak-Şubat/Mart-Nisan: 46-51.
11. Jung, Franziska UCE, et al. "Dietitians and nutritionists: stigma in the context of obesity. A systematic review." *PloS one* 10.10 (2015): e0140276.
12. Ksinan, A. J., Carlos Arturo Almenara, and Martin Vaculík. "The effect of belief in weight controllability on anti-fat attitudes: An experimental manipulation." *European Review of Applied Psychology* 67.3 (2017): 117-124.
13. Cetinkaya, S., & Sert, H. yılmaz University students' fat phobia levels and attitudes towards obese individuals and their correlation with healthy lifestyle behaviours: Knowledge, attitude and practice (KAP) study. *JPMA. The Journal of the Pakistan Medical Association*, (2018) 68(9), 1358-1362.

14. Himes JH, Dietz WH. Guidelines for overweight in adolescent preventive services: recommendations from an expert committee. The Expert Committee on Clinical Guidelines for Overweight in adolescent Preventive Services. *Am J Clin Nutr* 1994; 59: 307-16.
15. World Health Organisation. Obesity and overweight. [Online] [Cited 2021 November 5]. Available from: URL: <https://www.oecd-ilibrary.org/sites/a47d0cd2-en/index.html?itemId=/content/component/a47d0cd2-en> .
16. Cotugna, N., & Mallick, A. Following a calorie-restricted diet may help in reducing healthcare students' fat-phobia. *Journal of Community Health*, (2010) 35(3), 321-324.
17. Hayden, Melissa J., et al. Perceived discrimination and stigmatisation against severely obese women: age and weight loss make a difference. *Obesity Facts*, 2010, 3.1: 7-14.
18. Bacardi-Gascón, Montserrat, Maria Juana Leon-Reyes, and Arturo Jiménez-Cruz. "Stigmatization of overweight Mexican children." *Child Psychiatry and Human Development* 38.2 (2007): 99-105.
19. Pantenburg, B., Sikorski, C., Lupp, M., Schomerus, G., König, H. H., Werner, P., & Riedel-Heller, S. G. Medical students' attitudes towards overweight and obesity. *PloS one*, (2012) 7(11), e48113.
20. Koroni, Maria, et al. "The stigmatization of obesity in children. A survey in Greek elementary schools." *Appetite* 52.1 (2009): 241-244.
21. GBD 2015 Obesity Collaborators. "Health effects of overweight and obesity in 195 countries over 25 years." *New England Journal of Medicine* 377.1 (2017): 13-27.
22. Gregg, E.W., Shaw, J.E.. Global health effects of overweight and obesity. *N Engl J Med* 2017; 377(1): 80–81
23. Hatun Ş. Çocukluk çağı obezitesinin dünya ve Türkiye’de sıklığı. *Turkish J Pediatr Dis* 2012;1(2):7-14.
24. Jackson, Sarah E., Beeken, Rebecca J. ve Wardle, Jane. Obesity, perceived weight discrimination, and psychological well-being in older adults in England. *Obesity*, 2015, 23.5: 1105-1111.
25. Belue R, Francis L, Colaco B. Mental health problems and overweight in a nationally representative sample of adolescents: Effects of race and ethnicity. *Pediatrics* 2009 ;123(2): 697e702.
26. Staffieri J. A study of stereotype of body image in children. *Journal of Personality and Social Psychology* 1967;7:101e4.

27. Warschburger P. Unhappy obese child. *International Journal of Obesity* 2005;29:S127e9.
28. Britz B, Siegfried W, Ziegler A, Lamertz C, Herpetz-Dahlmann B, Remschmidt H, Wittchen H, Hebebrand J. Rates of psychiatric disorders in a clinical study of adolescents with extreme obesity and in obese adolescents ascertaining via a population based study. *International Journal of Obesity* 2000;24:1707e14.
29. Stevens, Serena D., et al. Adult and childhood weight influence body image and depression through weight stigmatization. *Journal of Health Psychology*, 2017, 22.8: 1084-1093.
30. Jackson, Sarah E. ve STEPTOE, Andrew. Obesity, perceived weight discrimination, and hair cortisol: a population-based study. *Psychoneuroendocrinology*, 2018, 98: 67-73.
31. Stevens, Serena D., et al. Adult and childhood weight influence body image and depression through weight stigmatization. *Journal of Health Psychology*, 2017, 22.8: 1084-1093.
32. Başaran İE. *Eğitim psikolojisi: Modern eğitimin psikolojik temelleri*. Nobel Tıp Kitapevi, Ankara ,1969
33. Sungur MZ. Fobik bozukluklar. *Psikiyatri dünyası*, 1997, 1(1):5-11.
34. Öztürk O, Uluşahin A. *Ruh sağlığı ve bozuklukları* Nobel Tıp Kıtabevleri Ltd. Şti., Ankara, 2008. s.462-466.
35. Wicker, A. W. Attitudes versus actions: The relationship of verbal and overt behavioral responses to attitude objects. *Journal of Social issues*, 1969. 25(4), 41-78.
36. Campbell, D. T. The indirect assessment of social attitudes. *Psychological Bulletin*, 1950. 47(1),15-38.
37. Eiser, J. R., Eiser, J. R. Social psychology: Attitudes, cognition, and social behaviour. *Cambridgeshire: Cambridge University Press*. 1986.
38. Robinson, B. BE, Bacon, Jane G. ve O'reilly, Julia. Fat phobia: Measuring, understanding, and changing anti-fat attitudes. *International Journal of Eating Disorders*, 1993, 14.4: 467-480.
39. Bohner, G., Schwarz, N. Attitudes, persuasion, and behavior. *Blackwell handbook of social psychology: Intraindividual processes*, 2001. 413-435.
40. Tomiyama, A. Janet, et al. How and why weight stigma drives the obesity 'epidemic'and harms health. *BMC Medicine*, 2018, 16.1: 123.

