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7-21-2019

## An Interpretative Phenomenological Analysis Investigating UK Female Experiences of Psychosocial Adjustment Following Bariatric Surgery

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### Recommended APA Citation

Maxwell, M. J. (2019). An Interpretative Phenomenological Analysis Investigating UK Female Experiences of Psychosocial Adjustment Following Bariatric Surgery. *The Qualitative Report*, 24(7), 1714-1730. <https://doi.org/10.46743/2160-3715/2019.3837>

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## **An Interpretative Phenomenological Analysis Investigating UK Female Experiences of Psychosocial Adjustment Following Bariatric Surgery**

### **Abstract**

The psychosocial impact of bariatric surgery has not been studied as diligently as the physical impact, particularly within the first 6 months following surgery. The aim of the present study was to explore psychosocial adjustment in UK bariatric candidates within this time-scale. Six female participants were purposively recruited to complete a semi-structured interview, and Interpretative Phenomenological Analysis was used to analyse their experiences. Four super-ordinate themes emerged from the interview data which were: (1) "It was me but it wasn't me": pre-surgery identity, (2) "I don't see myself as this fat blob of a person anymore": transforming identity, (3) "No easy road to weight loss": the challenges of living with stomach restriction, (4) "I'm letting people in more now": re-engaging with others and the world. Participant accounts highlighted a largely positive psychosocial experience following surgery. Results are discussed in support of previous literature and suggest (1) the exploration of identity more thoroughly, and (2) the importance of routine pre- and post-surgery psychosocial support to be incorporated as part of Tier 3 and 4 bariatric services.

### **Keywords**

Bariatric, Bariatric Surgery, Weight Loss, Health, Psychosocial Functioning, Interpretative Phenomenological Analysis

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### **Acknowledgements**

This is dedicated to each of the participants who shared their stories so generously and extended to all others adjusting to life post-bariatric surgery. I would like to thank Neill Thompson, senior lecturer from Northumbria University who supported and guided me through the research process.

# An Interpretative Phenomenological Analysis Investigating UK Female Experiences of Psychosocial Adjustment Following Bariatric Surgery

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## Introduction

### Trends in Obesity

Obesity has quickly become a global public health concern with the World Health Organisation (2014) projecting that at least one third of the adult population is overweight. This reveals that worldwide, more than 1.9 billion adults over the age of 18 are overweight (BMI: 25 – 29.9), and of those, 650 million are obese (BMI: 30 – 34.9). Additionally, there are 340 million overweight 5 – 19 year olds and over 41 million children under the age of five who also fall into this category (World Health Organisation, 2018).

Western countries are particularly affected, with the UK reported as having the highest recorded levels of obesity in Western Europe (UN Food and Agriculture Organisation, 2013). The House of Commons briefing paper on obesity (2016) indicates that 24% of adults in England are obese or morbidly obese (BMI > 40) and a further 36% are overweight (Baker & Bate, 2016). Cumulatively this reveals that over 60% of adults in England are above the recommended healthy BMI range (18.5 – 24.9).

### Consequences of Obesity

Being overweight or obese can have serious health implications as it increases a person's risk of developing conditions such as hypertension, type II diabetes and high blood

pressure, and more serious diseases such as cardiovascular disease and some cancers (Ahima & Lazar, 2013). This increases burden on health services, where the UK spends on average 5.1 billion pounds a year on the healthcare costs of an increasingly obese population; a cost which is 5% of the entire budget for the NHS (Collins et al., 2015).

Obesity also carries an increased risk of psychological morbidity, which includes, depression, anxiety, low self-esteem and body dissatisfaction (Jorm et al., 2003; Klaczynski, Goold & Mudry, 2004; Luppino et al., 2010; Schwartz & Brownell, 2004). As this is a stigmatized condition in western cultures, discrimination and humiliation of these groups are common (Vartanian & Fardouly, 2013), with one survey finding that obese individuals are often perceived as less responsible for their actions (Mattingly, Stambush & Hill, 2009). Moreover, morbidly obese individuals tend to have lower incomes, lower socio-economic status and have higher rates of unemployment (Willett, Dietz, & Colditz, 1999), yet, the directionality of this association is not known.

Presently, weight-loss intervention is primarily focused on promoting healthy eating and physical activity, yet for those with larger BMI's, these strategies have generated poor outcomes (Ochner, Tsai, Kushner, & Wadden, 2015). Anti-obesity tactics have been coordinated by governments, retailers and food and drinks manufacturers, yet national statistics suggest that despite these efforts, obesity rates are continuing to rise (Baker & Bate, 2016).

