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## Obesity – a determinant affecting the quality of life

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## Ожиріння – детермінанта, що впливає на якість життя

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### Introduction

Obesity is defined as abnormal, excessive fat deposition, which leads to the development of health complications [1]. It is a chronic progressive disease caused by an energy imbalance between calorie intake and expenditure. The accumulation of fat and its insufficient mobilization in tissues causes structural and functional changes that culminate in multiple organ-specific pathological complications.

Obesity is a multifactorial disease caused by the interaction of genetic predispositions with environmental factors [2; 3]. The endogenous factors causing obesity include genetic predisposition, epigenetic factors, pregnancy, and certain endocrine abnormalities [4]. Exogenous factors include environmental factors, employment, energy intake, dietary habits, limited physical activity, sedentary lifestyle, quitting smoking, lack of sleep, exposure to chronic stress, various eating disorders, psychosocial factors, depression, anxiety and psychosis, negative perception of one's own body, low self-esteem, use of certain medications, and many others. High BMI and accumulation of adipose tissue in the body are significant predictors, making obesity a disease that affects about 15% of men and 22% of women. In recent decades, obesity has affected populations in both developed and developing countries. In Slovakia, approximately 2/3 of the adult population

is obese. The number of adults with stage 3 obesity is increasing, especially among women. The incidence of obesity as a disease in Slovakia correlates with global findings [4; 5]. Despite these findings, obesity is not perceived as a disease [6].

Obesity is a frequent cause of other diseases and complications that affect the quality of life. It negatively determines the quality of life in the physical, psychological and social domains (Table 2) [7]. Deficits in physical health and psychological health affect the overall condition and satisfaction with life. The ability to self-realize can be changed, disharmony verbalized as dissatisfaction arises.

The extent of changes in quality of life depends mainly on the level of obesity, age and gender. Studies point to changes in reproductive health and reduced self-esteem. Stigmatization often occurs [10; 11]. Obese people are considered lazy, which makes it difficult to find a job. Other authors [12] describe obesity as a health-damaging dysfunction in appearance, which is considered a social shame. Low quality of life in the area of social interaction determines changes in thinking, attitudes and emotions. According to Stephenson et al. [13] and Zawiszka et al. [14], in obese people, a bad attitude towards their own body is dominant, which can result in self-stigma. An obese person devalues themselves, experiences feelings of shame and inferiority, and has reduced self-esteem [15; 16].

Table 1

### People at risk of obesity development

<input type="checkbox"/> people with a positive family history – children of obese parents are often obese, and in addition to genetics (40%), family eating and exercise habits (60%) are also responsible for this
<input type="checkbox"/> women during puberty, pregnancy, breastfeeding, menopause, seniors
<input type="checkbox"/> people taking medications with a risk of weight gain (thyroid-stimulating drugs, sedatives, antidepressants, antipsychotics, estrogens, glucocorticoids and others)
<input type="checkbox"/> people who have recently quit smoking
<input type="checkbox"/> people with a lower level of education, lower income
<input type="checkbox"/> people suffering from sleep deprivation

Source: own processing according to Fábryová et al., 2021 [4].

Table 2

## Quality of life domains

domain	components	examples
physical	symptoms	pain, fatigue
	physical functions	daily activity, mobility
mental	symptoms	depression, anxiety, fear
	kognitive functions	concentration, memory
	mental well-being	equanimity
social	social well-being	family, social relationships
	activity	work, employment, coping with household duties
other	global health assessment	satisfaction with health, health-related expectations
	personal constructs	religion, stigmatization
	satisfaction with care provided	satisfaction with treatment and outcomes

Source: own processing according to Řehulková et al., 2008; Martinez-Martin, 2017 [8, 9].

## Purpose

Table 4

*The aim of the research.* In our research, we focused on investigating the problem of the quality of life of obese people.

We set the following research goals:

- to assess and analyze the quality of life of obese people in selected domains of health
- to compare the quality of life in selected domains with respect to gender
- to determine the overall quality of life with respect to gender
- to identify the relationship between BMI and overall quality of life with respect to gender.