41. Ruffman, Ted, et al. Toddlers' bias to look at average versus obese figures relates to maternal anti-fat prejudice. *Journal of Experimental Child Psychology*, 2016, 142: 195-202.
42. Yılmaz, C.Y., Dinç, Z.F. Beden eğitimi ve spor yüksekokulunda öğrenim gören genç kadın ve erkek öğrencilerin kilofobi düzeylerinin karşılaştırılması. *Spormetre Beden Eğitimi ve Spor Bilimleri Dergisi*, 2010. 8(1):29-34.
43. Schwartz, M.B., Chambliss, H.O.N., Brownell, K.D., Blair, S.N., Billington, C. Weight bias among health professionals specializing in obesity. *Obesity research*, 2003. 11(9):1033- 1039
44. Puhl, R.M., Latner, J.D., O'Brien, K., Luedicke, J., Danielsdottir, S., Forhan, M. A multinational examination of weight bias: predictors of anti-fat attitudes across four countries. *International Journal of Obesity*, 2015. 39(7):1166-1173.
45. Sutin, Angelina R. ve Terraciano, Antonio. Perceived weight discrimination and obesity. *PloS One*, 2013, 8.7: e70048
46. Puhl, Rebecca M., Luedicke, Joerg ve Heuer, Cheslea. Weight-based victimization toward overweight adolescents: observations and reactions of peers. *Journal of School Health*, 2011, 81.11: 696-703.
47. Neumark-sztainer, Diane, et al. Weight-teasing among adolescents: correlations with weight status and disordered eating behaviors. *International Journal of Obesity*, 2002, 26.1: 123
48. Swift, J. A., et al. "Weight bias among UK trainee dietitians, doctors, nurses and nutritionists." *Journal of human nutrition and dietetics* 26.4 (2013): 395-402.
49. Puhl, R.M., King, K.M.. Weight discrimination and bullying. *Best Pract Res Clin Endocrinol Metab.* 2013 ;27(2):117–127
50. Greenleaf, Christy, et al. Weight stereotypes and behavioral intentions toward thin and fat peers among White and Hispanic adolescents. *Journal of Adolescent Health*, 2006, 39.4: 546-552
51. Haines, Jess, et al. "Weight teasing and disordered eating behaviors in adolescents: longitudinal findings from Project EAT (Eating Among Teens)." *Pediatrics* 117.2 (2006): e209-e215.
52. Rich, Shannon S., et al. Predictors of body size stigmatization in Hispanic preschool children. *Obesity*, 2008, 16.S2: S11-S17.

53. Gray, Wendy N., et al. Moderators of weight-based stigmatization among youth who are overweight and non-overweight: the role of gender, race, and body dissatisfaction. *Journal of Developmental & Behavioral Pediatrics*, 2011, 32.2: 110-116.
54. Golaszewski, Natalie M., et al. Perceived Weight Discrimination and School Connectedness Among Youth: Does Teacher Support Play a Protective Role?. *Journal of School Health*, 2018, 88.10: 754-761
55. Davison, Kirsten K., et al. Overweight girls who internalize fat stereotypes report low psychosocial well-being. *Obesity*, 2008, 16.S2: S30-S38.
56. Hand, Wren B., et al. The identity threat of weight stigma in adolescents. *Western Journal of Nursing Research*, 2017, 39.8: 991-1007
57. Juvonen, Jaana, et al. Emotional implications of weight stigma across middle school: The role of weight-based peer discrimination. *Journal of Clinical Child & Adolescent Psychology*, 2017, 46.1: 150-158
58. Swami, Viren ve Monk, Rachael. Weight bias against women in a university acceptance scenario. *The Journal of General Psychology*, 2013, 140.1: 45-56
59. Puhl, Rebecca M. ve Brownell, Kelly D. Confronting and coping with weight stigma: an investigation of overweight and obese adults. *Obesity*, 2006, 14.10: 1802- 1815.
60. Papp, Ildikó ve Tury, Ferenc. The stigmatization of obesity among Gypsy and Hungarian children. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, 2013, 18.2: 193-198
61. Aıme, A., Leblanc, L. ve Maiano, C. Is weight-related bullying addressed in school-based anti-bullying programs?. *Revue Européenne de Psychologie Appliquée/European Review of Applied Psychology*, 2017, 67.3: 163-169.
62. Cathleen, M. , Shultz, S. Lifestyle assesment. *Nursing Clinics of North America*, 1984. 19(2): 271-281.
63. Çepni, S. A. *Üniversite Öğrencilerinde Sağlıklı Yaşam Biçimi Davranışları ile Sağlık Kontrol Odağı Ve Sağlık Öz Yeterliği ilişkisi*, Ankara, Gazi Üniversitesi Sağlık Bilimleri Enstitüsü, 2010.
64. Esin, N. *Endüstriyel Alanda Çalışan İşçilerin Sağlık Davranışlarının Saptanması ve Geliştirilmesi*. İstanbul Üniversitesi, İstanbul, 1997.
65. Pasinlioğlu, T. ve Gözümlü, S. Birinci Basamak Sağlık Hizmetlerinde Çalışan Sağlık Personelinin Sağlık Davranışları. *C.Ü. Hemşirelik Yüksekokulu Dergisi*. 1998. 2 (2), 60- 68.
66. T.C. Sağlık Bakanlığı. *Ulusal Sağlık Politikası*. Ankara, 1993.

