An interpretative phenomenological enquiry into individuals' experience following Roux-en-Y gastric by-pass surgery.

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August 2018

Word Count: 43965

Acknowledgements

To Claire, thank you for your patience, and to my mum for who without your support and encouragement

I would never of have got this far. I'm sorry you never got to see me complete this.

Abstract

The aim of this study was to explore the lived experience following Roux-en-Y gastric bypass surgery in a UK sample. This phenomenologically based research utilised semi-structured interviews with eight men and women who had undergone gastric bypass surgery a minimum of 12-months prior. Analysis using Interpretative Phenomenological Analysis (IPA) resulted in four major themes being identified; i) managing change and uncertainty, ii) the affective experience of change, iii) the post-operative body within its relational context and iv) the presence and absence of appropriate support.

The study seeks to contribute to the limited amount of phenomenologically focused UK based research exploring the postoperative experience of those who have chosen to have bariatric surgery. Its findings highlight the complex nature of postoperative experience and highlight the deeply personal nature of adjustment which is required of individuals following surgery and the ways in which these are inextricably intertwined with the persons social, cultural and personal histories. Despite the experience of weight loss being a long-awaited change, the process of change and adjustment did not represent a smooth transition from pre- to postoperative life but instead was characterised by ambivalent feelings towards the imposed restrictions participants' now recognised and feelings of disappointment that surgery had failed to result in the transformations they had hoped for. In addition to the changes and adjustments participants' recognised having to make, the experience of weight loss was also intertwined with their social relationships requiring them to renegotiate the way in which they both understood others and themselves within social encounters.

The clinical significance of this study lies in its attempt to highlight the contribution of an existential phenomenological approach can offer in supporting individuals who choose to have bariatric surgery through its acknowledgment of the body as site of experience which is situated within a person's wider social, cultural and historical background. Furthermore, the

findings contribute to the discussion regarding the availability of appropriate long-term support for those undergoing bariatric surgery.

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Chapter 1. INTRODUCTION

1.1 Prologue

This research reflects the exploration of the experiences of eight men and women who had undergone Roux-en-Y gastric by-pass (hereafter referred to as RYGB) with the aim of gaining an understanding of the lived experience postoperatively. Holding an existential-phenomenological perspective this research reflects a faithful commitment to the phenomenological exploration of my participants' accounts with the aim of understanding their embodied experience postoperatively and the ways in which they experience forms of support available to them. Despite having worked extensively in the field of weight management and bariatric surgery, this study represents my first step in contributing to the knowledge base within this area as a counselling psychologist. Parros (2006) notes that the process of writing occurs within a context of other experiences including personal feelings, setbacks and supervisory and collegial discussions to name but a few. My intention therefore throughout this thesis is to acknowledge the surrounding circumstances as and when they occurred as they formed a substantial part of my developmental process as an emerging counselling psychologist.

1.2 Personal Relevance

My interest in the lived experience of individuals who have undergone RYGB surgery represents an integration of my own lived experiences and my relationship with my body and the ways in which this has influenced my professional work. Whilst I have never been overweight, I notice how within my own personal historical context my socialisation with commercial diets and efforts to lose weight represented normative practices within my family.

The death of my father from a heart attack when I was 11-years-old however signalled the beginning of an increased surveillance of my own body, through annual monitoring of indicators of cardiovascular disease and close attention to food choices. Although I was unable

to find the words to understand the impact of this loss until much later, I realise how I had perceived the sudden death of my father, who I had regarded as physically powerful and robust, as highlighting the fragility of one's body. Over the course of my training as a counselling psychologist, discussion within personal therapy would frequently acknowledged my underlying anxiety in relation to my health and how over the years this had manifested at times in an objectifying view of my body characterised by the need to maintain control. Over time I came to acknowledge the ways in which my experience of living with and through my body had been influenced by social and cultural factors as a well as my own personal historical context. Alongside my own exploration of embodiment at the time, I was also working within healthcare contexts which opened me up to the ways in which, to use Karen Throsby's term of "the body multiple", the body represents a site of multiple and sometimes contradictory epistemological views and discourses including social, political and medical and established my interest in exploring the ways in which these influences are experienced and managed by the individual.

My starting point of this study reflects my experience of having worked both as part of a multi-disciplinary team within a bariatric service and with clients who were either considering bariatric surgery or had undergone surgery within my private practice. Through my experience within these two contexts I have come to regard obesity as a highly ambiguous state and view the experience of being obese as unique for the individual. Whilst I do not regard individuals who are obese as necessarily unhealthier than those regarded as a healthy weight, nor align with the view of obesity as a disease that necessarily results in a restricted life I realise that these might be the ways in which individuals understand their weight status. Equally I have had the privilege to witness clients describe the vulnerability they experienced after losing weight and how their body size had offered both protection in the world and a sense of identity that they had valued. It is through these experiences that I regard the first-person account as essential to exploring the experience of undergoing and living with bariatric surgery.

1.3 Significance of the study

Weight loss surgery (hereafter referred to as WLS) is currently regarded as the most effective treatment for the long-term treatment and management of obesity and associated conditions. The recent definition of obesity as a "chronic and relapsing progressive disease" (World Obesity Federation, 2017, p. 1) further supports a medicalized approach to treatment however bariatric surgery also results in major changes to the person's life including daily practices, body image and relationships (Bocchieri, Meana and Fisher, 2002a; Ogle and Park, 2016). The current guidelines for individuals undergoing bariatric surgery includes the assessment of both physical and psychosocial factors as well as the provision of post-operative support relating to diet and nutrition, physical activity and psychological support tailored to the individual (NICE, 2014). Psychology has been recognise as offering a valuable contribution to not only identifying factors that might result in poorer weight loss outcomes but in exploring the experience of adjustment following bariatric surgery including eating behaviours (Natvik et al, 2014), body image (Groven, Råheim and Engelsrud, 2012) and quality of life (Ogden Avenell and Ellis, 2011; Groven, Råheim and Engelsrud, 2010). Whilst studies have acknowledged the need for support following surgery, few have focused on the experience of this specifically. This study aims to hopefully highlight the significant contribution counselling psychology, with its foundations in the existential-humanistic traditions, can offer through the practice of an ethic of embodiment that incorporates the lived experience of those living with RYGB surgery. Over the last five years the interest in individuals lived experience following bariatric surgery has increased considerably however with a few exceptions (Ogden et al, 2006; 2011; Jones et al, 2016) studies have been carried out outside of the UK. By exploring the lived experience of a small sample of individuals I hope to contribute to the increasing amount of research looking at individuals lived experience following RYGB surgery with a focus on their experience of support.

1.4 Structure of the study

In this introductory chapter, I will give an overview of the definition of obesity, including the social and physical implications of being obese that are identified in the literature. I will then review qualitative research that has sought to understand the experience of individuals who have had bariatric surgery before reviewing qualitative approaches that have specifically adopted a phenomenological approach. Through a comprehensive review of the literature I will highlight the need for the current study within the area of WLS and why a phenomenological approach is best suited for this study before suggesting the ways in which I feel this study will contribute to the field of counselling psychology and to the area of postoperative support more broadly.

Chapter 2. LITERATURE REVIEW

2.1 Context of the research

The UK has recently been reported as having the third highest rates of overweight or obesity in Europe with 67% of men and 57% of women aged over 20 years regarded as either overweight or obese (Ng et al, 2014). Although research suggests that effective treatment for long-term maintenance of weight loss should include multiple approaches including diet, exercise and behaviour therapy (Racette et al, 2003; Wadden et al, 2014), Booth et al (2014) argue that few primary care interventions are informed by behavioural science theory. Despite this however studies evaluating the effectiveness of behavioural interventions for obesity have consistently reported that behavioural interventions delivered within primary care settings result in small reductions in body weight with limited longer-term success assessed at 12 and 24-month follow-ups (Booth et al, 2014).

Given the ineffectiveness of lifestyle interventions for achieving significant or sustainable weight loss, bariatric surgery is currently regarded to be the most effective treatment for severe obesity (NICE, 2014). Within medicine and health, obesity has recently been defined as a "chronic relapsing progressive disease" (World Obesity Federation, 2017: p.1). The use of the term disease is significant as it implicitly implies a physiological basis and as such places the "boundaries and scope of responsibility" firmly within the realm of medicine (Farre and Rapley, 2017: p.1). Whilst this perspective adopts one ontological perspective, the role of psychology has been recognised as being increasingly important within the area of long-term health conditions (Karademas, 2009) and bariatric surgery (Ogden, 2012). Although psychology is grounded within the bio-psycho-social approach to understanding health and illness (Engel, 1981), a model that acknowledges the ways in which various biological, psychological and social factors impact on a person's experience of wellness and chronic illness and help-seeking behaviour (Farre and Rapley, 2017; Hilton and Johnston, 2017), much of the research conducted continues to evaluate success based on biomedical indicators of success such as

percentage of excess weight loss. As will be evident from the literature review below research exploring the individuals experience following surgery has expanded exponentially within the last five years. Whilst I regard this to reflect a positive shift away from the identification of factors that have been shown to affect weight loss to attending to the lived experience of those who have undergone bariatric surgery, this study seeks to address some of gaps within this knowledge base.

2.2 Medical science: Surgery as a response to overweight body

In response to this societal trend and apparent ineffectiveness of lifestyle interventions WLS is now widely regarded within the medical profession as the most effective treatment for individuals who are obese and have comorbid Type 2 diabetes (NICE, 2014). Although there are several different procedures the most commonly used are the RYGB and the adjustable gastric band (Carlin et al, 2013; Welbourn et al, 2014), however a recent study reported approximately 32% of patients underwent revision surgery from a gastric band to RYGB within a 15-year longitudinal study (O'Brien et al, 2013). Both procedures operate by imposing a physical restriction on the amount the person can eat however the RYGB, through the physiological changes made during surgery, also reduces the amount of nutrients absorbed into the body. Individuals typically lose between 40% and 70% of their excess weight with a mean loss of approximately 60% two years postoperatively (Buchwald et al, 2004). In a more recent review (Chang et al, 2014), the gastric by-pass was reported to be more effective in achieving greater weight loss when compared to the gastric band however was also associated with increased complications. Despite being regarded as offering the most consistent long-term results in terms of maintenance of weight loss (Karlsson et al, 2007), reduced mortality rates and health related comorbidities (Sjostrom et al, 2012), improved body image (Sarwer et al, 2010), health related quality of life and psychological well-being (Kubik et al, 2013), the RYGB has also been associated with a number of adverse physical complications including vomiting, diarrhoea, nutritional deficiencies and dumping syndrome (Bult, van Dalen & Muller, 2008). Dumping syndrome refers to a cluster of symptoms including

irregular heartbeat, diarrhoea, drops in blood pressure and vomiting resulting from food arriving rapidly into the small intestine triggering a series of physiological responses (van Beek et al, 2017). Weight regain postoperatively also represents a major problem with some studies reporting weight recidivism in 50% of cases at 24-months (Magro, 2008; Karmali et al, 2013). Similarly, despite the RYGB being the suggested approach for individuals with Type 2 diabetes some research has reported that remission rates are lower than previously suggested (Arterburn et al, 2013). Sarwer et al (2005) report that approximately 20% of patients undergoing surgery fail to benefit significantly from either weight loss or improved quality of life with those failing to lose weight continuing to report difficulties with both psychological and physical hunger (de Silva and Maia, 2013) and episodes of emotional eating (Chesler, 2012).

WLS requires individuals to comply with numerous nutritional and lifestyle behaviours and engage with regular clinical follow-up appointments (Wimmelmann et al, 2014). Although Elkins et al (2005) point out that during the months immediately following surgery the sudden change to the size of the stomach can be regarded as "forced behaviour modification" (p. 549), 40% of individuals failed to comply with nutritional or exercise guidelines over the first twelve months post-surgery with some studies reporting between 60% and 80% of samples failing to maintain follow-up appointments with nutritional and psychological support respectively (Magro et al, 2008). Given the risk of complications postoperatively and the risk of weight regain, research has focused on the identification of psychological and behavioural factors that might predict poorer outcomes (van Hout, Vershure and van Heck, 2005; Odom et al, 2010; Sillén and Andersson, 2017). Studies have identified a number of psychological factors including binge-eating (De Zwann, 2001; Sallet et al, 2007), current or historical substance misuse (Kalarchian et al, 2007), and early childhood trauma (Felitti et al, 1998) that might not only result in a failure to proceed for surgery following a suitability assessment (Beck et al, 2012; Sockalingam et al, 2012) but also account for suboptimal outcomes postoperatively (Hsu et al, 1998), including increased rates of self-harm (Bhatti et al 2015) and involvement with mental health services (Clark et al, 2007).