## Research sample according to age

Age/years	n	%
20–29	10	10,5
30–39	21	22,1
40–49	29	30,5
50–59	26	27,4
60–65	9	9,5
Σ	95	100

n=absolute number, %=relative number, Σ= summ

Table 5

## BMI in research sample

BMI value (n=95)	n	%
30–34,9 kg/m <sup>2</sup>	2	2,1
35–39,9 kg/m <sup>2</sup>	33	34,7
40–44,9 kg/m <sup>2</sup>	33	34,7
45–49,9 kg/m <sup>2</sup>	12	12,6
50–54,9 kg/m <sup>2</sup>	10	10,5
≥55 kg/m <sup>2</sup>	5	5,3
Σ	95	100
BMI value, men		
30–34,9 kg/m <sup>2</sup>	1	2,2
35–39,9 kg/m <sup>2</sup>	12	26,1
40–44,9 kg/m <sup>2</sup>	19	41,3
45–49,9 kg/m <sup>2</sup>	8	17,4
50–54,9 kg/m <sup>2</sup>	4	8,7
≥55 kg/m <sup>2</sup>	2	4,3
Σ	46	100
BMI value, women		
30–34,9 kg/m <sup>2</sup>	1	2
35–39,9 kg/m <sup>2</sup>	21	42,9
40–44,9 kg/m <sup>2</sup>	14	28,6
45–49,9 kg/m <sup>2</sup>	4	8,2
50–54,9 kg/m <sup>2</sup>	6	12,2
≥55 kg/m <sup>2</sup> a viac	3	6,1
Σ	49	100
M	42,9	
SD	6,18	
Mdn	41,5	
BMI	34,6–58,8 kg/m <sup>2</sup>	

n=absolute number, %=relative number, Σ= summ, M=mean, SD=standard deviation, Mdn=median, BMI=body mass index.

## Object, materials and research methods

A total of 95 participants of both genders participated in the research. The inclusion criteria were: BMI values  $\geq 30$ , age from 20 to 65 years, dispensary at the obesity treatment centre, and willingness to participate.

The group consisted of 46 men and 49 women (Table 3). Most participants (n=29) were in the age group of 40–49 years (Table 4). 38 respondents had a university education, 37 had secondary education with a high school diploma, and 20 had secondary education without a high school diploma. The BMI of most participants was between 35 and 45% (Table 5).

Table 3

## Research sample according to gender

gender	n	%
men	46	48,4
women	49	51,6
Σ	95	100

n=absolute number, %=relative number, Σ= summ

To obtain data, we used a short version of the standardized questionnaire on the impact of body weight on quality of life (IWQOL – Lite) [17], which consists of 31 items with scores in multiple domains, on a 0–100 scale (100 being the best quality of life). It maps the quality of life of an obese person in five dimensions:

physical functions, self-esteem, sexual life, social relationships, public distress, and work. Likert scales with five-point response options (always, usually, sometimes, rarely, never) were used. For each item, the respondent marked one answer that best described his situation over the past week. The InBody 230 device was used to measure body impedance.

We evaluated the data using descriptive and inferential statistics using Excel and SPSS version 22.0. In descriptive statistics, we used absolute (f) and relative frequencies (%). For quantitative variables, arithmetic mean (M), standard deviation (SD), median (Mdn), minimum (min) and maximum (Max) values were used. In inferential statistics, we used tests for comparison and the detection of relationships between variables. We used the normality test (skewness, kurtosis) to analyze the data distribution. When detecting differences between genders, we used Student's t-test for two independent samples. To detect relationships between categorical variables, we used Pearson's correlation coefficient.

**Research results**

The results confirmed or refuted the statistical hypotheses.

**Hypothesis 1:** We assume that there is a difference between the quality of life of obese men and women in selected health areas.

In the domain of physical function (Table 6) for men, we found an average value of M = 45.28 (SD = 13.33) and for women M = 45.9 (SD = 11.78). The difference is not statistically significant (t(93) = -0.255, p = 0.8).