67. Murathan F. *Üniversite Öğrencilerinde Obezite Sıklığı, Fiziksel Aktivite Düzeyi ve Sağlıklı Yaşam Biçimi Davranışlarının incelenmesi*, Elazığ, Fırat Üniversitesi Sağlık Bilimleri Enstitüsü, 2013, 1-38.
68. Ebbeling, C.B., Pawlak, D.B., Ludwig, D.S. Childhood obesity: publichealth crisis, common sense cure. *Lancet* 2002; 360(9331): 473–482
69. Spellbring, A. M. Nursing's Role in Health Promotion : An Overview. *Nursing Clinic North of America*, 1991. 26 (4), 805-813.
70. Steinbrook, R. Healthcare reform in Massachusetts a work in progress. *N Engl J Med*. 2006. 354(20), 2095-2098.
71. Tambağ H. *Huzurevindeki Yaşlılara Sağlıklı Yaşam Biçimi ve Yaşam Doyumu Geliştirmeye Yönelik Verilen Psikoeğitimin Değerlendirilmesi*, Ankara, Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü, 2010, 12.-13.
72. Davies, L. E. and Thirlaway K. The Influence of Genetic Explanations of Type 2 diabets on patients' attitudes to prevention, treatment and personal responsibility for health. *Public Health Genomics*, 2013. 16(5),199-207.
73. Minkler, M. Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End. *Health Education Behaviour*. 1999. 26(1), 121-141.
74. Schultz, D.P. Schultz, S. E. Aslay Y. (Çev.), Modern Psychology. *Modern Psikoloji Tarihi*. Kaknüs Yayınları, İstanbul, 2007.
75. Maslow, Abraham H. "New introduction: Religions, values, and peak-experiences." *Journal of Transpersonal Psychology* (1970): 83-90. 2.2
76. Bozhüyük, A., Özcan, S., Kurdak, H., Akpınar, E., Saatçı, E., Bozdemir, N. Sağlıklı Yaşam Biçimi Ve Aile Hekimliği. *Turkish Journal Of Family Medicine And Primary Care*, 2012, 6(1):13.-21.
77. On, B. *Bir Üniversite Hastanesinde Çalışan Hemşirelerin Sağlığın Geliştirilmesi İle İlgili Görüşleri ve Sağlıklı Yaşam Biçimi Davranışları*. Ankara , Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü Halk Sağlığı Hemşireliği Programı, 2016.
78. Bahtiyar, T. *Hipertansiyon Tanısı İle İzlenen Adölesanların Sağlıklı Yaşam Biçimi Davranışları*. İstanbul , Okan Üniversitesi Sağlık Bilimleri Enstitüsü Hemşirelik Anabilim Dalı, 2017.
79. Michaud, P. A., et al. Sports activity, physical activity and fitness of 9-to 19-year-old teenagers in the canton of Vaud (Switzerland). *Schweizerische Medizinische Wochenschrift* (1999): 691-699. 129.18

80. Daley, Amanda J. "School based physical activity in the United Kingdom: Can it create physically active adults?." *Quest* (2002): 21-33. 54.1
81. Peterson, Jane Anthony. "Get moving! Physical activity counseling in primary care." *Journal of the American Academy of Nurse Practitioners* (2007): 349-357.19.7.
82. LaFollette, H., Graham, G. *Person to person*. Temple University Press, Philadelphia, 1989.
83. Fiske, Susan T., and Shelley E. Taylor. *Social cognition*. Mcgraw-Hill Book Company, 1991.
84. Şahin, T. *Borlu, A. Adıyaman il merkezinde 15-49 yaş kadınlarda obezite sıklığı, fiziksel aktivite düzeyi ve sağlıklı yaşam biçimi davranışları*. Kayseri, Erciyes Üniversitesi Sağlık Bilimleri Enstitüsü, Halk Sağlığı Anabilim Dalı, 2018.
85. Turner, JC., John C., Penelope, J. Oakes. "The significance of the social identity concept for social psychology with reference to individualism, interactionism and social influence." *British Journal of Social Psychology* 25.3 (1986): 237-252.
86. Sönmezer H. *Kayseri il Merkezinde Seçilmiş Bir Sağlık Ocağı Bölgesinde 18-64 Yaş Grubu Kadınların Sağlıkla ilgili Yaşam Biçimi Davranışları*. Kayseri, Erciyes Üniversitesi Sağlık Bilimleri Enstitüsü, 2009, 21-22, 25-27.
87. Rowshan, A. Cüceloğlu, Ş. (Çev.). *Stres Yönetimi*. Sistem Yayıncılık, İstanbul, 2011
88. Bozhüyük A. *Çukurova Üniversitesi Sağlık Bilimleri Öğrencilerinin Sağlıklı Yaşam Biçimi Davranışlarının Değerlendirilmesi*, Adana, Çukurova Üniversitesi Tıp Fakültesi Aile Hekimliği Anabilim Dalı, 2010, 22.-24.
89. Aksoy T. *Hemşirelik Öğrencilerinin Sağlıklı Yaşam Biçimi Davranışları*, Ankara, Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü, Ankara, 2010, 20.-23.
90. Yeşilfidan D., *Obezite Açısından Riskli Ergenlere Verilen Olumlu Sağlık Davranışları Geliştirme Eğitiminin Sağlıklı Yaşam Biçimi Davranışları Ve Fiziksel Aktivite Üzerine Etkisi*, Adnan Menderes Üniversitesi Sağlık Bilimleri Enstitüsü, Aydın, 2016
91. Demir, E. *Spor bilimlerine giriş*. Ankara, Nobel Akademik Yayıncılık. (2015).
92. Sürücüoğlu, M. S. Beslenme ve sağlığımız. *Standart*, 1999. 38 (448), 40-52.
93. Aykut, M. Yeterli ve dengeli beslenme. Erciyes Üniversitesi Halk Sağlığı 2013 Ders Notları. Erişim:http://tip.erciyes.edu.tr/Ders_Notlari/Dâhili_Tip/Halk_Sagligi/MAYKUT%20DERSLERİ%20yeni/ders.htm