Whilst the increased interest in identifying factors that might predict successful and unsuccessful outcomes following surgery highlights the role of psychology within bariatric services (Hollywood, Ogden and Pring, 2015), research looking at predicting outcomes presents a number of limitations. Firstly, this research has tended to adopt large scale quantitative analysis and therefore limits the heterogeneity of participant responses, meaning participant experiences are only ever partially conveyed and understood (Bocchieri, Meana and Fisher, 2002b). Secondly, by looking at pre-surgical factors to predict postoperative outcome the assumption is that challenges encountered postoperatively are associated and have not developed as a result of the person's experience of undergoing WLS (Ogden et al, 2011).

One study that appears to highlight the discrepancy between research approaches emanating from a positivistic position followed a group of thirty individuals on the bariatric surgery pathway from prior to surgery to 12-months post-surgery with a view to understanding the changes in health problems, health complaints and coping strategies, during the WLS process as well as how individuals think about their treatment and the demands and impact of surgery on their lives (da Silva and Maia, 2013b). Although exploring individuals experience of undergoing bariatric surgery, participants were allocated into either a success or failure group depending on whether they had achieved ≥50% estimated weight loss (EWL) at the 12-month follow-up. Despite the classification of participants to either the success of failure group based on weight loss achieved a small number of participants classified as failures by the researchers, self-reported themselves as successes. The authors account for this disparity as existing in relation to two concepts, "outcome" and "treatment" in that whilst the success group refer to outcomes and future treatment as being within their control, such as diet and exercise, the 'successful failures' placed far greater emphasis on the need for further surgery in helping them manage their weight. Although there exist several limitations within this research including the use of self-report measures, and the relatively short period of time over which

participants were followed up, the study explicitly shows the way in which success and failure represent subjective as opposed to objective judgements.

To understand this apparent discrepancy between healthcare providers/researchers and patients/participants' views on successful and unsuccessful outcomes, Toombs (1993) offers a phenomenological perspective and proposes four ways in which views of an issue can differ: through a focus on the current situation, their attitude towards the disease, the identification of what is relevant and important and through the perception of time. Whilst Toombs points out that both are valid, if psychology is to offer a valuable contribution to the area of bariatric surgery there is a need to gain a greater understanding of the lived experience of having gastric by-pass surgery, as opposed to merely being able to acknowledge factors that might predict outcomes. Recognising the potential for individuals to experience a multitude of challenges following surgery, the current National Institute of Clinical Excellence (NICE) guidelines state that services providing bariatric surgery are required to provide a comprehensive 'diagnostic workup' (Peaple, 2016: p.11) including counselling, education and information giving as well as ensuring that a "structured, systematic and team-based follow up should be organised by the surgical provider for 2 years after surgery" (p. 11).

2.3 The role of psychology within bariatric surgery

2.3.1 Psychological Assessment

Unlike many other surgical procedures lifelong follow-up following bariatric surgery is recommended and as such individuals are required to complete a pre-surgery assessment by a multi-disciplinary team (MDT) who assess not only their suitability for surgery but readiness to proceed. NICE guidelines state that multidisciplinary teams offering bariatric surgery must be capable of offering not only comprehensive preoperative assessment of any psychological or clinical factors that may affect adherence to postoperative care but psychological support prior to and following surgery (NICE, 2014). The view that pre-operative psychological support

leads to positive outcomes is mixed with some suggesting that this recommendation should be dropped from NICE guidelines (Ogden, Hollywood and Pring, 2015) however the authors acknowledge a possible limitation within their study as outcomes were assessed after only 12-months post-surgery. One study that would seem to address this limitation was carried out by Kruseman et al (2010) who followed-up participants eight years after undergoing RYGB surgery. Adopting a mixed-methods approach within their follow-up, Kruseman et al. reported that whilst more than half of their participants achieved successful weight loss, disordered eating behaviour appeared frequently within participants' accounts of the challenges they experienced. Supporting the role of psychology within the patients journey the authors found that one factor that was found to be associated with successful weight loss was greater number of psychological consultations prior to surgery. Whilst the reason for this is unclear from the study, psychological support beyond the first year has been argued to be essential given the increased rates of suicide and self-harm within bariatric patients post-surgery as well as the significant challenges individuals might experience postoperatively whether from pre-existing mental health issues or from difficulties adjusting and adhering to changes required of them following surgery (Stunkard and Wadden, 1992; Bocchieri, Meana and Fisher, 2002a; Ghaferi and Lindsay-Westphal, 2015).

Sogg and Freidman (2015), writing in the U.S, emphasise the utility of the pre-surgery psychological assessment as a way of not only representing a move away from the sole focus on weight loss as a marker of success to the acknowledgment of other forms of outcome such as psychosocial functioning and adjustment and quality of life, but also to familiarise patients with what the authors refer to as the 'behavioural health clinician' should they encounter difficulties adjusting or adhering to lifestyle and behavioural changes post-surgery. Sogg and Friedman suggest several important features of the assessment process including patient education, both in terms of the surgical procedure itself and the necessary post-operative behavioural changes, as well as an opportunity for both the clinician and patient to identify factors which might affect postoperative weight loss, psychosocial functioning and quality of

life following surgery. From this perspective the inclusion of psychology within the assessment process is said to offer an opportunity for the psychologist, along with the patient, to "formulate a set of specific recommendations designed to minimise their impact on postoperative adjustment and success" (Sogg and Friedman, 2015: p.453). Although the inclusion of a pre-surgery assessment has been suggested as reflecting a form of prejudice (Ashton et al, 2008), others suggest the psychological assessment offers an opportunity for a discussion of individuals' expectations for surgery as well as the importance of lifestyle factors for maintaining weight loss so as to reduce the likelihood of the person experiencing disappointment with unexpected results (Alegria and Larson, 2014). Despite pre-surgery psychological assessments being a standard provision within WLS (NICE, 2014), Ratcliffe et al (2014) found that within a sample of twenty-two NHS services, responsible for carrying out 3691 surgeries a year, less than a third routinely carry out a psychological assessment with all patients and none offer routine post-surgery psychological assessments or any form of post-operative psychological group interventions to support patients.

Despite the abovementioned role of the psychological assessment to educate prospective patients and discuss expectations to avoid disappointment postoperatively, some have suggested that gaining informed consent is more difficult than it might appear (Hofmann et al, 2010). Combined with findings suggesting that patients undergoing bariatric surgery often do not remember information on potential complications (Madan et al. 2007), Arbwani et al (2009) found that individuals applying for bariatric surgery tended to present themselves favourably during the psychological evaluation by underreporting psychological problems. Adopting a phenomenological perspective of the pre-surgery assessment, Leder's (1990) concept of "dys-appearance" within the clinical encounter highlights the intersubjectivity of this assessment process in which the professionals "clinical gaze" is not only in search of a diagnosis but also represents a level of power over the persons future situation. Acknowledging this power imbalance within her ethnographic study of a bariatric clinic, Throsby (2012) uses the concept of "the body multiple" to highlight the "inextricability of clinical practice from those moral

judgements" (p. 9) when considering the different contexts in which obesity, and more specifically the judgement of excess, can appear either as a barrier to treatment, such as in joint replacement surgery, or as a validation of suitability for treatment as is the case within bariatric surgery. Given this ambiguity surrounding the notion of obesity as potentially limiting or validating the need for support the pre-surgery assessment represents a complex intersubjective encounter.

2.3.2 Adopting a psychosocial perspective on bariatric surgery

Although the RYGB procedure has been shown to typically result in significant and rapid weight loss and reductions in medical risk factors, these changes are accompanied by psychosocial changes that appear to be equally noteworthy. Among these, the need to change eating behaviours (frequency, amount, food type) alongside changes in perceived body image, psychological and emotional well-being and interactions with others and social relationships (Stunkard and Wadden, 1992; Bocchieri, Meana and Fisher, 2002a). Adopting a sociological perspective, Parros (2006) points out that whilst opening up "social coherences" such as fitting in and attention from others, bariatric surgery simultaneously opens up "bodily incoherence's" (p.162) such as a smaller stomach and a malabsorptive intestine. The management of such incoherence's has been reported in studies describing how following RYGB a person's family can initially experience a period of disruption to established patterns and roles but that over time these changes often result in closeness and an expansion of inter-personal relationships both within and beyond the family (Bylund, Benzein and Persson, 2013).

When considering the biopsychosocial view of obesity and bariatric surgery, the impact of stigma cannot be omitted. Goffman (1963) explains how society establishes means of categorising people into "normal" and "abnormal," defining the term stigma as a deeply discrediting attribute that involves feelings of shame. Within western society the aesthetic ideal of thinness against which the obese body is compared forms a pervasive discourse (Puhl and

Brownell, 2003). Some have suggested that, possibly because of reported health implications, as a society we have internalised the belief that fat is bad to such an extent that 'fat prejudice' is not regarded as a discrimination or a societal construct with expressions of such attitudes often appearing to be an accepted form of prejudice (Puhl and Brownell, 2003; Reader, 2014). Given the apparent embeddedness of 'fat prejudice' it is perhaps, whilst concerning, unsurprising that such views have been reported by both medical (Epstein and Ogden, 2001) and allied healthcare professionals including psychologists and counsellors (Davis-Coelho, Walt and Davis-Coelho, 2000).

Whilst the experience of stigma and shame associated with the obese body have been suggested as motivating factors in undergoing bariatric surgery as a means of liberating the person from these experiences as well as in maintaining commitment to behavioural changes postoperatively (Groven, Råheim and Engelsrud, 2010; Ogden and Clementi, 2010), others have suggested that such motivations can result in unrealistic expectations of hoped for changes in physical and mental health (Homer et al, 2016). There exists a growing body of literature exploring the impact of stigma on postoperative adjustment (Ogden and Clementi, 2010; Raves et al, 2016) with research indicating a particularly detrimental impact on behaviours that individuals are either required to restrict or implement postoperatively including emotional eating and increased physical exercise and dietary restriction respectively (Benson-Davis et al, 2013; Warholm et al, 2014; Raves et al, 2016). Adopting a mixed-methods approach, Raves et al (2016) explored patient experiences of stigma throughout the bariatric journey and the potential impact of this on dietary adherence. The authors note weight-related stigma being experienced from several sources including healthcare professionals outside of the bariatric field as contributing to dietary non-adherence following surgery. Supporting previous findings, the authors note several factors that correlated with non-compliance with dietetic recommendations including internalised weight-related stigma, gender and time since surgery. Whilst there are several limitations with this study, including the use of cross-sectional design and self-report dietary measures, the findings from this study

highlight the complex ways in which internalised stigma and experiences of generalised weight-related stigma established over time continue to impact on the individual even after significant weight loss.

It would seem therefore that whilst bariatric surgery offers the individual the hope of liberation from a stigmatised body, the decision to undergo WLS can result in discrimination akin to that experienced by individuals who are obese. Vartanian and Fardouly (2013) showed participants an image of a 'lean' man or woman and were asked to rate their impressions on several characteristics before informing them that the person had either lost weight through dieting or following WLS. After learning that the person had lost weight following surgery, participants' rated the individual more negatively viewing the person as being lazier, less competent and sociable, less attractive, and having less healthy eating habits than those who had lost weight by dieting. The shift in perspective noted above aligns with Throsby's (2008) observation that weight loss achieved through surgery can be regarded as 'cheating' with the person's decision regarded as taking the "easy option" or "short cut" (p.119) which is seen as conveying an unwillingness to adopt socially sanctioned methods of diet and exercise.