39.1 % of men stated that they had the biggest problem tying their shoelaces. 40.8 % of women expressed the opinion that active movement does not bring them joy. It was remarkable to find that only 6.1 % of women worry about their health.

In the domain of self-esteem (Table 7), we identified a statistically significant difference considering the gender (t(93) = -5.004, p < 0.001). Men have higher self-esteem (M=13.43, SD=7.25) than women (M=20.1, SD=5.6). 8.7% of men and as many as 26.5% of women (n=95) do not like looking in the mirror and at their own photo.

In the domain of sexual health (Table 8), we identified a statistically significant difference (t(93) = -2.27, p = 0.026). The data confirmed that men have a higher quality of life in the area of sexual life (M=10.17, SD=4.54) than women (M=12, SD=3.43). Dysfunction in sexual activities was confirmed in the whole sample (n=95).

In the domain of social relations and public distress (Table 9), we did not find statistically significant differences between men (n=46) and women (n=49) (t(93) = -7.545, p = 0.453).

10.9% of men reported that obesity is a cause of concern about whether they will fit/enter into a seat in public, whether they will pass through a turnstile

Table 6

**Quality of life of obese men and women in the field of physical function**

	M	SD	skewness	kurtosis	t	df	p
men	45,28	13,33	-0,309	-0,956	-0,255	93	0,8
women	45,9	11,78	-0,17	-0,785			

M – average, SD – standard deviation, t – value of Student's t test, df – degrees of freedom, p – statistical significance.

Table 7

**Quality of life of obese men and women in the area of self-esteem**

	M	SD	skewness	kurtosis	t	df	p
men	13,43	7,25	1,39	1,24	-5,004	93	< 0,001
women	20,1	5,6	0,452	-0,118			

M – average, SD – standard deviation, t – value of Student's t test, df – degrees of freedom, p – statistical significance.

Table 8

**Quality of life of obese men and women in the domain of sexual health**

	M	SD	skewness	kurtosis	t	df	p
men	10,17	4,54	0,5	-1,02	-2,27	93	0,026
women	12	3,43	0,718	-0,234			

M – average, SD – standard deviation, t – value of Student's t test, df – degrees of freedom, p – statistical significance.

Table 9

**Quality of life of obese men and women in the area of social relations and public distress**

	M	SD	skewness	kurtosis	t	df	p
men	20,89	7,27	0,641	-0,35	-0,754	93	0,453
women	21,9	5,7	0,169	-0,073			

M – average, SD – standard deviation, t – value of Student's t test, df – degrees of freedom, p – statistical significance

Table 10

## Quality of life of obese men and women in the domain work

	M	SD	skewness	kurtosis	t	df	p
men	9,8	3,04	0,742	0,18	-2,423	93	0,017
women	11,2	2,66	0,314	-0,104			

M – average, SD – standard deviation, t – value of Student's t test, df – degrees of freedom, p – statistical significance.

Table 11

## Comparison of overall quality of life with respect to gender

	M	SD	skewness	kurtosis	t	df	p
men	99,59	30,36	0,155	-0,917	-2,131	93	0,036
women	111,2	22,19	-0,074	0,026			

M – average, SD – standard deviation, t – value of Student's t test, df – degrees of freedom, p – statistical significance.

or an aisle, or whether they will find a suitable chair which will withstand their weight. 32.7% of women feel socially restricted because they cannot dress according to fashion trends.

In the domain of work (Table 10), obese men achieve a statistically higher quality of life (M=9.8, SD=3.04) than obese women (M=11.2, SD=2.66) The difference is statistically significant ( $t(93) = -2.423, p = 0.017$ ).

We conclude that in terms of overall quality of life (Table 11), men (n=46) have a higher quality of life (M=99.59, SD=30.36) than women (M=11.2, SD=22.1). The difference between them is statistically significant.

We accept hypothesis H1 and conclude that there is a difference in overall quality of life between obese men and obese women, with men achieving a higher quality of life (M=99.59) than women (M=11.2).