94. Tiriyaki, K. *Üniversitede Görev Yapan Akademik Personelin Sağlıklı Yaşam Biçimi Davranışlarının İncelenmesi*, Gaziantep, Gaziantep Üniversitesi Sağlık Bilimleri Enstitüsü, 2013
95. Koçak S, Saraç L, Hürmeriç I. Determining the relationships among body mass index, body composition and attitudes toward fat people”, The ICHPER-SD Anniversary World Congress, İstanbul, 2005 November 9-13.
96. Walker SN, Sechrist KR, Pender NJ. The Health promoting lifestyle profile: Development and psychometric characteristics. *Nursing Research*, 1987, 36(2), 76-81.
97. Walker SN, Hill-Polerecky DM. Psychometric evaluation of the Health-Promoting Lifestyle Profile II. Unpublished manuscript, University of Nebraska Medical Center. 1996
98. Bahar Z, Beşer A, Gördes N, Ersin F, Kısıl A. Sağlıklı yaşam biçimi davranışları ölçeği II'nin geçerlik ve güvenirlik çalışması. *Cumhuriyet Üniversitesi Hemşirelik Yüksekokulu Dergisi* 2008 ;12:1-13.
99. Rauscher, L., & Cooky, C. Ready for anything the world gives her?: A critical look at sports-based positive youth development for girls. *Sex Roles*, 2016. 74(7), 288-298.
100. Teachman, B. A., & Brownell, K. D. Implicit anti-fat bias among health professionals: is anyone immune?. *International journal of obesity*, 2001. 25(10), 1525-1531.
101. Gleeson K, Frith H. (De)constructing Body Image. *Journal of Health Psychology* 2006 Vol 11 (1) 79-90
102. Tucci, S. A., Boyland, E. J., Halford, J. C., & Harrold, J. A. Stigmatisation of a formerly obese young female. *Obesity Facts*, 2013. 6(5), 433-442.
103. Fidancı, İ., Aksoy, H., Yengil Taci, D., Ayhan Başer, D., & Cankurtaran, M. Evaluation of factors affecting the fat phobia level. *International Journal of Clinical Practice*, 2021. 75(8), e14297.
104. Tapking, C., Benner, L., Hackbusch, M., Schöler, S., Tran, D., Krug, K., ... & Nickel, F. Influence of body mass index and gender on stigmatization of obesity. *Obesity Surgery*, 2020. 30(12), 4926-4934.
105. Karakaya M. Comparing fat phobia attitudes of faculty of health sciences students in a foundation university. İstanbul, Yditepe University, 2019.