Based on these findings, the obese body could be regarded as representing a site within which pathology and stigma unite (Moss, 1992) with some questioning whether the current medicalisation of obesity means that bariatric surgery could become a tool for the "politicisation of body size" (Hofmann, 2010, p. 6) reflecting an acceptance of the society's moral disdain for obesity. Furthermore, Hofmann (2010) also questions whether bariatric surgery can be regarded as a "conversion of an emotional, mental, or psychological problem to a physical one" (p. 6). This view has received some support with qualitative studies reporting how participants' report their mind being neglected (Ogden et al, 2011) and how surgery '*…just feels like the whole operation was a physical cure for a mental problem and of course it doesn't actually affect a cure*" [original italics] (Jones et al, 2016; p. 255). Indeed, the need for individuals to let go of their previous eating habits and lifestyles and replace these with

healthier ones has been suggested as representing more of a moral obligation than an option an individual chooses (Groven et al, 2013). As a result, bariatric surgery has been suggested as being somewhat different to other surgical practices through its modification of healthy organs and the fact that it does not represent a cure per se, but instead offers symptom relief from a condition often associated with significant levels of prejudice (Hoffman, 2010). Given that weight-related stigma does not appear to reduce in-line with weight lost and the decision to undergo WLS has been shown to carry its own form of stigma, weight-related stigma represents a deeply embodied and enduring experience for the person who chooses to undergo WLS.

Whilst the research reviewed so far highlights the ways in which bariatric surgery exists both as a medical/biological phenomenon as well as being imbued with social meaning, studies attempting to predict outcomes fail to offer any understanding of the experience of living with bariatric surgery in any depth. Another feature of this research has also been an emphasis on rating success or failure based on the amount of weight lost and whether this has been maintained. Within this perspective is the implicit assumption that the amount of weight lost and maintained reflects both the persons level of compliance with recommended lifestyle changes and that weight loss leads to a 'positive' outcome. Instead, a move from research emanating from a nature of 'knowledge' to one of understanding 'practices' which seeks to understand how the "social and the natural are enacted in practice and how these come to constitute reality" (Parros, 2006: p. 154) has led to the increased use of qualitative approaches to understand more about individuals experience of bariatric surgery.

2.4 Qualitative approaches to bariatric surgery

Recognising the limitations of standardised measures to capture the complex nature of the impact of gastric by-pass on a person's life, qualitative research exploring this area represents a shift in attention from attempts to predict outcomes through statistical analysis to the use of highly descriptive language that offers the potential to explore the nuanced ways in which

individuals experience being overweight (Ogden and Clementi, 2010; Sillén and Andersson, 2017). Within the next section research adopting qualitative approaches will be critically reviewed.

Acknowledging the usefulness of qualitative approaches to understanding the effectiveness of bariatric surgery, Ogden et al (2005) adopted a mixed-methods approach in an attempt to identify specific factors associated with the increased sense of well-being often reported by participants following surgery. Using a cross-sectional design Ogden et al. compared post-surgical patients with waiting list controls on subjective health status, quality of life, level of impairment on daily activities and experience of eating. Besides the positive impact of weight loss on participants' reports of increased energy and confidence, the authors also identified factors that they regarded as directly associated with surgery including increased feelings of satiety and reduction in hunger sensations. Based on their findings, Ogden et al. suggest that by "handing control over to their stomach" (p. 271) participants' experienced a sense of regaining control. Whilst the qualitative findings within this study were presented in more depth elsewhere (Ogden et al, 2006) and will be reviewed later, this study represented an early attempt to understand individuals experience of surgery-specific factors postoperatively.

The decision to undergo surgery has been shown to represent both a desire for a healthier life and an acknowledgement of concerns relating to health and fears for the future (Forsberg et al, 2014; Groven et al, 2010; 2015). Whilst Ogden et al. identified factors that resulted in participants' feeling an increased sense of control around eating, other studies have looked at participants experience more generally following surgery. A study in the US by Boccieri et al (2002) adopted a grounded theory approach using focus groups and semi-structured interviews to explore the psychosocial impact of surgery and the ways in which psychosocial outcomes were related to participants ability to maintain weight loss. The authors conceptualised participants experiences as representing a "rebirth/transformation" (p. 783) following surgery and a "landmark in their psychic landscape" (p. 782) that divided their pre

and post-surgery lives. Despite participants' reporting changes being "unequivocally positive" (p. 781) there existed tensions resulting from life changes associated with surgery that arose in most areas of their lives; confronting them with feelings of loss and challenges at adjusting to unknown and unfamiliar circumstances. Tensions were described as existing within three realms of their lives; the self/existential, the social realm and skills acquisition. Based on their findings, the authors present their emergent theory suggesting it is the extent to which individuals can successfully negotiate tensions that determines their long-term outcome following gastric bypass surgery. Whilst the emergent theory proposed by the authors offers a valuable perspective on the impact of RYGB surgery on a person's life, it offers little insight into how these tensions were managed by participants or their understanding of these within the wider context of their lives. A further limitation concerns the methodology used. The authors outline their rationale for using a qualitative approach based on criticisms of previous research being guided by "constructs emanating from the assumptions of researchers" (p. 781). Whilst this is certainly the case for quantitative studies looking at factors predicting poor post-surgery outcomes, the authors simply say that once participants' were no longer able to elaborate further on the ways in which surgery had impacted their lives "the interview proceeded with semi-structured prompts of areas not yet addressed" (p. 782). The absence of clarification on the areas covered within these prompts leaves the reader uncertain as to the extent these might have also reflected potential researcher assumptions (Brown and Gould, 2013).

In a more recent study, Lier et al (2015) applied content analysis to explore men's and women's daily life experiences five-years after undergoing RYGB surgery proposing an overarching theme acknowledging ways in which "the process of weight loss influenced every aspect of daily life" (p. 5). Consistent with Boccieri et al. the authors noted that whilst the experience of surgery was described as mostly positive in terms of both physical health, activity and social relationships, participants' described how these experiences were intertwined with more challenging encounters such as feelings of ambivalence over their

smaller bodies which despite allowing them to feel "normal" and attractive when dressed also left them feeling vulnerable within intimate situations when they had to reveal their body. In contrast to Ogden et al's (2005) findings, participants' recognised the continued significance of food within their lives resulting from the changed rhythm, restrictions, hunger and interest in food they experienced following surgery and how their days evolved around planning and implementing of meals; representing a stark contrast to their pre-surgery habits. Although a strength of this study is its focus on the long-term follow-up of individuals who had undergone RYGB surgery, half the sample had undergone surgery to remove loose skin which whilst acknowledged within the demographics is not explored within the findings. Research exploring individuals' experience of undergoing body contouring surgery following WLS have reported participants' experience considerably less distress in relation to their bodies following contouring surgery suggesting a possible lack of homogeneity within the sample (Gilmartin et al, 2014).

Whilst Boccieri et al and Lier et al. interviewed participants postoperatively, Engström and Forsberg (2011) attempted to understand the process of change after bariatric surgery by interviewing participants prior to surgery and then again at 12 and 24-months post-surgery. Adopting a grounded theory approach the authors describe how their participants experienced a "wishing for deburdening through a sustainable control over eating and weight" (p. 5901) prior to surgery. Consistent with Boccieri et al's description of transformation, Engström and Forsberg describe how the first-year represented a transformation period during which their participants' relationship to food changed from being complex to balanced with reasons for eating becoming more dependent on their bodies' own physical signals; resulting in the establishing of routines that offered a sense of control. Despite this initial sense of control however over time participants' noticed the restriction they initially experienced faded and emerging doubts regarding the sustainability of the control they had noticed previously as well as fears of regaining weight emerged.

Whilst this study provides an interesting perspective on the individuals journey over the two years following surgery, the authors offer little exploration of the ways in which their participants make sense of these coexisting yet potentially conflicting experiences. Similarly, whilst the development of their overarching theme is consistent with a grounded theory approach, it suggests a seemingly sequential process that participants moved through as opposed to one that is characterised by ambiguity and ambivalence as suggested by others (e.g. Boccieri et al, 2002). Although the authors note a small group for who this process was not as straightforward, and instead involved feelings of anxiety and fear over regaining weight, there is no elaboration on this potentially vulnerable group. A further limitation concerns the type of bariatric procedures participants had undergone. Whilst the authors note that the sample represents a subsample from a larger study, it is unclear why these participants were selected and indeed which of the two bariatric procedures being compared in the larger study, gastric bypass and laparoscopic duodenal switch, they had undergone. Research exploring patients' reasons for and against different bariatric procedures have shown that individuals can hold very different reasons for opting for particular procedures (Opozda et al, 2017) and therefore a more explicit acknowledgement of the selection rationale, including the type of procedures participants had undergone, would have allowed for this to be considered within the findings.

Given the significance of physical changes reported above (Lier et al, 2015), studies exploring the ways in which these are understood by the individual have increased in attempts to inform healthcare professionals involved in providing support postoperatively. One study exploring negative self-evaluation following WLS was carried out in the U.S by Alegria and Larson (2014) who found that participants' experienced various forms of negative self-evaluation relating to distortions and dissatisfaction with body-image, distress regarding excess skin, and perceived stigma. Adopting schema theory to inform their analysis, which regards identity (i.e. self-schema) as representing the integration of the views one holds of oneself, such as those that the person regards as being their most relevant characteristics, values or traits (Fiske and

Taylor, 1991), the authors describe participants experiencing a discrepant self-image following surgery reflecting an incongruence between their perceived self and the objective reality of a smaller self. Within this discrepancy, several significant experiential features are described including body-image distortions in which participants' continued to regard themselves as large despite significant weight loss, dissatisfaction with their post-operative body image and perceived obesity-related stigma which continued to limit the extent they felt able to integrate into social situations. The discrepancy referred to highlights the complex psychological impact of undergoing such significant physical changes following surgery and the need for such discrepancies to be openly addressed within post-operative follow-up. A notable limitation to this study is its exclusive focus on women who had undergone surgery. Whilst the authors state their rationale for this being due to weight related discrimination being more prevalent for women than men, some studies that have exclusively looked at the experience of men reported how their participants had experienced not only being bullied but also ''socially emasculated'' (Groven e al, 2015: p. 9) prior to surgery due to lacking the capabilities and resources required to maintain a hegemonic masculinity; a physique often defined by healthy, well-functioning, and muscular body that is capable of completing tasks and fulfilling normative roles such as father, worker and mate. Whilst statistics indeed show that more women than men currently undergo bariatric surgery the number of men is increasing and therefore it is important to recognise ways in which men make sense of the physical changes associated with weight loss.

As noted above, although bariatric procedures utilising restriction and malabsorption result in permanent changes to the persons physiology, the restriction provided by these is not permanent with some suggesting the transient sense of success can result in difficulties assimilating a view of oneself as smaller (Alegria and Larson, 2014) and in profound existential uncertainty about one's future (Natvik et al, 2014; 2015). Exploring the experience of weight regain, Carvalho et al (2014) interviewed a sample of Brazilian women who had regained weight following RYGB. The authors acknowledge the experience of regaining weight as an

incredibly complex experience including feelings of defeat, failure and abandonment. They note how unrealistic expectations regarding the effectiveness of the RYGB and weight loss were felt by participants' to result in feeling that they had let others, including the surgery team, down.

Addressing some of the limitations in Carvalho et al's study, such as potential cultural differences and the exclusively female sample, Jones et al (2016) explored the experiences of weight regain in a UK sample of men and women who had undergone RYGB surgery between two and six years prior. Supporting previous findings by Ogden et al (2011) participants described how they had felt unprepared for the potential of regaining weight after experiencing weight loss during the first year. The authors use the metaphor of "passive spectator" (p. 249) to describe the way in which their participants recognised moving from feelings of euphoria and liberation immediately after surgery to feeling "abandoned and disempowered" (p. 253) when they noticed signs of weight regain. Whilst this study represents a positive step in exploring the experience of weight regain within a homogenous UK sample, I find the term "passive bystanders" a rather contentious one. As has been seen so far, the experience of weight-loss and physical changes present the individual with several challenges in which they are required to manage various practical and existential tensions (Boccieri et al, 2002; Ogden et al, 2005; Alegria and Larson, 2014). Taking these findings into account alongside the extensive literature concerning the stigmatisation of obesity within society I find the view of individuals as passive bystanders to the changes brought about by surgery not only risks reinforcing the social view of obesity as resulting from the individual's inability to take control but of also underscoring the notion of individual responsibility inherent in medical discourse where issues of control and responsibility have been suggested as permeating; with the current medicalisation of obesity having "the potential to relieve and also to exacerbate the attribution of personal responsibility" (Chang and Christakis, 2002: p. 151).