**Hypothesis 2:** We assume that there is a relationship between quality of life and BMI in obese men.

In men (n=46), the higher the BMI, the lower the quality of life in all examined domains except self-esteem (Table 12). We accept Hypothesis 2 and conclude that there is a negative relationship between BMI and quality of life in men ( $p=0.001$ ).

**Hypothesis 3:** We assume that there is a relationship between BMI values and quality of life in women.

In the group of women (n=49) we found a statistically significant, strong negative relationship between BMI values and the physical function domain. The higher the BMI value, the lower the quality of life in the domain

of physical function. The BMI value explains 39.44% of the variance in the physical domain of obese women.

We found a moderately strong negative relationship between BMI values and social relationships and problems in the public domain. We found a statistically significant and moderately negative relationship between BMI value and the overall quality of life of women (n=49).

The relationship between BMI and the domains of self-esteem ( $r = -0.628, p = 0.642$ ), sex life ( $r = 0.018, p = 0.904$ ) and work ( $r = 0.009, p = 0.951$ ) was not statistically significant ( $p > 0.05$ ). Data analysis confirms the acceptance of hypothesis H3 (Table 13).

## Discussion of the research results

The quality of life is influenced by a wide range of factors. One of them is obesity. This is pointed out by numerous authors [11; 16]. Pimenta et al. [11] examined 60 patients of Brazilian origin, divided according to the BMI value into three monitored categories (respondents with normal body weight, obese and morbidly obese). The results of their research (n=60) showed that respondents regardless of gender with a BMI value in the normal range (18.5–24.9 kg/m<sup>2</sup>) report a better quality of life than respondents with a BMI in the obesity range (1st stage: BMI = 30.00–34.9 kg/m<sup>2</sup>, 2nd stage: BMI = 35.0–39.9 kg/m<sup>2</sup>) and morbid obesity (BMI ≥ 40 kg/m<sup>2</sup>). This finding correlates with the validity of our hypothesis 1. In our sample (n=95) there is

Table 12

## Relationships between BMI and quality of life in men

Quality of life domains	r	p	R <sup>2</sup>
physical functions	-0,614	< 0,001	0,377
self-esteem	-0,043	0,777	–
sex life	-0,372	0,011	0,1384
social relationships and problems in public	-0,594	< 0,001	0,3528
work	-0,484	0,001	0,2343
overall quality of life	-0,526	< 0,001	0,3767

r – Pearson correlation coefficient, p – statistical significance, R<sup>2</sup> – coefficient of determination.

Table 13

## Relationships between BMI and quality of life in women

Quality of life domains	r	p	R <sup>2</sup>
physical functions	-0,628	< 0,001	0,3944
self-esteem	-0,068	0,642	–
sex life	0,018	0,904	–
social relationships and problems in public	-0,445	< 0,001	0,198
work	0,009	0,951	–
overall quality of life	-0,461	< 0,001	0,2125

r – Pearson correlation coefficient, p – statistical significance, R<sup>2</sup> – coefficient of determination.

a statistically significant difference in overall quality of life, with men achieving a higher quality of life ( $M=99.59$ ) than women ( $M=11.2$ ). In the area of self-esteem, we also identified a statistically significant difference ( $t(93) = -5.004, p < 0.001$ ). In our sample, men had higher self-esteem ( $M=13.43, SD=7.25$ ) than women ( $M=20.1, SD=5.6$ ). 8.7% of men and 26.5% of women ( $n=95$ ) do not like looking in the mirror and at their own photo. It turns out that the aesthetic aspect plays a significant role in the quality of life of obese people. Women feel discriminated against in employment and in relationships. According to Hainer et al. [3], people with obesity are 37 times more likely to experience employment discrimination than people with normal body weight. At the same time, employment discrimination is 16 times more common in women than in men. Levine, Schwetzer [18] are of the opinion that people with obesity are more often assigned to work with fewer competencies. Discomfort in physical fitness limits their mobility, worsens breathing, causes sleep disorders, fatigue, varying degrees of pain and limits self-sufficiency. In the domain of physical fitness, we identified a comparable finding ( $p=0.8$ ).