## **Bariatric Surgery**

Consequently, bariatric surgery has become an attractive option to those with morbid obesity who have been unable to lose weight using traditional methods. Following surgical intervention, in most patients, major weight loss occurs within the first 2 years before it begins to stabilise. Although the level of weight loss may depend, in part, on pre-surgery weight and the surgical procedure used, in general the highest weight loss occurs within the first year. At 6 months patients typically lose between 30% and 40% of excess body weight if they have had gastric bypass surgery or 25 – 50 pounds if they have had a gastric band. At 1-year patients should expect to have lost over 100 pounds (Davis, 2008).

## **Post-Surgery Psychosocial Functioning**

As obesity is associated with negative psychosocial consequences, there is agreement that bariatric surgery can lead to improvements in a person's mental health and psychosocial functioning (Karmali, 2013). Herpertz et al. (2003) conducted a systematic review of 40 studies focusing on psychosocial outcome following bariatric surgery at a 1-year follow-up period. Their findings indicated that psychosocial status improved following surgery which contributed to improved quality of life (QoL) ratings among participants. Studies have reported that anxiety and depression ratings decreased from baseline measures in 2- and 4-year postsurgical reports (Karlsson, Sjöström, & Sullivan, 1998; Sullivan, Karlsson, Sjöström, & Taft, 2001), and studies evaluating the psychological constructs: self-esteem, self-confidence, liking oneself, body image and sense of attractiveness, also indicated considerable improvement at post-surgical follow-up (Buddeberg-Fischer, Klaghofer, Sigrüst, & Buddeberg, 2004; Chandarana, Conlon, Holliday, Deslippe, & Field, 1990; Hawke et al., 1990; Larsen & Torgerson, 1989).

Identity and personality have also been explored in pre- and post-surgery patients, yet studies of this kind have presented conflicting results. Despite Sutin et al.'s (2013) report that weight gain is attributable to identity loss through the complex transformation of personality traits, literature within this domain overwhelmingly reports the opposite. Persons who are obese tend to accept weight as part of their identity, and hence coping with a changing shape

and size following surgery can lead a person to feel insecure, vulnerable and exposed (Carr & Jaffe, 2012; Jung & Hecht, 2004). This can be attributed to the internal image one holds of themselves as an obese person which can be very powerful and difficult to change (Meana & Ricciardi, 2008).

Due to stigmatization, obese individuals are more likely to avoid public places and group activities (Myers & Rosen, 1999). Often obesity is perceived as a reflection of a character flaw and their psychosocial difficulties are attributed to themselves as a person rather than the obesity condition itself (Vallis et al., 2001). Consequently, people often feel neglected and misunderstood by friends, work colleagues and healthcare providers (Vallis et al., 2001).

Significant weight reduction has been demonstrated to reduce this type of social distress by increasing a person's willingness to engage in social activities (Stunkard & Wadden, 1992). This is supported by studies of 2- and 4-year post-surgical patients which have demonstrated that bariatric surgery can lead to dramatic improvements in social health (van Hout, Boekestein, Fortuin, Pelle, & van Heck, 2006) and social networks (Kinzl, Traweger Trefalt, & Biebl, 2003). Obesity related social difficulties were found to be the most responsive treatment effect of weight reduction, with reported problems reducing by 63% in males and 57% in females; findings which were significantly lower when compared to control cases (Karlsson et al., 1998; Sullivan et al., 2001).

Intimate relationships and sexual functioning have been investigated with one-year post-surgery patients who reported positive changes in their partnership following surgery. This includes marital relations and a significant change toward a more satisfying sexual life (Chandarana et al., 1990). However, Isacsson, Frederiksen, Nilsson, and Hedenbro (1997) reported inconsistencies with the literature in his finding that a significant change in size can increase self-esteem/confidence and may open up opportunities for other more fulfilling relationships. This could serve to de-stabilise some marriages.

Although overall improvements are found postoperatively, these improvements may depend on the psychosocial construct under investigation. Body image dissatisfaction, particularly the experience of increased or sagging skin, is a commonly reported problem following bariatric surgery, which has been reported to affect as many as 70% of patients in one study (Kinzl et al., 2003). Notably, individuals who lost less weight following surgery reported greater satisfaction in their appearance, likely because their 'skin problems' were less pronounced (Kinzl et al., 2003).