106. Kadioğlu, B. U., Fatoş, U. N. C. U., Nazik, F., & Sönmez, M. İki farklı üniversitede eğitim gören üniversite öğrencilerinin kilofobi ve fiziksel aktivite düzeyleri. *Adıyaman Üniversitesi Sağlık Bilimleri Dergisi*, 2015.1(2), 77-86.
107. Çetinkaya, S. *Sakarya üniversitesi öğrencilerinin kilofobi düzeyleri ve obez bireylere yönelik tutumlarının değerlendirilmesi*. MS thesis. Sakarya Üniversitesi, 2016.
108. Alperin, Anandi, et al. "Applying the contact hypothesis to anti-fat attitudes: Contact with overweight people is related to how we interact with our bodies and those of others." *Social Science & Medicine* (2014): 37-44.123
109. Katz, Daniel. "The functional approach to the study of attitudes." *Public opinion quarterly* (1960): 163-204.24.2
110. Emiroğlu, D. *Üniversiteye Giriş Sınavına Hazırlanan Öğrencilerin Sosyal Fizik Kaygı ve Kilofobi Düzeylerinin İncelenmesi*. MS thesis. Aydın Adnan Menderes Üniversitesi, Sağlık Bilimleri Enstitüsü, 2020.
111. Erdem, Nigâr B., and YILDIZ B. C. "'İdeal" in Sınırında Bir Mücadele: Beden Olumlama Hareketi Üzerine Bir Alımlama Analizi." *Erciyes İletişim Dergisi* (2019): 1483-1506. 6.2.
112. Yılmaz, Hacı Ömer, and Nurcan Yabancı Ayhan. "Is there prejudice against obese persons among health professionals? A sample of student nurses and registered nurses." *Perspectives in psychiatric care* (2019): 262-268. 55.2.
113. Chahardah-Cherik, Shima, et al. "The relationship between health literacy and health promoting behaviors in patients with type 2 diabetes." *International journal of community based nursing and midwifery* (2018): 65. 6.1.
114. Bae, Eun Jung, and Ju Young Yoon. "Health Literacy as a Major Contributor to Health-Promoting Behaviors among Korean Teachers." *International Journal of Environmental Research and Public Health* (2021): 3304. 18.6.
115. Ardıç A. *Adölesanların Sağlıklı Yaşam Biçimi Davranışları*. Halk Sağlığı Hemşireliği Yüksek Lisans Tezi, İstanbul Üniversitesi Sağlık Bilimleri Enstitüsü, İstanbul, 2008.
116. Kirag, Nukhet, and Esin M. Ocaktan. "Analysis of health promoting lifestyle behaviors and associated factors among nurses at a university hospital in Turkey." *Saudi Med J* (2013): 1062-7. 34.10.
117. Musavian, Sadat A., et al. "Health promoting behaviors among adolescents: A cross-sectional study." *Nursing and midwifery studies* 2014. 3.1.

118. Daş C. *Geştalt Terapi Bütünleşmek ve Büyüme*. Ankara. Altnordu Yayınları;2017.
119. Latner, Janet D., et al. "Weight and health-related quality of life: The moderating role of weight discrimination and internalized weight bias." *Eating Behaviors* 2014.15.4. 586-590.



7.APPENDIX

7.1. Volunteer Form

BİLGİLENDİRİLMİŞ GÖNÜLLÜ OLUR FORMU

Sayın (gönüllü adayı / gönüllü adayı yasal temsilcisi);

Sizi Emine Örnek Eğitim Kurumları'nda yürütülen "Öğretmenlerin Kilo fobi Düzeyleri ile Sağlıklı yaşam Biçimi Davranışlarının Değerlendirilmesi" başlıklı araştırmaya davet ediyoruz. Bu araştırmaya katılıp katılmama kararını vermeden önce, araştırmanın ne amaçla ve nasıl yapılacağını, bu araştırmanın gönüllü katılımcılara getireceği olası faydaları, riskleri bilmeniz ve kararınızı bu bilgilendirme çerçevesinde özgürce vermeniz gerekmektedir. Bu nedenle bu formun okunup anlaşılması büyük önem taşımaktadır. Bu form araştırma sorumlusu olarak bizler tarafından size sözel olarak aktarılan bilgilendirmenin yazılı şeklini içermektedir. Formu imzalamadan önce size sözel olarak da anlatılan aşağıdaki bilgileri bir kez de dikkatlice okumak için zaman ayırınız. Katılmayı kabul ettiğiniz takdirde, tarafınız ve bilgilendirme esnasında yanınızda olan tanık kişi tarafından imzalanan bu formun bir kopyası saklamanız için size verilecektir.

Araştırmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Çalışmaya katılmama veya katıldıktan sonra herhangi bir anda çalışmadan çıkma hakkına da sahipsiniz. Her iki durumda da hiçbir yaptırıma ve hak kaybına maruz kalmayacağınızı bildirmek isteriz.

Dr. Öğr. Üyesi İrem KAYA CEBİOĞLU

Dyt. Tansu TUĞCU

Araştırmanın Adı

Öğretmenlerin Kilofobi Düzeyleri ile Sağlıklı yaşam Biçimi Davranışlarının Değerlendirilmesi

Araştırmanın Amacı

Gönüllü olarak katılmanızı teklif ettiğimiz çalışma bir yüksek lisans tez araştırmasıdır. Bu araştırmanın amacı; öğretmenlerin kilolu insanlara karşı bir ön yargı taşıyıp taşımadığını saptamaktır. Bununla beraber öğretmenlerin, eğitim verdikleri öğrencileri sağlıklı yaşam alışkanlıkları ile etkileyebilecekleri göz önüne alınırsa, sağlıklı yaşam alışkanlıklarının sorgulanması amaçlanmaktadır.

Araştırmanın Yöntemi

Katılım beklediğimiz tahmini gönüllü sayısı 123'tür. Anket yöntemi ile yapılacak olan bu çalışmada gönüllülerden herhangi başka bir veri talep edilmeyecektir. Gönüllüler herhangi bir risk altında kalmayacaktır. Gönüllüler çalışmaya katılmakla parasal yük altına girmeyeceklerdir ve herhangi bir ödeme yapılmayacaktır.