Vantighem et al. [19] conducted research in adolescents ( $n=500$ ) and found that obesity causes fatigue. Similar findings are reported by the Kolotkin et al and Donini et al, who conducted the research in a group of respondents ( $n=100$ ) aged 18 to 75 years and with a BMI  $>30$  kg/m [20; 21]. They found that a higher BMI value is associated with a worse quality of life in the domains of physical health and survival. Obese people were discriminated and stigmatized. They demonstrated a lower quality of life in the domain of social relationships. In our research, we note that in our sample ( $n=95$ ) 10.9% of men reported that obesity is a source of concern for activities in public life. 32.7% of women feel social restrictions. The reason is that they cannot dress according to fashion trends. Our findings correlate with the results of the study of Kánská [22]. The author states that obese people feel embarrassed, have reduced self-esteem, fear rejection, and are reluctant to appear in public. Obesity also affects work performance. Obese people subjectively report that they have a bad experience with the acceptance of their person in job interviews. Flint and Snook [23] describe that during job interviews, obese people were evaluated as having low potential for leadership positions. Employers predicted lower success and performance of obese applicants compared to applicants with normal body weight. In the given area in our sample, we found that obese men have a higher chance of being accepted at work than ( $M=9.8, SD=3.04$ ) obese women ( $M=11.2, SD=2.66$ ). A professor of sociology [24] pointed out obesity as a factor of mental health.

From the point of view of psychosomatics, the psyche is inextricably linked to the body. Self-esteem is considered a sign of mental health. In this area, we identified

a statistically significant difference ( $t(93) = -5.004, p < 0.001$ ). Men have higher self-esteem ( $M=13.43, SD=7.25$ ) than women ( $M=20.1, SD=5.6$ ). The risk of social isolation in the obese community is high. This risk has been highlighted [12]. Obesity has been characterized as social shame. Several studies have confirmed that stigmatization is not a motive for weight reduction. We did not find statistically significant differences in this area ( $t(93) = -7.545, p = 0.453$ ). Obesity also affects the choice of a partner. Obese women are disadvantaged in choosing a partner, as they are perceived as less attractive and are often confronted with negative insinuations from a potential partner. There is a risk of a negative partner relationship. Obesity reduces sexual activity and exposes partners to stress. This is also indicated by the results of the study [25; 26]. The results of our research in the field of sexual health confirmed a statistically significant difference ( $t(93) = -2.27, p = 0.026$ ) between the sexes. Men signaled a higher quality of life in the field of sexual life ( $M=10.17, SD=4.54$ ) than women ( $M=12, SD=3.43$ ). Dysfunction in sexual activities was confirmed in the sample ( $n=95$ ).

### Prospects for further research

When it comes to obesity, more attention needs to be paid to women. It is a civilization disease that determines the quality of life and especially its psychological dimension. We recommend multidisciplinary collaboration to achieve balanced lifestyle coordination with a predominance of preventive interventions. The risk of obesity and its negative impact on quality of life should become the subject of repeated research in generational cohorts. Differentiation of risks and early interventions have preventive significance. In the future, the focus of research should primarily be on alternative preventive measures in order to obtain evidence of their importance in promoting population health.

### Conclusions

Obesity is a global pandemic and the most common metabolic disease affecting all age groups. In Slovakia, the number of adults with stage 3 obesity is increasing, with a predominance of occurrence mainly in women [4; 5; 27]. It affects many areas of life. It affects social life, employment, family and partner relationships. Therefore, we consider it right to examine the issue of the quality of life of the obese. We believe that primary prevention in the form of education, especially of the young population, can bring success. We recommend continuing to examine the risks of obesity with the aim of changing lifestyle. We consider knowledge of preventive programs and the involvement of different age groups in the implementation of obesity prevention action plans to be high-priority interventions.

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Obesity is a preventable disease; however, in recent decades it has increasingly affected populations of both developed and developing countries. It is a complex condition involving an excessive amount of body fat. Obesity leads to structural and functional changes culminating in multiple organ-specific pathological complications that significantly influence morbidity as well as the quality and length of life.