Moreover, studies exploring psychological morbidity in long-term post-surgical patients (>2 years post-operative) have provided a different perspective on QoL with reports that psychological health worsened over time (Karlsson, Taft, Ryden, Sjöström, & Sullivan, 2007). These findings may reflect both the stabilisation of weight loss between 18 and 24 months post-surgery and slight weight regain which often occurs after 3 years (Sugerman et al., 1989). As individuals begin to notice the often dramatic weight loss in the first year either slow or halt, they may become frustrated or despondent, particularly if they had unrealistic weight-goals or expectations of long-term QoL following surgery (Kaly et al., 2008).

### **Rationale for the Present Study**

Research investigating psychosocial functioning post-bariatric surgery typically uses a follow up period of between 1 and 3-years. During this period, individuals are beginning to experience a weight-loss plateau and changes in multiple aspects of a person's life are beginning to stabilise. Research has capitalised on this by seeking to understand the often-complex changes an individual's experiences once they have had the opportunity to adapt to their new bodies.

Research investigating psychosocial adjustment within the first 6 months following surgery is scarce which makes it difficult to assert what is actually occurring within this timeframe. We do know, however, that this is somewhat of a grace-period where a person can expect to see a rapid acceleration in weight loss due to a reduced appetite. Moreover, as patients can expect to lose up to 40% of excess body weight within this period (Davis, 2008), they are likely to be contending with considerable life changes—not just in their relationship with food, but with themselves and those around them.

Assessing psychosocial outcomes in postoperative patients is important to evaluate the effectiveness of surgery in resolving pre-existing psychological difficulties. In addition, the rapid weight loss, surgical complications and side effects which commonly occur in the few months following surgery may have some relation to how a person is psychologically managing this transition. This study aims to inform our understanding of what is occurring during this period; and identify if short-term post-operative psychological support needs to be incorporated routinely into bariatric services.

In this study I captured the experiences of 6 female participants who had received bariatric surgery within a 6-month time scale. A social constructivist approach (Harré, 1986) was applied where participant experiences were viewed as active constructions, mediated by their social, historic and situational conditions. In choosing this paradigm for the current study, the philosophical focus is on each participant's constructed reality, by interpreting their weight loss in their own words. This approach was used to answer the research question: How do UK females experience and psychosocially adjust to bariatric surgery within the first 6 months following their procedure?

As the primary researcher of this study, I have been involved in the development, implementation and delivery of a psychological pathway within a Tier 3 bariatric service in North East England. I co-wrote a 'Weight and Wellbeing' self-help book which was used as a therapeutic tool with patients within the service and I also delivered on a series of pre-surgery group sessions for patients preceding bariatric surgery. Following this I spent a brief period of time working for a separate bariatric team as an Assistant Psychologist where I took the lead on the development of a brief weight management intervention.

As a therapist, I have witnessed first-hand the enormous adjustment that bariatric candidates contend with following surgery. I have consistently received feedback from the patients whom I have supported that the psychological adjustment is far more challenging than the physical adjustment. I became interested in learning more about how patients make sense of their transition and of the areas of psychological and social functioning which they saw improvements in or those which they found particularly problematic.

I identified a gap in the literature within the first 6-months following surgery and intended to offer a new perspective on adjustment during a time when patients are very quickly managing various changes in their lives.

## **Method**

### **Study Design**

Interpretative Phenomenological Analysis allowed detailed examination of the personal lived experiences of bariatric patients. This approach was utilised due to its commitment to the examination of how a person makes sense of their personal and social experiences (Smith, Flowers, & Larkin, 2009) and was selected as it was consistent with the research aims. This enabled exploration of each participants weight-loss journey, particularly focusing on their psychosocial adjustment. Semi-structured interviews permitted important issues to be addressed and allowed freedom to make additional enquiries and raise aspects of interest. This

contributed to a more thorough understanding of how participants made sense of their life before surgery, the surgical procedure itself and its impact on post-surgical functioning.

## **Participants**

A purposive sample of participants (n=6) were selected on the basis that they granted access to a short-term perspective of psychosocial adjustment following bariatric surgery. The chosen demographic were females as research has reported that females tend to report more weight-related psychosocial dysfunction than do males (Karlsson, Taft, Sjöström, Torgerson, & Sullivan, 2003).

A summary of the participants is as follows. Participants were between the ages of 33 and 56 with a mean age of 43. Two participants received a gastric bypass, two received a gastric band, one received a mini-bypass and one received a gastric sleeve. All participants were within 6-months post-surgery. The average weight prior to surgery was 315 lbs. The average weight of participants at the time of interview was 255 lbs. The average weight loss for the group was 59 lbs.