Araştırmanın Gizliliği

Çalışmaya katılacak gönüllülerin kimliğini ortaya çıkaracak bilgiler gizli tutulacak ve kamuoyuna açıklanmayacaktır. Araştırma sonuçlarının yayımlanması halinde dahi gönüllünün kimliği gizli kalacaktır. İzleyiciler, yoklama yapan kişiler, etik kurul, kurum ve diğer ilgili sağlık otoritelerinin gönüllünün orijinal tıbbi kayıtlarına doğrudan erişimlerinin bulunacaktır. Ancak bu bilgilerin gizli tutulacaktır. Yazılı bilgilendirilmiş gönüllü olur formunun imzalanmasıyla gönüllü veya kanuni temsilci söz konusu erişime izin vermiş olacaktır.

Araştırmacının Sorumlulukları

Araştırma konusuyla ilgili ve gönüllünün araştırmaya katılmaya devam etme isteğini etkileyebilecek yeni bilgiler elde edildiğinde gönüllünün veya kanuni temsilcisinin zamanında bilgilendirilmesi araştırmacının sorumluluğu olacaktır. Gönüllünün; araştırma, kendi hakları veya araştırmayla ilgili herhangi bir advers olay hakkında daha fazla bilgi temin edebilmesi için temasa geçebileceği kişiler ile bu kişilere ait günün 24 saatinde erişilebileceği telefon numaraları verilecektir.

Bilgilendirilmiş gönüllü olur formundaki tüm açıklamaları okudum. Bana yukarıda konusu ve amacı belirtilen araştırma ile ilgili yazılı ve sözlü açıklama aşağıda adı belirtilen araştırmacı tarafından yapıldı. Araştırmaya gönüllü olarak katıldığımı, istediğim zaman gerekçeli veya gerekçesiz olarak araştırmadan ayrılabilceğimi biliyorum. Söz konusu araştırmaya, hiçbir baskı ve zorlama olmaksızın kendi rızamla katılmayı kabul ediyorum. Bu çalışma sonuçlarının kullanılmasını kısıtlamamayı, yayın, rapor ve benzeri bilimsel dokümanlarda kullanılmasını kabul ediyorum.

<u>Gönüllünün;</u>	<u>Araştırmacı;</u>	<u>Tanık;</u>
Adı:	Adı:	Adı:
Soyadı:	Soyadı:	
Soyadı:		
Adresi:	Adresi:	
Adresi:		
Telefon Numarası:	Telefon numarası:	Telefon
numarası:		
Tarih:	Tarih:	Tarih:
İmza:	İmza:	İmza:

7.2. Questionnaire Form

1. Cinsiyet:

a) Kadın b) Erkek

2. Yaş (Doldurduğunuz yaş).....

3. Medeni Durum:

a) Bekar b) Evli

4. Eğitim verdiğiniz seviye;

a) Anaokulu b) ilkokul c) ortaokul d) lise

5. Branşınız;.....

6. Meslek yılınız....

7. A) Boy uzunluğu (cm):

B) Vücut Ağırlığı (kg):

8. Sağlık durumunuzu 1'den 10'a kadar derecelendirin;

1 (çok kötü).....10 (çok iyi)

9. Çocuğunuz var mı?

a) Evet b) Hayır

7.3. Fatphobia Scale

Aşağıda kimi zaman obez veya şişman kişileri tanımlamak için kullanılan 14 sıfat çifti verilmiştir. Her bir sıfat çifti için duygularınızı ve inançlarınızı en iyi ifade eden sıfata en yakın rakamı lütfen işaretleyiniz.

Obez bireyleri nasıl tanımlarsınız?

Tembel	5	4	3	2	1	Çalışkan
İradesiz	5	4	3	2	1	İradeli
Çekici	5	4	3	2	1	Çekici değil
İyi özdenetim	5	4	3	2	1	Zayıf özdenetim
Hızlı	5	4	3	2	1	Yavaş
Dayanıklı	5	4	3	2	1	Dayanıksız
Hareketli	5	4	3	2	1	Hareketsiz
Zayıf	5	4	3	2	1	Güçlü
Bencil	5	4	3	2	1	Fedakar
Yemeyi sevmez	5	4	3	2	1	Yemeyi sever
Biçimsiz	5	4	3	2	1	Biçimli
Az yer	5	4	3	2	1	Çok yer
Endişeli	5	4	3	2	1	Emin
Düşük benlik saygısı	5	4	3	2	1	Yüksek benlik saygısı

7.4.Lifesyle Behavior Scale II

Bu ankette řu anki yařam tarzınız ve alışkanlıklarınız ile ilgili sorular yer almaktadır. Lütfen soruları mümkün olduđu kadar doğru ve eksiksiz yanıtlayınız. Her alışkanlığınızın sıklığını uygun seçeneđi daire içine alarak belirtiniz. Hiç birzaman 1, bazen 2, sık sık 3, düzenli olarak 4 olarak değerlendirilmektedir.