Viewing individuals as "passive bystanders'" to weight regain also risks overlooking the situatedness of such an experience in which individuals report not only concealing physical complications they experience after surgery from friends, family and others through fear of judgement (Groven et al, 2012) but also how feelings of shame and stigma that the surgery had not worked resulted in individuals withdrawing from social situations, including follow-up support within bariatric teams (Carvalho et al, 2014; Groven et al 2010). Considering the issue of responsibility, Throsby (2012) highlighted the ambiguity of surgery not only as an intervention to address excess weight, but as a procedure that can be experienced by the individual as a form of excess consumption in its own right where the shame of failure is seen less in terms of the impact on the person and more from the point of view of wasting public time and money. Viewed in this way the experience of regaining weight postoperatively not only represents a distressing experience for the person who might feel surgery represented a "second chance at life" (Boccieri et al, 2002: p. 784) but one that is imbued with social and cultural meaning through both implicit and explicit practices.

2.4.1 Critical reflections

Despite the encouraging use of qualitative approaches to understand the postoperative experience, there are a number of issues that warrant consideration. Firstly, whilst the rationale for studies focusing exclusively on women's experience is understandable given the prevalence of weight-related stigma for women, the experience of men undergoing surgery has been somewhat neglected. Furthermore, given the prevalence of stigma reported within the studies, there is also a notable absence of consideration of the ways in which the research interview was experienced by participants or of any acknowledgment of researcher factors and the ways in which these influenced the data collection and analysis (Brown and Gould, 2013), a point that will be addressed more fully at the end of this chapter. Considering these limitations, I would argue that rather than seeking to provide causal explanations of the experiences reported by participants, research seeking to enhance our knowledge and understanding should explore the lived realities as they are experienced whilst all the time

maintaining an awareness of the social, political, biological, psychological factors impacting on the individual.

2.5 Existential Phenomenological views of the body

Studies adopting a phenomenological approach attempt to understand the lived experience of undergoing WLS, a position that sits in stark contrast to the Cartesian perspective that underpins the biomedical perspective which not only proposes a mind-body dualism but views bodies as "malfunctioning machines…to be solved using a hypothetico-deductive thought process" (Thomas, 2005: p.64). Instead phenomenology has been said to represent an "attempt to complete the picture of the human being and his or her body that physiology and psychology begins" (Moss, 1989: p.64) by proposing a view of health and disease not as mere physiological facts but instead as comprising qualitative differences in the individual's relations to their environment in terms of spatial and temporal features as well as in relationships with others and with themselves through challenges to their identity (Moss, 1992). Drawing on the words of Gadamer (1996) who regards health not as "a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one's fellow human beings". (p.113), the process of undergoing bariatric surgery signals a disruption within many areas of a person's life confronting them with the challenge of finding a balance between the physiological and the psychological experiences following surgery.

Existential phenomenology combines two interconnected perspectives, existentialism and phenomenology. Initially proposed by Edmund Husserl (1859-1938), the approach seeks to understand human existence free of assumptions grounded in the 'natural attitude' which is seen as reflecting our everyday way of seeing and understanding the world around us. Instead, through the process of description existential phenomenology seeks to understand human subjectivity as an expression of values, beliefs, assumptions, relationships and cultural meaning which are referred to within phenomenology as constituting a person's "lifeworld".

In his Phenomenology of Perception (1965/2005) Merleau-Ponty addresses specifically the nature of perception and human embodiment describing how the body represents a "vehicle of being in the world" (p. 160). Focusing on the "lived body", Merleau-Ponty sought to offer a phenomenological account of the human body to explore what constitutes our bodily existence (Keat, 1982), in which he emphasises the ambiguity of the body as both physiological and psychological which intertwine to form a unified field. A central principle within Merleau-Ponty's philosophy is the concept of the "lived body" emphasising the unity and interconnectedness of the mind-body-world and the way in which the body is inseparable from socio-historical and cultural milieu in which the person exists. The "lived body" can be understood as a person's lived relationship with the world where the body is regarded not "as an object of the world, but as our means of communication with it…as the horizon latent in all our experience and itself ever-present and anterior to every determining thought" (Merleau-Ponty, 1965/2005: p.162). Explicit within this statement is the inextricable connection between the body and perception in which the body represents both our means of communication and the horizon to all our experiences, and as such represents "not just one thing in the world, but a way in which the world comes to be" (Leder, 1992: p.123).

In addition to the notion of embodiment outlined above, another key tenet of Merleau-Ponty's philosophy related to the notion of intentionality. The notion of intentionality was first suggested by Franz Brentano (1838-1917) however came to constitute a central tenet of existential phenomenology's notion of the lived-body to describe the way in which consciousness, and as such the lived-body, is always orientated towards something outside of itself and comes to structure our experience of the world in which the body is situated. Adopting the view of the body as an "intending entity" (Leder, 1992: p.123) acknowledges its situatedness in the world in which, far from being passively located, shapes the way in which the world appears as either one of opportunities or of limitations which are "bodily meaningful" (Gallagher and Zahavi, 2008: p.137).

Like Merleau-Ponty, Sartre also regarded the body as a point of reference and a place of action and interaction through which meaning is created (Moran, 2010). Whilst both Merleau-Ponty and Sartre acknowledged that our bodies are constituted in relation to other living bodies, they differed in their perspective on the dynamics which characterise this connection. Merleau-Ponty held an egalitarian view of relationships with Others using terminology such as "double" and "twin" (1968: p.104) whereas Sartre viewed relationships with others as reflecting power dynamics characterised by dominance and submission (van Deurzen, 2010). In his work Being and Nothingness: A Project in Ontological Phenomenology, Sartre proposed a multi-dimensional view of how the body manifests in three distinct positions: the body as "being-for-itself", in which the body exists as a medium through which the person experiences the world from a first-person perspective, the "body-for-others" reflecting the body as seen by both self and others, and the "body-for-itself-for-others", a position described by Sartre as representing the way in which "I exist for myself as a body known by the Other" (2005: p.351). Implicit within this tripartite view of the body is the rejection of perspectives that have prioritised the body-for-others as a basis for understanding which Sartre regarded as placing "the corpse at the origin of the living body" (2005: p.344).

Sartre's view of the "body-for-itself" regards the body as a "transparent medium for my experience of the world" (Moran, 2010: p.271). We are not always conscious of our bodies and may often take them for granted within day-to-day life however Sartre notes how our bodies can intrude upon our consciousness during times of illness or disability. It is at such times that the notion of intentionality has been used to highlight the way in which our attention is turned towards our bodies "affective call" (Leder, 1990: p.73).

Sartre's second ontological position of the "body-for-others" comprises two aspects, the "objective" material body as seen within the sciences and the instrumental body which acts as a reference point to a person's engagement with the world (Moran, 2010). Whilst this view highlights the way in which we occupy a third-person perspective of our body in interaction

with the world, the embodied nature of this experience is emphasised by Sartre who states, "We do not use this instrument, for we are it" (2003: p.324).

The third ontological position proposed by Sartre, in which he describes the "body-being-for-itself-for-others" (2003: p. 351) acknowledges the body within the intersubjective dimension and the way in which the person experiences their body not from their own view of it but through the view of it as seen by the Other (Moran, 2010). This perspective presents several paradoxes as whilst Sartre regarded interaction with others to offer a way in which we come to know ourselves, his third ontological position also highlights the way in which control of our body image can be taken away from us through "the look" of the Other (Sartre, 2003: p.xii).

Considering the perspectives offered by Merleau-Ponty and Sartre outlined above within the field of medicine, the view of the "lived body" represents a departure from the view of the body as an object, in which illness and disease are regarded as medical affairs, to a position of understanding in relation to "how we live our lives and inhabit our world" (Leder, 1992: p.127). Despite this departure, Leder (1992) is quick to acknowledge that an existential perspective does not seek to replace the biological account but situate it within a broader context recognising the ways in which physical structure and interactions with the world "fold back" on each other and that any medicine of the lived body "dwells in this intertwining" (p.125). Adopting this stance, bariatric surgery and the associated changes to both the persons physiology and the associated behavioural demands represent an interruption to a person's "life world" (Hofmann, 2010). Similarly, the tripartite view of the body proposed by Sartre offers a potentially valuable lens through which to explore individuals experience following bariatric surgery by recognising the way in which the body can enter one's consciousness at times of interruption as well as through "the look" of the Other.

2.5.1 Phenomenological studies of bariatric surgery

Phenomenological studies attempt to enhance our knowledge and understanding through the exploration of the lived realities of those experiencing the phenomena being studied through careful attention to the ways in which they describe their lived experience. In positioning this study, this section will present qualitative research (distinguished by their adoption of phenomenological approaches), which have explored the experience of bariatric surgery, and shall identify gaps which this study will seek to address.

Drawing on the qualitative findings from an earlier study (Ogden et al, 2005), Ogden, Clementi and Aylwin (2006) sought to understand patients' experience of undergoing surgery and the impact on quality of life and eating in relation to their decision to undergo surgery and previous attempts at weight loss. In recounting the ways which they felt surgery had impacted their eating behaviour and relationship to food, participants described a mind-body split in which some described feeling "the stomach is now controlling the mind" (p. 256) by preventing overeating through signalling fullness, whereas for others they felt that whilst they also recognised their body exercising restriction they had been able to internalise this sense of control themselves. The authors highlight the seemingly paradoxical relationship described in their study, in which the removal of choice appeared to increase feelings of control, and how this perspective sits in contrast to current initiatives within healthcare practice of increasing patient-centred care and empowerment (NICE, 2014; Jones, 2015).

Despite the noteworthy findings reported, there exist several methodological issues that warrant attention. Firstly, the sample included various procedures, with the most common being the adjustable gastric band. As mentioned above, an individual's reasons for and against different bariatric procedures have been shown to differ markedly when opting for gastric band over RYGB surgery including the potential for reversal and removal as well as the view that the band represents a less invasive and dramatic option than the by-pass (Opozda et al, 2017). In line with this, two participants within Ogden et al's study had their gastric bands

removed during the time they were involved with the research. Given the reasons reported for choosing one procedure over another, I would argue that the experience of undergoing surgery, and adjusting postoperatively, might be extremely different for individuals undergoing different procedures. A second issue concerns the length of time since surgery, with two thirds of the sample having undergone surgery within the past 12-months. Given that the initial 12-months represents a distinctly different period for patients in which the surgery is experienced more as a form of external control as opposed to something the individual works with, it might be unsurprising that participants experienced a high degree of control via the physical restriction imposed by surgery. Noting the way in the restriction imposed by surgery has been said to reduce over time (Engström and Forsberg, 2011), gaining a more in-depth exploration of this experience would seem important.

In a later study, Ogden, Avevell and Ellis (2011) interviewed ten participants following unsuccessful weight loss. In contrast to more objective measures of weight-loss failure such as percentage of excess weight lost, Ogden et al defined weight loss as "unsuccessful" if: weight had been regained since surgery, the individual did not deem their weight loss as sufficient or where weight loss had been sufficiently small to necessitate further surgery. Overall participants identified surgical factors, such as the procedure failing to provide the level of restriction necessary, as well as personal reasons, such as 'cheating' the surgery after realising their body was able to "accommodate more food" (p. 955), in accounting for why surgery had been unsuccessful. An important finding within this study concerns participants' view that despite feeling their body had been treated by the surgical team they felt their mind had been regarded as separate and unimportant and subsequently neglected within the process. Whilst this study builds on the authors earlier findings, the sample represented a diverse group in terms of current engagement with support, participants were recruited from a hospital clinic (n = 4) and a weight-loss support group (n = 6), the surgical procedures they had undergone, with only two having originally undergone the Roux-en-Y, as well as time since surgery during which seven had undergone revision procedures after the first was

deemed unsuccessful. Given the abovementioned differences between the RYGB and adjustable gastric band I would argue that whilst this study offers a valuable insight into participants' experiences of unsuccessful weight loss and their experience of feeling their mind had been "neglected" there exist potentially significant variations in the ways in which participants might have understood and responded to their experience of failure.