## **Data Collection**

Following the receipt of full ethical approval from the Northumbria University ethics committee, I contacted individuals with whom I had worked with who were within 6-months post-surgery. Individuals who agreed to participate in the study completed an activity and mood diary each day for four days prior to their interview. This provided the researcher with information regarding their level of activity and their mood status. This was read prior to the interview to guide the researcher's line of enquiry. The semi-structured interviews took place over the telephone or at a local community service and were audio-recorded for transcription purposes. Care was taken during the interviews to consider reflexivity as the researcher acknowledged that the style of questioning can affect the data obtained. This was important as the interviews in the present study were structurally different to those that I was familiar with as a CBT therapist. These experiences were tethered during the study interviews to allow myself to fully submerge into the world of each participant in a more flexible, less structured way.

## **Analytic Strategy**

The first stage of data analysis involved transcription of the interview data. As interviews were transcribed careful attention was paid to any areas of importance or interest which may have provided insight into the research question.

Secondly, in-depth analysis of each individual transcript ensued, with data analysis occurring within cases before moving to a cross-case analysis (Smith et al., 2009). Transcripts were read and then re-read and commenting of interesting or significant points were recorded in the left-hand margin. Re-reading was important in order to become familiar with the interview data, and as each transcript was re-read new insights were obtained. This free-textual analysis identified descriptions, explanations and the emotional reactions of participants which developed understanding of their experience of weight-loss surgery and recovery. As familiarity with each transcript deepened, connections and contradictions were commented upon and preliminary interpretations were made.

Once the commenting process was complete, the next level of analysis was theme development. Themes emerged from initial comments and were recorded in the right-hand margin which helped progress the analysis to a higher level of interpretation. At this level

psychological terminology was introduced, but care was taken to ensure that emerging themes were tied to what the participant actually said. Theoretical connections were made within each transcript and when this occurred the same theme title was repeated. At this stage the transcripts were considered as a whole and no effort was made to try and refine the data to aspects which were going to undergo a more detailed analysis.

Following this, similar themes were organised into larger super-ordinate themes until there was a fit to a higher conceptual title. An example are the themes: unrecognisable self, longing to rekindle old self, shameful self and negative picture of self, which all connected to a clear negative pre-surgical identity as its higher-level concept. Although the amount of themes identified reflected the richness of the data, as the analysis continued, the quantity became overwhelming and so the decision was made to group emerging themes into sub-themes under each super-ordinate theme. Although many of the themes were similar in meaning, they all served different functions in the text so initial theme names were not changed, but sub-themes were developed to capture aspects of discourse more succinctly. Using the previous example, unrecognisable self and longing to rekindle old self were given the sub-theme name *not the true self*, and shameful self and negative sense of self were given the sub-theme name *negative self-concept*. This process was repeated with each transcript and allowed a three-tiered analysis to evolve.

The complex process of connecting themes across participants was the final stage in analysis. Themes which seemed most important to the individual during the interview, those which explicitly answered the research question, or those which emerged across most or all participants were considered for the master table. A final table of 4 master super-ordinate themes consisting of 5 sub-themes were selected on this basis. Initially additional sub-themes were selected, yet a focus on depth rather than breadth of analysis was felt to be of most value, and so more tenuous themes were dropped. The sub-theme *improved physical health* is an example of this, discussed by every participant, yet it seemed too far removed from the research question and so was dropped from the final analysis.

The final master table of themes reflected each participant's "journey" and process of change. This was, for every participant, an important narrative which helped them to make sense of any changes in their psychosocial status. In line with this, super-ordinate themes captured their pre-surgical identity, their post-surgical identity, the challenges of living with stomach restriction and a re-connectedness to others.

## **Rigour**

Maintaining rigour was of importance throughout the research process (Jones, 2007) and so a reflexive journal was kept as a means of evaluating my position as a researcher at every step in the process. Rigour was also achieved through developing a thorough analytic trail. I also obtained peer review from a previous colleague working in bariatric care, who also had experience of using IPA. This helped to improve the quality and transparency of the analysis.

## **Results**

Interpretative Phenomenological Analysis of the six semi-structured interviews resulted in the emergence of four master themes:

- "It was me but it wasn't me": pre-surgery identity
- "I don't see myself as this fat blob of a person anymore": transforming identity

- "No easy road to weight loss": the challenges of morbid obesity and living with stomach restriction
- "I'm letting people in more now": re-engaging with others and the world

These master themes are not exhaustive; they were selected on the basis of their relevance to the research question and the experiences which were most important to the participants. Exploration of these master themes and their sub-themes will form the basis of this section.