		Hiçbir Zaman	Bazen	Sık sık	Düzenli Olarak
1	Bana yakın olan kişilerle endişelerimi ve sorunlarımı tartışırım				
2	Sıvı ve katı yağı, kolesterolü düşük bir diyeti tercih ederim				
3	Doktora ya da bir sađlık görevlisine, vücudumdaki olađandışı belirti ve bulguları anlatırım				
4	Düzenli bir egzersiz programı yaparım				
5	Yeterince uyurum				
6	Olumlu yönde deđiřtiđimi ve geliřtiđimi hissedерim				
7	Đnsanları başarıları için takdir ederim				
8	řekeri ve tatlıyı kısıtlarım				
9	Televizyonda sađlığı geliřtirici programları izler ve bu konularla ilgili kitapları okurum				
10	Haftada en az üç kez 20 dakika ve/veya daha uzun süreli egzersiz yaparım (hızlı yürüyüş, bisiklete binme, aerobik, dans gibi)				
11	Her gün rahatlamak için zaman ayırırım				
12	Yaşamımın bir amacı olduđuna inanırım				
13	Đnsanlarla anlamlı ve doyumlulu ilişkiler sürdürürüm				
14	Hergün 6-11 öğün ekmek, tahıl, pirinç ve makarna yerim				
15	Sađlık personeline önerilerini anlamak için soru sorarım				
16	Hafif ve orta düzeyde egzersiz yaparım (Örneđin haftada 5 kez ya da daha fazla) yürürüm				
17	Yaşamımda deđiřtiremeyeceğim şeyleri kabullenirim				
18	Geleceđe umutla bakarım				
19	Yakın arkadaşlarıma zaman ayırırım				
20	Her gün 2-4 öğün meyve yerim				
21	Her zaman gittiğim sađlık personelinin önerileri ile ilgili sorularım olduđunda başka bir sađlık personeline danıřırım				
22	Boř zamanlarımda yüzme, dans etme, bisiklete binme gibi eđlendirici fizik aktiviteler yaparım				
23	Uyumadan önce güzel şeyler düşünürüm				
24	Kendimle barışık ve kendimi yeterli hissedерim				

25	Başkalara ilgi, sevgi ve yakınlık göstermek benim için kolaydır				
26	Hergün 3-5 porsiyon sebze yerim				
27	Sağlık sorunlarımı sağlık personeliyle konuşurum				
28	Haftada en az 3 kere kas güçlendirme egzersizleri yaparım				
29	Stresimi control etmek için uygun yöntemleri kullanırım				
30	Hayatımdaki uzun vadeli amaçlar için çalışırım				
31	Sevdiğim kişilerle kucaklaşıyorum				
32	Hergün 3-4 porsiyon süt, yogurt veya peynir yerim				
33	Vücudumu fiziksel değişiklikler, tehlikeli bulgular bakımından ayda en az bir kez kontrol ederim				
34	Günlük işler sırasında egzersiz yaparım (örneğin, yemeğe yürüyerek giderim, asansör yerine merdiven kullanırım, arabamı uzağa park eder ve yürütürüm)				
35	İş ve eğlence zamanı dengelerim.				
36	Hergün yapacak değişik ve ilginç şeyler bulurum				
37	Mahrem ihtiyaçlarımı karşılayacak yollar bulurum				
38	Her gün et, tavuk, balık, kurubakliyat, yumurta, çerez türü gıdalardan sadece 3-4 porsiyon yerim				
39	Kendie nasıl daha iyi bakabileceğim konusunda sağlık personeline danışırım				
40	Egzersiz yaparken nabız ve kalp atışlarımı kontrol ederim				
41	Günde 15-20 dk gevşeyebilmek, rahatlayabilmek için uygulamalar yaparım				
42	Yaşamımda benim için önemli olan şeylerin farkındayım				
43	Benzer sorunu olan kişilerden destek alırım				
44	Gıda paketlerinin üzerindeki besin, yağ ve sodium içeriklerini belirleyen etiketleri okurum				
45	Bireysel sağlık bakımı ile ilgili eğitim programlarına katılırım				
46	Kalp atımım hızlanana kadar egzersiz yaparım				
47	Yorulmaktan kendimi korurum				

48	İlahi bir gücün varlığı ile ilişkim olduğunu hissedirim				
49	Konuşarak ve uzlaşarak çatışmaları çözerim				
50	Kahvaltı yaparım				
51	Gereksinim duyduğumda başkalarından danışmanlık ve rehberlik alırım				
52	Yeni deneyimlere ve durumlara açığım				



7.5. Ethics



T.C. YEDİTEPE ÜNİVERSİTESİ
GİRİŞİMSSEL OLMAYAN KLİNİK ARAŞTIRMALAR
ETİK KURULU

Versiyon No
1.0
Sayfa 1 / 2

KARAR FORMU

13.08.2021

ETİK KURUL BİLGİLERİ	Etik Kurulun Adı	Yeditepe Üniversitesi Girişimsel Olmayan Klinik Araştırmalar Etik Kurulu
	Açık Adres	Yeditepe Üniversitesi Diş Hekimliği Fakültesi, Bağdat Cad. No. 238 Göztepe 34728 Kadıköy, İstanbul
	İnternet Sayfası	http://goetik.yeditepe.edu.tr/
	Telefon	
	E-posta	goetik@yeditepe.edu.tr