One study that addresses the issue of homogeneity in terms of the surgical procedure its participants underwent was carried out by Groven et al (2010) who sought to explore the way in which complications and side-effects following gastric by-pass surgery were experienced from a first-person perspective. Similarly to Engström and Forsberg (2011), the authors describe their participants' experiences as a trajectory from the months after surgery which represented "a positively life-transforming period" (p. 6) including feeling more attractive, noticing others responding more positively towards them and of becoming more sociable to feeling increasingly tired and worn-out. The exploration of a first-person experience however moves beyond the themes offered within other studies (e.g. Engström and Forsberg, 2011; Lier et al, 2015) in describing the nuanced ways in which participants described how feelings of fatigue, tiredness, and pain acted as constant reminders of how their lives had changed and led to the view that their "new life" was more restricted than prior to surgery. Despite the study being carried out in Norway and consisting exclusively of women who represented a subset of a larger study, its findings highlight the strengths of a phenomenological approach in exploring the human experience of change following surgery.

As can be seen from the studies reviewed so far, in addition to the physiological changes made during surgery and the resulting changes to eating, participants also describe radical shifts in their social encounters with others. Acknowledging the lack of studies exploring the long-term experience of undergoing bariatric surgery, Natvik et al (2013) interviewed a sample of Norwegian participants between five and seven years following surgery. The authors reported the essential meaning of their findings as expressing the way in which participants

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felt "totally changed, yet still the same" capturing the ambivalence which characterised their participants' accounts and how viewing the restriction immediately after surgery as representing a long-awaited improvement, it also signalled an abrupt transition which left them struggling to adjust to their altered body. Consistent with Groven et al's (2010) findings, Natvik et al. report how far from being a docile body, participants described how their bodies would frequently call for attention through feelings of discomfort or illness stemming from complications. Similarly, although weight loss signalled a process of rediscovering themselves through interactions with others, these encounters evoked mixed feelings of increased self-acceptance and self-esteem along with shame and contempt and reflections on the discrepancy between how others now related to them compared with when they were overweight. In addition to this, despite participants feeling relieved at their weight loss and smaller bodies, changes in body shape and loose skin created an uncertainty regarding the extent their smaller body conformed to "normal" bodies within society.

In interpreting their findings, Natvik et al. draw on Merleau-Ponty's view of the body existing on two levels, that of the "habit-body", which includes embodied knowhow and dispositions, and "the body at this moment" which acts and perceives based on the persons present bodily based understanding (1962/2005: p.95). These concepts regard habits as representing embodied practices which we assimilate through our interactions with the world. Aligning with Hoffman's view of bariatric surgery interfering in the person's "life world" this view suggests that the extent to which individuals can establish new habits and practices might depend on the extent to which they are able to both negotiate the experience of loss associated with previous habits and establish a meaningful relationship with new practices within their lives.

Whilst many of the studies so far have reported participants feeling increased control of their eating practices immediately following surgery (Ogden et al, 2006) followed by feelings of fear regarding weight regain once this restriction decreases (Natvik et al, 2013), some studies have attended to the experience of eating specifically. In one such study Natvik et al (2014) explored

the meanings associated with eating in a sample of 14 men and women who had undergone the duodenal switch procedure between five and seven years prior from a hospital sample in Norway. Over time, eating came to be recognised as an "embodied practice" (p.1703) which encompassed both an increased consciousness around eating and a shift in attention from a preoccupation with food, hunger and desire to a focus on eating healthily. Participants' sense of "embodied reconnection" (p.704) emerged not only via increased awareness of bodily expressions but also as an alteration to the experiential dimension of eating, signalling a loss of satisfaction and enjoyment which they had experienced prior to surgery. Consistent with others, this study highlights how despite the initial restriction imposed by surgery being regarded as a positive intervention, the rapid changes individuals experience can leave them feeling unsupported in their 'new' and unfamiliar body and unable to adapt at the rate they are being required to.

The social and emotional nature of eating has been well documented (Goodspeed-Grant, 2008; Delormier et al, 2009) and might account for the ambivalence participants described between surrendering themselves entirely to the surgery in the pursuit of long-term weight loss and the refusal to relinquish themselves entirely to the care of healthcare services. The sense of "being at the mercy of one's body" (Natvik et al, 2014: p.1706) was found to confront participants with challenges in finding time for self-care alongside the day-to-day necessities of their lives such as work and relationships, an experience the authors describe as like "being sentenced to inescapable awareness of their habits, sensations, emotions, and thoughts" (p. 8). The ambivalence noted in this study between participants' desire to maintain weight-loss and urges to eat signified a split within their relationship with eating in which they noticed being able to still engage in previously problematic behaviours such as binge eating. Whilst the return of 'problematic' eating behaviours resulted in confusion for some, others realised how the increased awareness of their bodies had resulted in them "re-embodying" their new habits (p. 8).

By adopting an existential phenomenological lens within their analysis, Natvik et al (2013; 2014) capture the ambiguity which characterises the long-term experience of life following bariatric surgery and the tensions individuals experience between relinquishing and maintaining control. Whilst acknowledging the valuable contribution from these studies, there appears to exist a disparity between the phenomenological approach adopted and the way in which this manifested within the study. Whilst it is possible this might be a result of limited space, despite stating that the interviews were considered a "collaboration between researcher and participant" (p.1204) there is no acknowledgment of researcher characteristics and the way in which these were regarded as impacting upon the data collection and analysis. This absence is further reinforced through the description of the way in which the essential meaning "emerged" (p.1205) from the text. Given the ambivalence described by participants in engaging in social encounters after losing weight, a more explicit consideration of the research interview as an intersubjective encounter would have appeared appropriate.

The ambiguity described by Natvik et al (2013; 2014) was captured by Warholm et al (2014) who interviewed two women on four separate occasions over the 12-months following surgery. Warholm et al. describe the ambivalence as "movements between opposites" (p.4) highlighting how, over time, the content of the interviews reflected a shift from issues relating to movement/activity and eating practices to experiences relating to social relationships, appearance and being oneself. Although Warholm et al acknowledged their small sample size as a possible limitation, their analysis highlights the complex experience individuals can experience following surgery where long awaited opportunities such as improved mobility become part of everyday life and give way to confusing and ambiguous physical and social experiences that require the person to revaluate their understanding of both self and others. Interpreting the participants' ambivalence, the authors use Merleau-Ponty's (1962/2005) notion of the "corporeal schema", which he describes as representing "an open system of an infinite number of equivalent positions" (1962/2005: p.163), to interpret their participants experiences as representing the ways in which their embodied experiences and culturally

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mediated meanings regarding their larger (habitual) bodies meant that they continued to view the world as stigmatising despite their bodies now being smaller (i.e. their body at this moment).

As can be seen from the studies presented so far, changes to eating practices following surgery are embedded within a person's wider life and therefore do not represent discrete behavioural factors that can be changed in isolation. Furthermore, many individuals who undergo surgery experience severe adverse consequences in relation to eating because of side-effects such as those experienced during episodes of dumping. Exploring the lived experience of dumping, Groven, Engelsrud and Råheim (2012) challenged previous studies that suggested an increased sense of control (Ogden et al 2006) and feeling of deburdening (Engström and Forsberg, 2011) and instead described an ongoing sense of ambivalence where the experience of dumping was experienced as an unpleasant bodily experience whilst simultaneously something participants found useful describing it as a "warning system" (p. 45). Furthermore, the authors described how dumping manifested in both an awareness of changes to participants' "inner body" and as an inter-relational phenomenon which participants had to learn to manage in different contexts. Participants described unpredictability as one of the greatest challenges after surgery and how in attempts to avoid dumping they would spend a lot of time and energy exploring what food and drinks their bodies could tolerate. Conceptualising the way in which dumping represents both an internal and inter-personal phenomenon, Groven et al expand upon Merleau-Ponty's perspective of the "lived body" using Leder's notions of the "inner body" and "surface body" which acknowledge the unity of the internal and external body in defining its position in the world through the "ceaseless stream of kinesthesias, cutaneous and visceral sensations" (1990: p.23). Adopting this perspective, the authors emphasise the ways in which the experience of dumping emanating from physiological changes represent far more than unpleasant side-effects and are inextricably intertwined with all areas of the person's Being.

Groven et al's study offers valuable insight into the lived experience of dumping following WLS highlighting the hugely ambivalent and subjective nature of the phenomena. Their inclusion of individuals who had undergone gastric bypasses is a strength as is there rigorous attention to the researcher's role within the study to illustrate the ways in which the phenomena of dumping presented itself both through and within the interview process. Several sample characteristics are worth mentioning however such as the study being carried out in Norway and the exclusive recruitment of women. Whilst the authors inclusion of women is understandable given their use of de Beauvoir's perspective to explore how demands placed upon women within society interfere with her own projects, it presents an obvious limitation to translating these findings to men undergoing surgery.

From the review of the studies that have adopted a phenomenological perspective to explore individuals' postoperative experience, far from being a procedure which merely reduces the size of the stomach and the amount a person can eat, the physical changes following surgery confront the person with the need to adjust and renegotiate their sense of their body in the world. Although studies have tended to focus on the specific aspects of change it is evident that none of these areas are experienced within a vacuum following surgery but instead are intertwined, both with each other and within the individual's history and current life situation.

Consistent with the view advocated by Parros (2006) that research should seek to understand practices, I regard research seeking to understand the lived experience of those choosing to undergo bariatric surgery offers significant benefit to healthcare professionals working in these areas. A commonly used metaphor for bariatric procedures is that they represent a tool for individuals to work with following surgery to achieve long-term weight loss (Ogden et al, 2011; Groven et al, 2013). I regard this view as being problematic in several ways. Firstly, this expectation exists within a context in which not only have individuals presenting for bariatric surgery experienced repeated attempts and failures at successful weight-loss but their very suitability for surgery is based to some extent on the understanding that these attempts have

thus far proved unsuccessful (Natvik et al, 2015). I would argue that not only does the assumption underlying this expectation reside firmly within the biomedical model which espouses a mechanistic view of the body but would also agree with Groven et al (2012a) who suggested that such an assumption confronts the person undergoing bariatric surgery with a dilemma. Whilst bariatric procedures such as the RYGB result in irreversible changes to one's anatomy and physiology, a person's eating habits cannot be located or reduced to one organ but instead reflect their lived body and its history.

Considering the empirical support for these disparities between current approaches within healthcare and the lived experience of individuals following surgery, Natvik et al (2014) described how their participants often felt they had to develop new eating habits through trial and error because advice from hospital was too general and superficial for their individual needs. This has obvious implications when supporting individuals following surgery and invites a possible departure from the somewhat disembodied view of eating practises and behaviours that seems to be frequently promoted within post-operative care (Groven et al, 2012a). Instead, research emphasising the ambivalence experienced by individuals in adapting their eating practices, particularly in the adoption of healthy eating, shows that this does not occur in isolation but is instead embedded within a normative field where the adoption of new eating practices are not only considered appropriate but a moral obligation, a sentiment captured by one participant who described their conscience being worse now than before when they didn't "stick to their diet"' (Groven et al, 2012: p.44).