### ***"It was me but it wasn't me": Pre-Surgery Identity***

This master theme captured the participant's pre-surgery identity. Participants discussed their experiences of life as a morbidly obese person and the beliefs and assumptions that they had about themselves, others and the world.

Participants overwhelmingly experienced a clear disconnection with themselves as a morbidly obese person. Lucy's description of her pre-surgery self exemplifies this theme: "It was me but it wasn't me, I hated the person I was before I lost the weight... I do think I was becoming a different person."

It was important to compartmentalise participants' pre-surgery experience to fully understand the transition each participant had made in the initial months following their procedure.

### ***Not the true self***

To be yourself, and be at peace with yourself, you must truly know yourself. However, all but Rose commented on a pre-surgical identity that wasn't theirs. This was most profound in Ella's account as she described a marked disconnection from herself:

I stopped looking in the mirror, really because I didn't realise it was me looking back at me, it was a different person altogether. I felt I've gone too far here but once you've gone too far it's difficult to get that back. I was like a stranger me, it was like I was in denial that it was actually me.

Ella's use of the word "denial" suggests her refusal to accept or believe she was a morbidly obese person. This disconnection led her to label herself as a "stranger," somebody who she felt she had no familiarity with. Ella later ascribed this to:

I didn't see the person that I used to be because I used to take pride in my appearance. I used to wear nice clothes. But now I just hide under plain clothes.

This denotes that Ella was protecting her vulnerable "obese" self by becoming self-effacing. Hiding under plain clothes was perhaps a mechanism to detract attention away from herself. Anna also described a false sense of self, but protected her "obese" self in a different way:

I don't need to walk into a room full of people and say the fat jokes before they do... I feel I don't have to take the piss out of myself sorry, before I'd be like all of the fat jokes you know whatever, but now it's like I don't feel like I need to do that.

Self-deprecation is tied to fundamental self-worth, and although Anna repeatedly states that she's "always been confident," her statement suggests that her obese status had damaged her self-concept. As humour often bleeds into reality, perhaps Anna is protecting core-beliefs she has about herself and her weight.

Jenny also described a lost identity, yet in contrast to Ella and Anna's descriptions, her account cut deeper than an aesthetic change: "I wasn't me. I'd lost my personality. I was very, erm, snappy with my partner as well because I was frustrated."

Jenny's revelation suggests that she experienced deeper changes as a result of her weight gain. She informs that she became "snappy" with her partner and described herself as "a drain. I was like constantly on their back." Combined with the experience of losing the characteristics and qualities, which distinguished her as a person, Jenny expressed a discontent with her appearance: "It's just embarrassing doing things like that like going on holiday. I did not want to look awful on my wedding day." This suggests that her obese identity undermined all of her favourable characteristics and qualities, leaving her disconnected with every aspect of her true self.

### ***"I don't see myself as this fat blob of a person anymore": Transforming Identity***

This master theme consisted of two sub-themes which captured the participants changing identities following bariatric surgery. This was an important process in every participant account and illuminated the transformation from their "obese" self to becoming a "normal-weight" person. As discussed, personality manifested as a crucial component in participant accounts and the examination of this construct helped develop a thorough understanding of the research question.

The transformative process was described by Lucy who stated that, "I see the person I was 20 odd years ago before the weight all got on... I'm not so negative in myself. I'm happier about myself. I have a more positive outlook on myself."

### ***Finding my lost identity***

Following surgery, all but Anna made reference to transforming back to the person they were at an earlier stage in their lives. This was less pronounced in Anna's interview as she was the only participant who made reference to her pre-surgery identity as being a "happy" and a "confident" one. This transformation was demonstrated when Ella described what she saw when she looked at herself in the mirror:

Like, every time I look in the mirror, I feel like it's the same person looking out than it was all those years ago when I was thin and carefree. It's a really nice feeling like I don't feel like she's the fat person that was looking in the mirror before.

Ella speaks about herself in the third person when describing herself looking in the mirror: "she's the fat person;" a statement highlighting her detachment from the person she had become. Yet, although only a short time had elapsed since her surgery, she began to recognise that person again and regressed to a former self that had fewer worries and insecurities.

Similarly, Jenny, Molly and Lucy all felt reconnected with their true identity with Jenny informing: "I'm more me. I'm more what I'm meant to be and the way I'm meant to feel."

Rose, however, seemed to be fixed in an internal conflict with who her true self actually is: "Mentally you look in the mirror and still see yourself as fat, but not."

Interestingly, Rose had lost the most weight in the group by a considerable margin, with a loss of 89 lbs. Despite this, Rose's self-perception did not match the reality of her changing shape and size and she found it difficult to untether her morbidly obese self from her current self. Earlier, however, Rose made a comment in contradiction to this statement: "I am now back to what I used to be when I was only 19."