DEĞERLENDİRİLEN BELGELER	İslak imzalı başvuru dosyası, CD'si ve elektronik başvuru	☒
	Araştırma başlığı ve araştırmacıların isimleri	☒
	Başvuru dilekçesi	☒
	Araştırmanın;	☒
	• Niteliği	☒
	• Önemi ve özgün değeri	☒
	• Amaç ve hedefleri	☒
	• Yöntemi	☒
	• Yönetimi	☒
	• Yaygın etkisi	☒
	• Araştırma bütçesi (Mevcutsa)	☒
	• Süresi ve uygunluğu (Zaman cetveli)	☒
	• Kaynakları	☒
	Araştırma izin belgesi / belgeleri	☒
	Bilgilendirilmiş Gönüllü Olur Formu (yapılan araştırmaya özel olarak hazırlanmış)	☒
	Taahhütname-1	☒
	Dünya Tıp Birliği Helsinki Bildirgesinin son versiyonunun ve Sağlık Bakanlığı'nın ilgili tüm kılavuzlarının okunmasına dair taahhüt	☒
	Taahhütname-2	☒
Daha önce yapılmış etik kurul başvuruları mevcut olup olmadığına dair taahhüt	☒	
Taahhütname-3	☒	
Araştırma sırasında araştırma bütçesinde yer almayan ve gönüllünün kendisine veya Sosyal Güvenlik Kurumuna ek yük getirecek hiçbir işlem uygulanmayacağına dair taahhüt	☒	
Taahhütname-4	☒	
COVID-19 hastalarında tedavi yaklaşımları ve bilimsel araştırmalar genelgesi okunmasına dair taahhüt	☒	
Araştırmacıların her birisine ait özgeçmiş formu	☒	
Ek belgeler (Varsa kullanılan ölçek izinleri vb.)	☒	

KARAR BİLGİLERİ	Başvuru Numarası	202106065
	Toplantı Tarihi	13.08.2021
	Toplantı Yeri	Çevirim içi (Google Meet)
	Karar No	16

Araştırmanın Başlığı Öğretmenlerin kilofobi düzeyleri ile sağlıklı yaşam biçimi davranışlarının değerlendirilmesi

Araştırmacılar Dr. Öğr. Üyesi İrem Kaya Cebioğlu, Dyt. Tansu Tuğcu



T.C. YEDİTEPE ÜNİVERSİTESİ
GİRİŞİMSEL OLMAYAN KLİNİK ARAŞTIRMALAR
ETİK KURULU

Versiyon No
1.0
Sayfa 2 / 2

BAŞVURU NUMARASI: 202106065

KARAR

13.08.2021

☒ KABUL	☐ RET ☐ KAPSAM DIŞI (GİRİŞİMSEL) ☐ BİLİMSEL VE/VEYA ETİK KURALLARA AYKIRI ☐ BİR SORUMLU ARAŞTIRMACININ (TEZ İŞE TEZ DANIŞMANI), BİR TOPLANTIYA İKİ (2) ADETTEN FAZLA ÇALIŞMA BAŞVURUSUNDA BULUNMASI ☐ KURUM İÇİ BAŞVURULARINDA YEDİTEPE UZANTILI E-POSTA HESABI İLE GİRİŞ YAPILMAMIŞ OLMASI ☐ ŞARTLI KABULDE BELİRTİLEN REVİZYONLARIN ZAMANINDA VE/VEYA İSTENİLDİĞİ ŞEKİLDE YAPILMAMIŞ OLMASI
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Prof. Dr. Didem ÖZDEMİR ÖZENEN
Başkan

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Doç. Dr. Gökhan ERTAŞ
Başkan Yardımcısı

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Doç. Dr. Elif SUNGURTEKİN EKÇİ
Raportör

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Prof. Dr. Feryal SUBAŞI
Üye

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Doç. Dr. Mehmet Engin CELEP
Üye

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Dr. Öğr. Üyesi E. Çiğdem KELEŞ
Üye

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Dr. Öğr. Üyesi Binnur OKAN BAKIR
Üye

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Dr. Öğr. Üyesi E. Nur ÖZDAMAR
Üye

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Dr. Öğr. Üyesi SEVİM ŞEN
Üye

Katılım	İlişki
☐ Var ☐ Yok	☐ Var ☐ Yok

Araştırmanın Başlığı Öğretmenlerin kilofobi düzeyleri ile sağlıklı yaşam biçimi davranışlarının değerlendirilmesi

Araştırmacılar Dr. Öğr. Üyesi İrem Kaya Cebioğlu, Dyt. Tansu Tuğcu

T.C. YEDİTEPE ÜNİVERSİTESİ

GİRİŞİMSSEL OLMAYAN KLİNİK ARAŞTIRMALAR ETİK KURULU BAŞKANLIĞI' NA,

Sorumlu araştırmacısı olan Öğretmenlerin Kilofobi Düzeyleri ile Sağlıklı Yaşam Biçimi Davranışlarının Değerlendirilmesi başlıklı araştırma önerisinin veri toplama kısmı kurumumuzda yapılacaktır. Gereğini arz ederim.

Kurum Bilgileri

Adı	Anabilim Dalı / Bölüm Adı
Yeditepe Üniversitesi	Beslenme ve Diyetetik

Kurum Yetkilisi

Unvanı, Adı - Soyadı	Görevi	İmza
Kurucu Müdür,Emine Örnek	Emine Örnek Eğitim Kurumları Kurucu Müdürü	

Araştırmanın Başlığı Öğretmenlerin Kilofobi Düzeyleri ile Sağlıklı Yaşam Biçimi Davranışlarının Değerlendirilmesi

Araştırmacılar Dyt. Tansu TUĞCU, Dr. Öğr. Üyesi İrem KAYA CEBİOĞLU