**Purpose.** The aim of this study was to determine which dimensions of quality of life are affected by obesity, to compare quality of life by gender, and to assess the relationship between quality of life and BMI among obese respondents.

**Materials and methods.** The research sample consisted of 95 respondents, 49 women and 46 men, with BMI  $\geq 30$  kg/m<sup>2</sup>, aged 20–65 years, monitored at a center for body weight regulation. The largest proportion of respondents (n = 29) belonged to the

40–49 age group. Data were collected using the shortened version of the standardized questionnaire *Impact of Weight on Quality of Life – Lite (IWQOL-Lite)*, consisting of 31 closed items. We evaluated quality of life in people with morbid obesity across five dimensions: physical functioning, self-esteem, sexual life, social relationships, public distress, and work. For each item, respondents selected the answer that best described their situation during the past week. Responses were rated on a five-point Likert scale: always, usually, sometimes, rarely, never. Anthropometric data were obtained using the InBody 230 bioimpedance device. Data were analyzed with descriptive and inferential statistics. Descriptive statistics included absolute (f) and relative (%) frequencies, arithmetic mean (M), standard deviation (SD), median (Mdn), minimum (min), and maximum (max). Within inferential statistics, we applied tests to compare and examine relationships between variables. Prior to selecting the appropriate test, we assessed data distribution using normality tests (skewness, kurtosis). To determine differences between two groups, we used Student's t-test for independent samples, and to examine relationships, we employed Pearson's correlation coefficient.

**Results.** Differences in overall quality of life were found between obese men and women, with men reporting a higher quality of life ( $M = 99.59$ ) compared to women ( $M = 111.2$ ). Significant differences were also identified in the dimensions of self-esteem, sexual life, and work. No statistically significant difference was observed in physical functioning between genders ( $p = 0.8$ ). In self-esteem, a significant difference was confirmed ( $p < 0.001$ ), with men reporting higher self-esteem ( $M = 13.43$ ,  $SD = 7.25$ ) than women ( $M = 20.1$ ,  $SD = 5.6$ ). In sexual life, men also reported better quality of life ( $M = 10.17$ ,  $SD = 4.54$ ) compared to women ( $M = 12$ ,  $SD = 3.43$ ). Sexual dysfunction was confirmed in the overall sample ( $n = 95$ ). In the work dimension, statistically significant differences were found ( $p = 0.017$ ), with obese men reporting higher quality of life ( $M = 9.8$ ,  $SD = 3.04$ ) than obese women ( $M = 11.2$ ,  $SD = 2.66$ ). Among men ( $n = 46$ ), data analysis revealed that higher BMI values were associated with lower quality of life across all dimensions except self-esteem. Among women ( $n = 49$ ), higher BMI values were associated with lower quality of life in physical functioning, with BMI explaining 39.44% of the variance in this dimension. A moderately strong negative relationship was found between BMI and the quality-of-life dimensions of social relationships and public distress. No significant associations were found between BMI and self-esteem ( $p = 0.642$ ), sexual life ( $p = 0.904$ ), or work ( $p = 0.951$ ).

**Conclusions.** The prevalence of obesity continues to rise across all age groups and significantly affects both health and quality of life, underscoring the urgent need for effective preventive measures.

**Key words:** obesity, Quality of life, dimensions of quality of life. BMI.

Ожиріння є захворюванням, якому можна запобігти, однак в останні десятиліття воно вражає дедалі більше населення як розвинених країн, так і країн, що розвиваються. Це комплексне захворювання, що включає надмірну кількість жирової тканини. Воно призводить до структурних і функціональних змін, які culminують у численних органоспецифічних патологічних ускладненнях, що суттєво впливають на захворюваність, а також на якість і тривалість життя хворих на ожиріння. Метою роботи було з'ясувати, у яких вимірах ожиріння впливає на якість життя, порівняти якість життя з огляду на стать та дослідити взаємозв'язок між якістю життя респондентів з ожирінням і рівнем їхнього ІМТ.