Despite Rose's considerable weight loss within the first 6 months, her contradiction suggests that she is struggling to maintain a narrative about her weight loss. Her self-perception was somewhere between her younger "fitter" self and her obese self. Perhaps, this suggests that Rose is still adjusting to her weight loss.

### ***Positive self-image***

Self-image was discussed by Anna, Lucy and Ella who all described a shift in the way they viewed themselves and the way they felt others perceived them. Anna stated:

I do feel like I look better, of course I do. I mean 3 stone is a lot to lose and it's a nice feeling you know. I definitely feel better about myself and don't feel as insecure about what I look like, you know.

Her use of "of course" suggests that Anna felt an improved sense of attractiveness was almost an obvious or expected consequence of weight-loss, which in turn helped her to feel better and less insecure about the way she looked.

Similarly, Lucy described her self-image positively:

Now, when I see myself in the mirror you know, when I am getting ready for a night out and I see myself with make-up on and my clothes on, I like what I see. Whereas before it was like oh well, I need to hide. I need to hide the fat.

Lucy's description suggests that she would hide behind clothes in an attempt to disguise her obesity. This helped her to feel less insecure and more comfortable going out in public. Following surgery Lucy became more accepting of herself.

Ella's self-image had also improved, which in part, was attributed to her social comparisons: "I'm looking better than some of the people I was intimidated by before, well I think I am."

The inferiority Ella felt about her morbidly obese self is reflected in her use of the word "intimidated." This denotes the fear she felt around "normal-weight" people. Although Ella is still in the very early stages of her weight-loss, the transformation in her self-image is astonishing as she is now able to place herself above others on a continuum of attractiveness. However, her final words "well I think I am" reflects a deeper uncertainty about her perception of size.

### ***"No easy road to weight loss": The Challenges of Morbid Obesity and Living with Stomach Restriction***

This master theme captured the difficulties participants experienced as a morbidly obese person and within the first 6-months following their surgical procedures. This theme was identified in every participant interview; however, the type of difficulties that were reported varied substantially.

Rose had concerns about how others may perceive her as a morbidly obese person: "People don't like fat people, they think they're thick or don't belong." Whereas Molly worried about the lasting effects of surgery: "I worry about my excess and sagging skin."

### *Falling victim to actual or perceived stigma*

The most prominent sub-theme was falling victim to stigma (actual or perceived). Participants discussed the impact of living with a body which is not accepted by society. This narrative extended beyond surgery with participants detailing the emotional consequences of the stigmatization they endured for being a bariatric patient.

Anna discussed a conversation she had with her friend at slimming world:

"Aw Anna, don't get a gastric band because you'll change you know. You'll get thin and your personality will change." I was like "it won't, I'll always be like this," but I do understand what she means.

This highlights the stigma Anna faced following her decision to have surgery. Her friends concern regarding the consequences of the procedure extended beyond dealing with practical adjustments but cut deeper into a sense of losing one's personality.

Anna takes an honest approach toward dealing with people's attitudes toward her decision and takes pride in her attempt to achieve a healthier lifestyle:

I'm quite an open person, I wear my heart on my sleeve, so I am quite open. I tell people everything. I'm like aw I've had a gastric band you know and it's helping me.

In contrast to Anna's "heart-on-sleeve" approach to dealing with stigma, Ella describes a sense of embarrassment about receiving surgery and a fear of other people finding out her secret:

I sometimes don't want people to think of me as someone who can't manage their weight without help ... in my head I think those waiters must think ooo she's had work done and it can get a bit embarrassing.

Ella attributes her fear to others perceiving that she lacks control and has failed to take responsibility of her weight. This explains her sense of embarrassment and shame in situations which could reveal her secret and leave her feeling vulnerable.

Jenny became animated when discussing the generalisations people make to those who have received bariatric surgery:

I would say people are the worst thing. Because people have this like, erm, stigma against people who have had surgery and they like need educated about it because it's like, you know these programmes they put on telly where these massive people are going for surgery and by massive I mean like, 40 50 stone or whatever, and they're coming out and pureeing McDonalds. People think that because there is one person that does that, that we all do that. Uh huh and that we don't deserve surgery, just because you're fat why should the tax payer's money be spent like that. It's hard having surgery.