2.5.2 Critical reflections

Besides Groven et al (2012), there is a noticeable absence within the aforementioned studies of reflexivity on the position and impact of researcher characteristics within the data collection or analysis. In a review of the methodological approaches used within 31 qualitative studies of obesity, Brown and Gould (2013) point out the way in which, given the stigmatisation of the obese body, the interview represents a "heightened challenge" (p.78) for the person in

managing self and identity. Similarly, Ellingson (2006) suggests that regardless of the method "researchers bodies matter" (p.303), a view supported by Sharma, Reimer-Kirkham and Cochrane (2009) who suggest that the adoption of an epistemology of embodiment acknowledges not only the intersubjective and co-constructed nature of knowledge emanating from research interviews but also signals a shift away from the positivist perspective to one that "dwells within researcher-participant encounters" (p.1643). The authors go on to note that a failure to do this potentially reinforces a "neutrality and position of power that can be exploitative" (pp.1647-1648). Within the literature there appears to exist a need for not only greater transparency but also greater attention to what the researcher brings to the study.

Except for Ogden et al (2006; 2011) all the studies took place in Norway. Although, like the UK, Norway offers publicly funded specialized healthcare to all members of society meeting certain criteria, given the intrinsically psychosocial nature of adjustment following surgery, there exist the potential for cultural differences that might affect the experience of undergoing and adjusting to life following bariatric surgery.

Most studies recruited samples who had undergone different bariatric procedures with some recruiting from multiple contexts including hospital clinics and weight loss support groups. Whilst some have argued that the differences in living with different procedures are negligible in the long-term, others have reported distinct differences in patients' choice of surgical procedure including reversibility and invasiveness (Opozda et al, 2017). Furthermore, whilst the process through which this occurs remains unknown, studies have also found that individuals can experience changes in food preferences following RYGB surgery (see Gero et al, 2017); presenting individuals with the challenge of not only establishing new eating routines but also food preferences postoperatively. Considered alongside the associated complications with the RYGB procedure (Bult, van Dalen & Muller, 2008), the social and emotional nature of food (Goodspeed-Grant, 2008; Delormier et al, 2009) and the ambivalence reported within participant accounts of surrendering themselves entirely to the surgery (Natvik et al, 2014), I

would argue that whether a procedure is irreversible or not could have a significant impact on existential concerns relating to issues of meaning, control and one's sense of embodiment (Boccieri et al, 2002). Given the complex and extensive nature of changes individuals experience following RYGB surgery and the experiential incomparability with other surgical procedures, I made the decision to recruit only participants who had undergone RYGB procedures in order to maintaining a surgically homogeneous sample.

In attempting to address the issues raised within the current literature, this study explored the lived experience of men and women recruited from a hospital clinic in the UK who undergone RYGB surgery at least 12-months prior to taking part in the interviews. Given the reported issues with support following surgery (e.g. Ogden et al, 2011; Jones et al, 2016; Natvik et al, 2014), attention was given to the ways in which participants utilised support postoperatively.

2.6 Reflexive exploration

Acknowledging the way in which the process of writing occurs within a context of other experiences including personal feelings, setbacks and supervisory and collegial discussions (Parros, 2006), I can recognise how the process of researching and writing this literature review was characterised by movement back-and-forth between apparent contradictory vantage points on the issue of obesity and bariatric surgery as well as my own pre-understandings and explicit understandings of the various perspectives evident in the literature. Reflecting on the dilemmas I encountered in writing this review I can recognise how its flow from considering the medicalized approach to obesity, the ways in which psychology contributes to the field to focusing on the lived experience of those who have undergone RYGB surgery reflects my own journey over the course of this study that will be elaborated on further later. Whilst uncomfortable at times, I regard the process of working through these dilemmas with supervisors and peers as representing my ongoing development and understanding of the area by remaining open to being changed by my experience undertaking my research.

Chapter 3. METHODOLOGY

This chapter will begin with an acknowledgement of my own epistemological position before describing my decision to initially adopt a phenomenologically (Interpretative Phenomenological Analysis, IPA) informed mixed-methods approach and the ways in which, through my reflexive engagement with the interviews and analysis process, I made the decision to remove the quantitative measures from the analysis process. The decision to adopt a phenomenological approach will also be considered in relation to alternative approaches. An acknowledgement of the limitations of IPA and the ways in which I sought to address these, including the ways in which ethical considerations were managed throughout the duration of the research process to ensure that the data presented is trustworthy, will also be addressed. Finally, the sample population chosen will be described in detail as will the recruitment strategy utilised and the procedural steps taken throughout the research process. To ensure transparency, I will present the research process as it unfolded, including the ways in which quantitative measures were utilised within the interviews but later removed from the analysis, alongside my personal reflections as they emerged over the course of the research process and the influence of these upon my methodological decisions throughout this chapter.

3.1 My own philosophical perspective

In considering my methodological approach I was keen to adopt an approach capable of capturing the complexity of change as well as the "multi-factorial and holistic nature of health" (Fiorini, Griffiths & Houdmount, 2016: p.38) which exists within healthcare settings. Working as an integrative therapist grounded within existential psychotherapy I regard the assumptions proposed by phenomenology (and particularly IPA) as being aligned with my own views on the nature of knowledge, reality and meaning. In addition to this, my view of the therapeutic/research encounter as a fundamentally intersubjective encounter which is both collaborative and co-constructed meant a methodological approach that acknowledges these features felt appropriate.

My own epistemological position is based on a constructivist perspective that regards knowledge and meaning as being inextricably linked with the persons particular social context. This position rejects the idea that there exists an objective reality that we can know but instead suggests that there exist multiple and equally valid accounts of reality. Constructivism views the individual as being an active participant in the creation of meaning through the process of giving meaning to that which is observed within their environment (Glasersfeld, 1984). From this perspective the body is regarded as the central axis for the organisation of experience, however it is always understood as being embedded within social relationships and therefore all meaning-making must be understood as being inextricably linked to the persons social, cultural and historical context (Mahoney and Granvold, 2005). The emphasis on the contextual nature of knowledge and understanding advocated by a constructivist epistemological position means that any research findings must be understood as resulting from the context in which data is collected and analysed (Madhill, Jordan and Shirley, 2000).

3.2 Methodological Considerations

As mentioned above, acknowledging the lack of professional support for psychological and emotional well-being reported in the existing literature, the current study also attempted to explore further participants' subjective experience of their own wellbeing and the ways in which they utilised support available to them within close relationships. Embracing Smith's (2004) invitation for researchers to adapt and developed IPA I felt a more in-depth exploration of the research area could be obtained using a mixed-methods approach, utilising quantitative measures exploring participants' experiences of close relationships as a source of support and subjective views on their current wellbeing alongside semi-structured interviews (Hanson et al., 2005; O'Cathain et al., 2007).

Outside of the clinical context, the use of mixed-methods have also been suggested as offering the opportunity to gain a "combination of insights" (Smith et al, 2009: p.192) and has received

increasing support within the area of counselling psychology research (Green et al, 2005; Hanson et al, 2005; McLeod, 2010; Smith et al, 2009) with similarities being drawn between the methodological approach and the work of applied psychological therapists when merging "quantitative assessments with qualitative information about a client's experiences and the meaning of those" (Plano-Clark and Wang, 2010: p.428). The benefits of adopting IPA within a mixed-methods approach therefore appeared twofold, in firstly allowing for triangulation of data offering the potential for a more in-depth understanding than one approach might offer by itself and secondly through the possibility of a measure exploring support to facilitate participants' reflection on this area of their experience during the interviews. The quantitative measures chosen were the General Health Questionnaire (GHQ-28) assessing general well-being and the Experiences of Close Relationship Scale Revised (ECR-R; Fraley et al, 2000) providing information regarding participants' attachment style.

The GHQ-28 is one of the most widely used and validated questionnaires for assessing emotional distress and is sensitive to short-term psychological and emotional disturbances. The GHQ-28 has been widely used within healthcare contexts (Sterling, 2011) including studies reporting an association between individual's mis-trust in healthcare systems and increased psychological distress (Ahnquist, Wamala, and Lindstrom, 2010). Given the current study's focus on individuals' experience at a particular postoperative stage the GHQ-28 was felt to offer a potentially useful tool for exploring participants current emotional well-being.

The second measure used was the Experiences of Close Relationship Scale Revised (ECR-R; Fraley et al, 2000). The ECR-R is a 36-item self-report measure exploring adult attachment on two continuous subscales (attachment anxiety and attachment avoidance) and requires participants to reflect on their typical ways of relating within close relationships. Previous research has highlighted the possible impact of a person's attachment style at both pre- and postoperative stages (Aarts et al, 2013; 2014a; 2014b) as well as the potential for it to offer a

helpful framework for those providing support to individuals to better understand the intersubjective dynamics of clinical encounters (Hooper et al, 2012).

As previously mentioned, this study emerged from my own experience of working within bariatric services, in which the use of a mixed-methods approach was familiar to me; representing a routine approach used in the assessment of individuals within both the primary care and specialist bariatric services I was working in. Despite the intention for a mixed-methods approach to offer a more in-depth understanding of participants' experiences postoperatively, during my engagement with my participants and the data, I began to question the appropriateness of integrating the quantitative data with the rich descriptions given by participants of their experiences since undergoing surgery. Through consultation with my supervisor I made the decision to remove the quantitative measures from the analysis.

Working with the limitations of language that requires the presentation of everything as a sequence (Glasersfeld, 1984), I will attempt to present the ways in which I came to recognise how the adoption of a mixed-methods approach reflected an epistemological conflict between my developing sense of myself as a counselling psychologist and my desire for my research to appear credible within the medical context as this process unfolded through my engagement with my participants during the data collection and emersion in the data during the analytic stages below.

3.2.1 Rationale for a phenomenological approach

I considered various qualitative methodologies (detailed later) however given the deeply embodied nature of the research, I regarded a phenomenological approach to be best suited for my enquiry into individual's experience of life following RYGB surgery. Phenomenology focuses "on descriptions of what people experience and how it is that they experience what they experience" (Patton, 1990: p.71) and aims to produce "fresh, complex, rich descriptions of a phenomenon as it is concretely lived" (Finlay, 2009b: p.6). A phenomenological approach

seeks to explore the participant's view of the world and to adopt, as far as is possible, an "insider's perspective" of the phenomenon under study (Smith, 1996: p.264). Drawing on the notion of intentionality outlined above, phenomenology acknowledges that the appearance of phenomena varies depending on the "context, angle of perception and, importantly the perceivers mental orientation (e.g. desires, wishes, judgements, emotions, aims and purposes" (Willig, 2013: p. 84) and therefore acknowledges how an individual's experience of what appears to be the same environment (e.g. bariatric surgery) can reflect profoundly diverse perspectives.

Phenomenology developed in response to the perceived dehumanisation within psychology and offered an approach that attempted to reflect the distinctive nature of human behaviour and first-person experience (Wertz, 2005). Originally developed by Edmund Husserl who regarded the approach to offer the potential to "identify the essential essence of experience" (Langdridge, 2007: p.11), the approach was influenced by existential thinkers such as Martin Heidegger and Maurice Merleau-Ponty. As previously mentioned, a central principle within Merleau-Ponty's philosophy is the concept of the "lived body" emphasising the unity and interconnectedness of the mind-body-world and the way in which the body is inseparable from the socio-historical and cultural milieu within which the person exists (Merleau-Ponty, 1965/2005). Given the current study's aim to explore the lived experience following RYGB surgery, the adoption of a phenomenological position that not only regards the body as the "fulcrum of experiencing" (Mahoney and Granvoled, 2005: p.76) through which meaning is structured in relation to social and relational encounters, but also views health as "not a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one's fellow human beings" (Gadamer, 1996: p.113) was felt to represent an approach which honoured the embeddedness of the individual within their lived contexts.

Another way in which a phenomenological approach felt most suited to the current study was due to the acknowledgement of the hermeneutical principle which suggests that researchers are inseparable from the worlds they inhabit and as such it is not possible, nor desirable, to bracket one's presuppositions (Finlay, 2009b). Instead, adopting a hermeneutic position suggests that meaning must be interpreted; a perspective that places the relationship between the researcher and researched at the centre of meaning making (Langdridge, 2007). Phenomenology's acknowledgement of the co-created nature of knowledge is consistent with Ellingson's (2006) suggestion that the researcher's body be acknowledge and implicated as a site of knowledge production and act as a method through which to remain "intellectually honest" (Sharma et al, 2009: p.1643) through the process of reflexivity.