**Матеріали та методи.** Досліджувану вибірку склали 95 респондентів: 49 жінок і 46 чоловіків з  $ІМТ \geq 30$  кг/м<sup>2</sup> віком від 20 до 65 років, які перебували під диспансерним наглядом у центрі з регуляції надлишкової маси тіла. Найбільша кількість респондентів ( $n=29$ ) була у віковій групі 40–49 років. Для збору даних було використано скорочену версію стандартизованого опитувальника впливу маси тіла на якість життя IWQOL-Lite, що складався з 31 закритого питання. Було досліджено якість життя людей із морбідним ожирінням у п'яти вимірах: фізична кондиція, впевненість у собі, сексуальне життя, соціальні стосунки, проблеми у публічному житті та робота. В кожному пункті анкети респондент обирав одну відповідь, яка найточніше відображала його ситуацію за останній тиждень. Відповіді оцінювались за 5-бальною шкалою Лайкерта: завжди, зазвичай, іноді, рідко, ніколи. Для отримання антропометричних даних використовувався біоімпедансний аналізатор InBody 230. Отримані дані були проаналізовані методами описової та інференційної статистики. В описовій статистиці застосовувались абсолютні (f) та відносні частоти (%), для кількісних змінних – середнє арифметичне (M), стандартне відхилення (SD), медіана (Mdn), мінімум (min) і максимум (max). У межах інференційної статистики застосовувались тести для порівняння та виявлення взаємозв'язків між змінними. Перед вибором тесту перевірялась нормальність розподілу даних (асиметрія, ексцес). Для визначення відмінностей між двома групами використовувався t-тест Стьюдента для незалежних вибірок, а для виявлення взаємозв'язків – коефіцієнт кореляції Пірсона.

**Результати.** Між чоловіками та жінками з ожирінням існує різниця у загальній якості життя: чоловіки досягають вищих показників ( $M=99,59$ ), ніж жінки ( $M=111,2$ ). Відмінності були виявлені також у вимірах впевненості в собі, сексуального життя та роботи. У вимірі «фізична кондиція» різниця з огляду на стать не була статистично значущою ( $p=0,8$ ). У сфері «впевненість у собі» виявлено статистично значущу різницю ( $p < 0,001$ ): чоловіки мають вищу впевненість ( $M=13,43$ ,  $SD=7,25$ ), ніж жінки ( $M=20,1$ ,  $SD=5,6$ ). У сфері «сексуальне здоров'я» підтвердилось, що чоловіки мають вищу якість життя у сексуальній сфері ( $M=10,17$ ,  $SD=4,54$ ), ніж жінки ( $M=12$ ,  $SD=3,43$ ). У вибірці ( $n=95$ ) було підтверджено дисфункції у сексуальній активності. У сфері «робота» виявлені статистично значущі відмінності ( $p=0,017$ ): чоловіки з ожирінням досягають вищої якості життя ( $M=9,8$ ,  $SD=3,04$ ), ніж жінки ( $M=11,2$ ,  $SD=2,66$ ). У чоловіків ( $n=46$ ) аналіз даних показав, що чим вищий ІМТ, тим нижча якість життя у всіх сферах, окрім впевненості в собі. У групі жінок ( $n=49$ ) було з'ясовано, що з підвищенням ІМТ знижується якість життя у сфері фізичної кондиції. Значення ІМТ пояснює 39,44% варіації фізичної кондиції жінок з ожирінням. Було виявлено помірно сильний негативний зв'язок між ІМТ та якістю життя у сферах соціальних стосунків і публічного життя. Зв'язки між ІМТ та впевненістю в собі ( $p=0,642$ ), сексуальним життям ( $p=0,904$ ) і роботою ( $p=0,951$ ) не були статистично значущими ( $p > 0,05$ ).

**Висновки.** Поширеність ожиріння постійно зростає в усіх вікових категоріях, суттєво впливає на здоров'я та якість життя людей з ожирінням, що зумовлює необхідність ефективних профілактичних заходів.

**Ключові слова:** ожиріння, якість життя, виміри якості життя, ІМТ.

**Conflict of interest:** absent.

**Конфлікт інтересів:** відсутній.

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