Jenny described the judgement she felt from others regarding her decision to have surgery. This left her feeling angry and frustrated as people were acknowledging the monetary cost but

failing to understand the practical and emotional cost of surgery. Jenny described preparing for surgery as "the hardest thing" and opened up about her struggles adjusting to the practical implications of a gastric sleeve. Her sense of worth was questioned as she felt others perceive those who are unable to take responsibility for their weight as being undeserving of surgery and ultimately costing the NHS valuable money.

### ***"I'm letting people in more now": Re-Engaging with Others and the World***

This final master theme documented the improved social functioning reported by all of the participants following surgery. It detailed participant experiences around increased meaningful activity, re-established social networks, improved functioning in romantic relationships and feeling close and connected to people that were important to them. Molly, in particular, felt surgery was a freeing experience for her: "I'm starting to let people see what was under all of that weight which is so important to me."

The reflections captured by participants within this theme seemed important to their narrative and contributed directly to the research aims.

#### ***Re-connecting with others***

It became clear that re-establishing relationships with family and friends was one of the most important and welcome changes following surgery.

Jenny, Lucy, Ella and Molly all described a new or re-established feeling of connectedness with those around them. Jenny described: "Everybody was saying that I looked well, and it was just a nice feeling." Lucy stated: "I can keep up with him [her grandchild] now. I have more energy for him." However, this feeling of connectedness was most pronounced in Molly's account, particularly in her description of becoming more open with her family. She described thus; "I've always had a good relationship with my family, but I do feel a lot more open with them now. I'm letting people in more." She then later elaborates: "I feel like even with family I had a bit of a barrier up, erm, but that's obviously started to come down now."

It seems that Molly's weight acted as a barrier and prevented her from getting close to people. In consequence, Molly became increasingly insular and closed herself off from the people that meant the most to her. Because Molly used her weight almost like a shield to protect herself, as her weight began to reduce, her barrier "started to come down," which helped improve her meaningful relationships.

Ella also described improved relationships, yet she attributed this to her ability to fulfil certain roles: "I can be a mother again, a friend, a work colleague. I didn't used to be that."

This statement reflects the extent to which Ella felt that she had lost all sense of purpose prior to surgery. She felt unable to dutifully fulfil multiple roles in her life and in consequence she completely succumbed to her obese status.

However, Ella now feels that she is able to fulfil and use these roles to increase her sense of value. Her weight loss has also helped place her back in society. Ella stated, "I really want to feel part of the community again because I tended to avoid it." Ella now has this wish. Her re-integration with society has increased her sense of self-worth and provided her with greater opportunities for positive and meaningful experiences.

## **Discussion**

The study highlighted a mostly positive process of adjustment within the first 6-months following surgery. In this section the interview data will be discussed in relation to existing psychological theory and literature.

An interesting finding was that in contrast to participant accounts, persons who are overweight or obese tend to accept their weight as part of their identity (Carr & Jaffe, 2012). This is less pronounced in persons who describe a previous "thinner" self, much like Ella and Jenny, who often struggle to maintain a narrative between two identities: their actual self and their perceived self (Carr & Jaffe, 2012).

Their difficulty in accepting their obese status is consistent with Temporal Comparison Theory (Albert, 1977), which posits that an important source of self-evaluation is an assessment of how well one is doing in the present compared to the past. By using their earlier weight as an evaluative standard, Ella and Jenny felt that their obese status was not their true or desirable self.

Additionally, Jenny described a "lost" or changed personality. Although there is literature exploring the personality traits which contribute to weight gain (Gerlach, Herpetz, & Lober, 2015), less is known about weight gain leading to a change in personality. One study, however, has demonstrated that personality traits do begin to transform as weight increases (Sutin et al., 2013). This suggests that weight gain transcends a physical transformation in its ability to dislodge the complex set of characteristics that define an individual's personality.

As participants lost weight, they reported improvements in their self-image and sense of attractiveness. Losing weight quickly has an uplifting effect as seeing rapid results inspires confidence and increases motivation (Klem, Wing, McGuire, Deagle, & Hill, 1997). However, consistent with Rose's account, it is still common for people to see themselves as overweight despite significant weight loss. This can be attributed to the internal image one holds of themselves which are very powerful and difficult to change (Meana & Ricciardi, 2008). Consequently, despite Rose's weight loss, her mind had distorted reality to fit her self-perception. For Jenny, Lucy, Ella, and Molly, weight loss bridged their identity gap (Granberg, 2006) leading to a re-connection with their 'true self'.