Within phenomenology various approaches to research have been proposed including descriptive phenomenology and hermeneutic phenomenology, the latter of which comprises interpretative phenomenological analysis (IPA) (Finlay, 2009a). Previous research has highlighted the unique challenges individuals can experience following bariatric surgery resulting from their diverse backgrounds (Natvik et al, 2014) and therefore I wanted to ensure that the current study captured participants' "personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself" (Smith, 1996: p.263). With this aim I was drawn to IPA due to its idiographic focus which is regarded as being lost within generalisations of the phenomena being studied within purely descriptive approaches (Shinebourne, 2011).

Furthermore, the way in which the descriptive and interpretative approaches address the principle of bracketing felt significant as did the acknowledgement and inclusion of the researcher-participant relationship in the meaning making process advocated by interpretivist positions (Smith, 2004; Finlay, 2009a). Given my experience within the area of WLS I recognised aligning with hermeneutic theorists in regarding any attempt to bracket my presuppositions and assumptions would be impossible given my embeddedness within the

area I am researching (Finlay, 2009b). I also regarded any attempt to do this could also overlook potentially valuable insights that could advance my understanding of the data collected during encounters with participants and am therefore in agreement with Creswell's (2007) suggestion to reframe this process as one of "suspending our understanding in a reflective move that cultivates curiosity" (p. 62). Given the prominence of this practice within phenomenology I will talk more about how I attempted to achieve this below.

Amongst the early proponents of hermeneutic phenomenology, Merleau-Ponty's work offers a helpful base from which to explore research within healthcare contexts (Thomas, 2005) with his view of the body as "the vehicle of being in the world" (1945/2005: p.160) his appreciation for the ambiguity of experience is regarded by some as encouraging the researcher to "embrace ambiguity, paradox, descriptive nuance, and a more relational unfolding of meanings" (Finlay, 2009b: p.15) within the research process. Drawing on the work of early existential theorists such as Heidegger and Merleau-Ponty was also consistent with my grounding within existential psychotherapy which adopts a phenomenological approach that encourages clients to explore their own meanings and understandings to allow their own "existential issues and concerns to come to light" (Adams, 2014: p.37). Given the position of bariatric surgery as existing within the area of biomedicine, I regarded the adoption of a phenomenological approach that acknowledges health and disease not as mere physiological facts but as influencing the person's relations to their environment as offering the potential to gain a rich and detailed account of the person's lived experience of postoperative adjustment (Moss, 1992).

3.2.2 Rationale for choosing Interpretative Phenomenological Analysis (IPA)

Having decided upon an interpretivist as opposed to a descriptively informed phenomenological position, IPA (Smith, 1996; Smith et al., 2009) felt most consistent with both my research aims and my adoption of a phenomenological stance within my therapeutic practice grounded within existential psychotherapy. My decision of use IPA alongside

quantitative measures is supported by Smith et al who regard IPA as complementing more traditional approaches such as quantitative methodologies by offering the potential to "make sense of quantitative findings" (2009: p.192). On a more pragmatic level Smith and colleagues also note how the use of quantitative measures within a primarily phenomenologically oriented study also offers more "capacity to bring about change (in practice and policies) than singular designs" (pp. 192-193) and how IPA's origins within healthcare research highlight its suitability for research interested in exploring the gap between an object and the persons perception of it, which can be seen most evidently when considering real bodies and the persons accounts of physical processes (Smith, 1996). Furthermore, IPA's divergence from other qualitative approaches with its emphasis on exploring the ways in which individuals ascribe meaning to their experiences through interaction with their environment also means it has the potential to contribute to bio-psycho-social theories prevalent within healthcare systems (Smith, 1996; Biggerstaff and Thompson, 2008).

Interpretative Phenomenological Analysis aims to grasp the "texture and qualities of an experience as it is lived by an experiencing subject" (Eatough & Smith, 2008: p.3). This approach aligns closely with Heidegger's concept of Dasein or "Being-in-the-world" (1962: p.201) which acknowledges individuals situatedness within socially and historically contextualised worlds and advocates a mutuality that is in stark contrast to the cartesian dualism which has been suggested as constituting the "paradigm of modern medicine" (Leder, 1992: p.117). Thompson (2011) distinguishes between the structural form of the physical body, comprising bodily structures such as limbs and organs, and its living and lived dynamic. Acknowledging the potentially contextualising influence of both my own and my participants' embeddedness within healthcare systems I sought a methodological approach that would enable me to highlight the importance of allowing the "lived body to speak forth" (Leder, 1992: p.126) to allow for the individual to describe in detail the world as they embody it.

Following the lead of others researching within healthcare contexts (Thomas, 2005; Murray and Holmes, 2014) I found the phenomenological approach proposed by Merleau-Ponty helpful in extending the functionality of IPA within my research through his attention to several important tenets of the phenomenological attitude; namely perception, intentionality, embodiment, being in relation to others, time and morality (Thomas, 2005). The importance of these will be referred to more within my analysis and discussion chapters.

IPA draws on three influential area of philosophy, namely phenomenology (described above), hermeneutics and idiography (Smith et al, 2009). In essence hermeneutics is a theory of interpretation and aligns with Heidegger's view that our engagement with the world is always through the act of interpretation (Smith et al, 2009). It feels natural to me to view interpretation as an inevitable part of being-in-the-world and that it is not possible to gain a 'first-person' account but rather that the analytic process constitutes a construction between the participant and researcher (Larkin et al, 2006). The role of the researcher relates to the belief that "human research involves a double hermeneutic" wherein the researcher is attempting to make sense of the participant's sense-making (Smith, 2004: p. 40). IPA's adherence to the hermeneutic principle aligns with my view of my own active involvement within the process of data collection and analysis, as opposed to a passive view sometimes referred to within qualitative research where patterns and themes are said to have *emerged* from the data (Braun and Clarke, 2006). At a more fundamental level the suggestion of a passive researcher ignores the presence and validity of my referent points when constructing my descriptions and labels within the analytic process representing another way in which researchers often *disembody* themselves from the research encounter (Ellingson, 2006). Expanding upon the active role of the researcher within the hermeneutic process, Sharma at el (2009) emphasises the importance of the researcher using their body as a form of hermeneutic, for example when the researcher is confronted by their own body in drawing attention to the ways in which difference is experienced and lived.

The previously mentioned double hermeneutic process warrants further attention as within this cyclical process exists important concepts relating to the researcher-participant dyad and the way in which the researcher's preconceptions and biases are acknowledged and managed. Finlay (2009b) suggests that a researcher adopting a hermeneutic approach who claims to bracket is "naïve and confused" (p.8). Originally proposed by Husserl, Heidegger later challenged the principle of "bracketing' arguing that it is impossible to stand outside of one's own "pre-understandings and historicality" (Laverty, 2003: p.14). In agreement with this perspective I feel that because of my experience of working within the area of WLS, any attempt to bracket my assumptions would be incongruent with the principle of openness and collaboration (Ballinger, 2006). Instead I align with Gadamer's (2006) view that one can only become aware of their fore-structures through engagement with the data and act of interpretation (Smith, 2009). Another way in which the double hermeneutic operates within IPA is within the position taken by the researcher when interpreting meaning. Here the distinction is made between a hermeneutic of empathy and questioning which represents an attempt to both gain an insider's view whilst also standing alongside to take a different perspective (Smith et al, 2009).

The third philosophical approach adopted by IPA is idiography. The idiographic quality of IPA prioritises a focus on the individual's account, whilst acknowledging the sometimes subtle meaning contained within the person's experience (Smith, 2004). The idiographic commitment can be understood as attempting to understand "how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context" (Smith et al, 2009: p. 29). Consistent with this commitment, I sought to honour my participants' accounts detailing their experience of living with RYGB surgery by approaching their narratives with receptivity and openness to the meanings expressed within their accounts. The idiographic commitment central to IPA presents the researcher with a tension between acknowledging the divergence between participant's and achieving a level of convergence of themes across participants. The way in which I managed

this paradox within my analysis will be addressed later when discussing the development of major themes and within my analysis.

3.2.3. Criticisms and Limitations of IPA

As is outlined above, one of IPA's strengths is in its ability to adopt an idiographic position whilst acknowledging the role of the researcher within the co-construction of meaning. However, several criticism and limitations have been suggested which I will now consider, including the ways in which these were managed within the current study.

Firstly, IPA has been criticised for its assumption that language provides participants with the necessary means through which to describe their experience (Willig, 2013). I would question this opinion as it is my understanding that IPA does not claim to be able to offer a first-person account of the experience but instead acknowledges that any understanding of an individual's experience is always "partial and complex" (Larkin et al., 2006: p.104) and emerges within the intersubjective encounter with the researcher. Addressing this partiality of the understanding, I regard the engagement with the hermeneutical positions of empathy and questioning as representing a way in which language is not always taken literally during the analytic process but is subjected to close interpretative engagement (Smith et al, 2009).

A second criticism relates to IPA's suggestion that it is concerned with cognition, an emphasis which it is argued is incompatible with phenomenological thought (Willig, 2013). Whilst this would seemingly represent a concerning dualism, interpretations reflect the way in which the researcher has made sense of their participant's description of the phenomenon being studied. Given the deeply embodied nature of my research, I align with the position adopted by Murray and Holmes (2014) who emphasise the inseparability of body, language and speech, and the importance of attending to participant's *speech* referring not to "disembodied language and abstract text" (p.19) but instead as emphasising the "corporeal dimensions and rhetorical situation within which it takes place" (p.19). As such I view meaning-making as a co-cocreation

between my participants and I, and understood their cognitions not as detached disembodied cognitive activity but as meaningful deliberations about their experiences reflecting their experience of Being-in-the-world (Eatough and Smith, 2008). Holding this view, I sought to engage in a thorough exploration of the existential implications of my participants' cognitions within the wider context of their lives.

Finally, the idiographic focus within IPA has been challenged due to being over-focused on individual experience and therefore failing to consider the social context within which participant's experience is situated (Pringle et al, 2011). Acknowledging this criticism, and in line with my abovementioned understanding of cognitions, within the current study I ensured that my exploration and interpretation of participants' experiences at each stage of the research process were considered within their social context and understood as being socially and intersubjectively situated.

3.3 Consideration of different approaches

As already mentioned, the epistemological and philosophical underpinnings of IPA are consistent with my own existential-phenomenological position. In considering the qualitative basis for my research several other approaches were considered, namely Critical Narrative Analysis and Discourse Analysis which are briefly reviewed below along with my rationale for deciding against these. This section will then conclude with a summary of why the methodological approach adopted felt most appropriate in answering the research question.

Narrative Analysis

Narrative analysis (NA) is based on the constructivist epistemological position that both acknowledges the vital role of the intersubjective encounter between researcher and participant and seeks to understand the 'lived' experience of the participant by attending to the language they use to tell their story (Willig, 2013). This approach has also been used to

contribute significantly to the understanding of the lived experience of the physical body and illness (Frank, 2013). Whilst narrative analysis was an attractive option, its acknowledgment of social theory at the analysis stage felt at odds with the aims of my research (Smith et al, 2009). There exists a great deal of social narratives regarding obesity and it was never the intention of my research to contribute to this field directly. IPA in contrast offered more opportunity for flexibility when it came to the interpretative lens through which my participants' data could be considered and therefore felt a more appropriate choice.

Discourse Analysis

Discourse Analysis (DA) views language as a social performance and suggests that participant interviews must take account of the context within which it was spoken; both the immediate context of the interview and the wider social context (Willig, 2013). This perspective is consistent with my existential-phenomenological position as both insist on the need to acknowledge the situatedness of the person. Given the embeddedness of myself and my participants within the medical system, although DA would have offered an opportunity to explore the ways in which my participants navigated this system through the language they employed its focus on understanding the interactive task of language has been suggested as overlooking the role of the body in the process of meaning-making and the intersubjective nature of language (Murray and Holmes, 2014). Furthermore, as was the case with NA, the introduction of socially constructed discourses felt as though they would lead me away from understanding the way in which my participants made sense of their experience of living with gastric by-pass surgery.