Ella's improved self-image led to her placing herself above others on a continuum of attractiveness. Her experience is consistent with Social Comparison Theory (Suls & Wheeler, 2012) which posits that we determine our own social and personal worth based on how we perceive ourselves against others. Participants improved self-image following surgery is consistent with studies evaluating post-surgery psychosocial functioning where considerable improvements in self-confidence and liking oneself are commonly reported following the procedure (Chandarana et al., 1990; Hawke et al., 1990). These improvements are especially pronounced in the first 6 months following surgery (Neven, Dymek, Maasdam, Boogerd, & Alverdy, 2002).

The challenges of life following surgery were discussed primarily in relation to stigma. Jenny and Ella's concerns about the perception of others is consistent with research which has demonstrated that individuals evaluate those who have lost weight through surgery as lazier, sloppier, less competent and less sociable (Vartanian & Fardouly, 2013). Similarly, Ella worried that people will perceive her as lacking control to manage her obesity. This is supported by studies that have demonstrated that those who have had weight-loss surgery are often perceived as less responsible for their actions (Mattingly et al., 2009).

Peoples' attitudes toward those who have received bariatric surgery is perhaps due to the misinterpretation that bariatric surgery is the "easy way out." Jenny became annoyed when discussing the negative views others have of her: "We've paid for her to get thin." This undermines the effort, commitment and determination that bariatric candidates need, as there must be adherence to strict dietary and exercise schedules to prevent weight regain (Sarwer, Wadden, & Fabricatore, 2005).

When Jenny discussed the eating habits of certain people who have received bariatric surgery, notably the pureeing of foods, she described people's generalisations to the whole bariatric surgery community. These concerns are not misplaced, which as Link and Phelan's

(2001) stigmatization model suggests, once an individual had been given a label, the labelled persons are attached to a stereotype. Jenny's comment that "people need educating about it" suggests her longing to break negative attitudes toward those who have received surgery as it often creates a separation into "us" and "them" (Goffman, 1963).

In line with participant accounts, research has demonstrated that following bariatric surgery, patients show better social functioning (Herpertz et al., 2003), particularly with improved social networks (Kinzl et al., 2003). In Jenny's account, her connection to others was manifested in social approval and encouragement about her weight loss. This is also consistent with research that has revealed that following surgery, social support and encouragement increases (Kinzl et al., 2003) and stigmatization and discrimination decreases (Rand & MacGregor, 1991).

As participants began to notice differences in their size, they observed improvements in their self-esteem and they began to feel more love for themselves. In doing so, they are better equipped to love others and "let people in." Research supports this notion, as losing weight and taking care of oneself brings energy, interest and the ability to improve closeness and optimize entire interactions with others (Clark, Saules, Schuh, Stote, & Creel, 2014).

Although there is research in support of many of the findings, the study explored a fundamentally under-researched area. The psychological implications of obesity have not been studied as diligently as the physical changes, especially within the first 6-months following surgery. This has helped to form a bridge with existing research to develop a more thorough understanding of post-surgical functioning from its inception.

On reflection, the study raised a number of interesting questions that would benefit from further exploration. As discussed, one finding and contradiction with the existing literature was how participants made sense of their pre-surgery identity. The literature posits that fundamentally, morbidly obese persons accept their weight as part of their identity, and a loss of identity can occur following bariatric surgery. The opposite was found in the current study as participants described their obese self as not their true self, and following surgery participants began to re-find their lost identity. Perhaps, in part, this could be attributed to participant's descriptions of an earlier "thinner" self, which had already been conceptualised as their true self. There may be benefit in exploring identity more thoroughly, particularly how a person's sense of identity is altered as they transition to post-surgery life. This could be an important concept to understand, as individuals may need to understand themselves before they can change the way they feel about themselves.

The research also raised questions about the level of psychological support available to bariatric patients. Anna stated that the main obstacle she faced was "adjusting mentally," and she described her disappointment at not receiving sufficient support. Similarly, prior to surgery Rose identified that "it's the mental side they don't prepare you for... they don't prepare you to look in the mirror," and also that "the aftercare is not very good." These revelations highlight the importance of incorporating psychosocial support in Tier 3 and 4 pathways. Some areas in this study, particularly dealing with stigma, need to be considered more thoroughly, and in doing so this would enable a smoother transition to post-surgery life.

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This is dedicated to each of the participants who shared their stories so generously and extended to all others adjusting to life post-bariatric surgery. I would like to thank Neill Thompson, senior lecturer from Northumbria University who supported and guided me through the research process.

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**Article Citation**

Maxwell, M. J. (2019). An interpretative phenomenological analysis investigating UK female experiences of psychosocial adjustment following bariatric surgery. *The Qualitative Report*, 24(7), 1714-1730. Retrieved from <https://nsuworks.nova.edu/tqr/vol24/iss7/13>

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