In summary, IPA represents an approach that is consistent with my epistemological stance through its valuing of the co-constructed nature of meaning, the acknowledgment of the researcher within the intersubjective encounter and that all meaning-making involves a process of interpretation. Acknowledging the criticism that IPA, like DA, overlooks the body through its focus on thoughts and beliefs (Murray and Holmes, 2014), given the explicitly

embodied nature of my research topic I also drew on the phenomenological perspective of the "lived-body" proposed by Merleau-Ponty to extend upon the functionality of IPA within my research. Drawing on the notion of the "lived-body" which not only acts a "vehicle of being in the world" but also "discloses the world to each of us in specific ways" (Merleau-Ponty, 1945/2005: p.160) offered the potential to explore the embodied nature of participants' postoperative experience following RYGB surgery.

Chapter 4. METHODS

4.1 Research Design

The study used semi-structured interviews with a sample of participants who had undergone RYGB surgery. Interviews were analysed using the stages set out by Smith et al (2009) for use when conducting an Interpretative Phenomenological Analysis (IPA) with data. During the stage of applying for ethics, through discussion with my supervisor who has worked clinically, researched and published extensively within the field of obesity and bariatric surgery I reflected on my own experience of working within a specialist bariatric service. This process was designed to facilitate reflections on my own part with the aim of gaining clarity around my own beliefs and assumptions of RYGB surgery to "acknowledge how [one's] own experiences, and contexts inform the process and outcomes of enquiry" (Etherington, 2004: pp. 31-32).

4.2 Sampling and Participants

Eight participants were recruited from a specialist bariatric surgery unit, five female and three male, who had undergone RYGB surgery at least 12-months prior to taking part in the research interview. This group were chosen as following surgery it is commonly acknowledged that the weight loss resulting directly from the surgical intervention usually begins to decline around 12-months postoperatively and therefore represents a transitional stage in which individuals are required to maintain the lifestyle changes necessary for continued weight loss and weight loss maintenance (Boccieri et al, 2002; Lynch, 2016; Magro et al, 2008; Wimmelmann et al, 2014). As this study was a phenomenological exploration of individual's experience living with RYGB surgery it was felt that recruiting participants beyond this stage would allow for exploration of the ways in which they have managed this transition period and ensure their 'lives involve a revelatory relationship' with the phenomena being studied (Wertz, 2005: p. 171). A small sample was chosen to enable the research to honour the 'rich and unique stories' alongside suggested recommendations for use of IPA regarding sample size (Wertz, 2005; Smith et al, 2009).

When deciding on the recruitment method for this research, I considered recruiting via WLS support groups however studies recruiting from such groups have highlighted how these tend to offer an almost exclusively optimistic view of bariatric surgery with those experiencing more negative outcomes tending to drop out early on (Throsby, 2008). In attempting to avoid excluding participants who might have experienced difficulties postoperatively I decided to recruit through the NHS bariatric service where I had previously worked. Whilst I acknowledge that recruiting through the service in which I had previously worked and where participants received their surgery also raises some limitations and challenges (discussed later) I regarded this to be the most inclusive option available.

Ahmed et al (2013), exploring eligibility rates for bariatric surgery in the UK, point out characteristics such as age, gender, ethnicity and socioeconomic status which should be considered to ensure equitable resource allocation. Although most individuals presenting for surgery are female (approximately 80%), rates of males are steadily increasing with differences between males and females reducing with increasing age (Welbourn et al, 2014). Similarly, although there have been inequalities reported in certain ethnic groups accessing surgery in the US recent figures suggest that bariatric surgery provision is equal across ethic groups within the UK (Old et al, 2013). Whilst participants were not excluded based on age, gender, ethnicity, socio-economic status of physical disability within the current study, given the attention to inequalities in eligibility demographic information relating to these areas was collected to allow for further contextualisation of my participants' accounts. Given the need for interview transcripts to be thoroughly transcribed, it was necessary for participants to be English speaking.

Table 1: Participant demographics

Participant pseudonym	Gender	Age	Ethnic Origin	Relationship Status	Duration of relationship	Months since surgery
Robert	Male	63	White British	Married	18 years	36 months
Stephen	Male	55	White British	Living with partner	19 years	19 months
Tony	Male	62	White British	Divorced	32 years	24 months
Jenny	Female	47	White British	Separated	10 years	24 months
Joyce	Female	57	White British	Divorced	6 years	15 months
Bronwyn	Female	37	White British	Married	14 years	24 months
Helen	Female	50	White British	Civil Partnership	Incomplete	36 months
Sophie	Female	42	White British	Single	42 years	21 months

4.3 Recruitment Methods

After the project gained ethical approval by both Middlesex University and Metanoia Institute (Appendix 1) and NHS ethics (Appendix 2), information for participants was circulated to the lead dietician assisting in the recruitment process.

Working in collaboration with the dietician allowed for a more purposive approach to sampling as all patients accessing the service who met the inclusion criteria were informed of the research during routine follow-up appointments and provided with information including contact details. Ahead of recruitment starting, an email address (wlsresearch1@gmail.com) was created to allow prospective participants to contact the researcher directly if they wished to ask any questions or to arrange an interview date. This email address remained active for 12-months following data collection had ceased.

Prospective participants were provided with information regarding the study and had the opportunity to either contact the researcher directly on details provided or to provide consent for the dietician to forward their contact details directly to the researcher to contact prospective participants directly. Given my previous involvement with the bariatric service I felt it was important that I had not had any previous involvement with participants throughout their involvement with the service. As the dietician did not have knowledge of whether I had had contact with prospective participants this was explored during initial contact and was not found to represent an issue with any of the participants. During the initial communications issues of confidentiality were explained as well as the commitment required. Participants were also reassured that the bariatric service would not have access to any information provided by them during their participation. Once verbal consent to taking part had been obtained a date was arranged for the interview to take place.

4.4 Data Collection

Ahead of each interview I went through the consent form with my participants. Ethical issues addressed at this stage are referred to below when I discuss ethical considerations. Once participants had been given the opportunity to ask any questions, I informed them of my experience working within bariatric services which has led to my interest in understanding more about their experience of living with RYGB surgery. I explained the structure of the interviews, including a brief description of the questionnaires they would be completing, as well as the reason for the interviews being audio recorded for transcription purposes. Once they had indicated a willingness to continue each participant was asked to complete a consent and demographics form to collect information relating to the time since their surgery and other demographic information including age, gender, occupation, ethnicity and relationship status, and highest level of education as well as the GHQ-28 and the ECR-R.

In conducting the interview, I was guided by a semi-structured schedule which I had familiarised myself with prior to starting the interview process (see Appendix 3). Honouring the idiographic nature of IPA, the schedule reflected a basis for conversation as opposed to a prescriptive or definitive list of topics to be covered in the interview so as to allow for participants to talk about what was most relevant for them in their postoperative experience (Larkin et al, 2006). Consistent with the approach proposed by Smith et al (2009) my intention was to allow my participants to take the lead during the conversation. All interviews were recorded using a dictaphone and where participants commented upon a potentially poignant experience, I noted this to refer to at an appropriate time.

I opened interviews with a broad enquiry to my participant's experience of their weight across their lifetime. Opening with a broad enquiry such as this was intentional as from a phenomenological perspective time is subjective and therefore offered a ground upon which their decision for surgery might exist. Following my participants' lead, I used follow-up questions and prompts to further explore their response and experiences. Having thoroughly familiarised myself with my interview prompts, I allowed myself to attend closely to my participants' words and suspend any potential "pre-existing concerns [and] hunches" (Smith et al, 2009: p 64). The eight interviews were conducted over a two-month period.

4.4.1 Personal reflexivity on the process of data collection

Ahead of my first interview I recognised feeling excited by the prospect of being a researcher rather than a clinician meeting the 'patient' to make a judgement on them but instead to be led by them regarding their lived experience of undergoing gastric by-pass surgery. As I noted in my research journal:

> '*Feeling excited and nervous about the interview tomorrow. Thinking about what to wear; shirt too formal yet t-shirt perhaps too casual and revealing of body shape, and*

about how I am looking forward to being in the role of researcher as opposed to 'gate-keeper' with those involved in the bariatric surgery pathway'.

<p align="right">*(Research Journal, 3rd April 2016).*</p>

It was interesting to note an immediate awareness of the murkiness of boundaries within my research and how I was conscious of wanting to prioritise the individual's voice over the competing discourse of healthcare services to which I had been used to. My desire to be seen differently to how I felt I had been perceived whilst working within the bariatric service highlighted the "slipperiness of categories" (Ellingson, 2006: p.306) for me and how we can be seen one way even when attempting to be seen another.

While completing the interviews I noticed how, despite stimulating rich reflections for some, for others I experienced the process of completing the quantitative measures as an administrative task which bore little connection to the rich and moving accounts of their experience described during the interviews. With the aim of remaining methodologically true I maintained the format of the interviews for each participant however began to question what the ECR-R and GHQ-28 had to offer in terms of providing more in-depth understanding (O'Cathain et al., 2007) of my participants' rich and moving account of their lived experience following RYGB surgery. In addition, I also noticed at times feeling hesitant to probe too deeply around issues some participants appeared reluctant to talk about. An example of this occurred when Tony appeared defensive towards my enquiry about the function of his frequent self-monitoring.

> You know, erm and then there's a difference between being aware and being paranoid. And I don't think I'm paranoid. [Tony]

Regarding my hesitancies as an intersubjective phenomenon, I understood these as reflecting an awareness of the context of our single meeting and my concern around disrupting the

functionality of the strategies my participants had come to rely on. Discussing these instances with my supervisor I also noticed how my awareness of the context of interviews, taking place in participants' homes, and my reluctance to question the strategies they utilised in coping postoperatively reflected my desire to distance myself within the interviews from the role I'd become familiar, yet not always comfortable with, of representing a gate-keeper to surgery which comprised an implicitly judgemental position. By drawing on multiple senses to monitor the embodied interpersonal dynamic of the research interviews I recognised the potential for the research interview to result in my participant, and I, taking on previously familiar roles within the bariatric system (Murray and Holmes, 2014). Recognising the ways in which my desire to abdicate the implicit position of power that I had previously felt when working within the bariatric service might hinder me from enquiring further about participants' experience during the initial interviews, through the use of supervision I was able to reframe my understanding of such feelings of discomfort. Rather than regard these feelings as something to be bracketed (Finlay, 2009b), I began to understand them as representing the "embodied intersubjectivity" (Finlay, 2005) between my participants and I that offered opportunities for not only greater depth of understanding but an important resource in remaining "intellectually honest" (Sharma et al, 2009: p.1643) in acknowledging the existence of power dynamics within the interview process. Acknowledging this phenomenon within the interviews enabled me to remain open to a participants' accounts of how such imbalances of power might have been experienced throughout their bariatric journey (Ellingson, 2006; Sharma et al, 2009).

Adopting a reflexive stance throughout the research process enabled me to recognise the impact my previous experience brought to the data gathering process. Acknowledging this early on emphasised to me the importance of attending to my own embodied experience during the research process, enabling me to move away from "a wholly observational sense of knowing to the more messy reality of embodied understanding" (Ellingson, 2006: p.305) a position consistent with the phenomenological approach where the challenge is to be "fully involved, interested and open to what may appear…to simultaneously embody contradictory

stances of being "scientifically removed from," "open to" and "aware of" while also interacting with research participants in the midst of their own experiencing" (Finlay, 2008: p.3). Despite recognising some ways in which my previous experience impacted upon the data collection process, my experience of transitioning from knowing to understanding referred to by Ellingson emerged more explicitly when I began analysing the interviews and so will be described in more detail below.

4.5 Data Analysis

All interviews were audio recorded and transcribed personally. Whilst time intensive this process allowed me to fully immerse myself in the transcripts enabling me to capture the subtleties of expression, both verbal and non-verbal from field notes, as well as recognise my own reactions to the text. As a novice researcher to IPA, analysis closely followed the process outlined by Smith et al (2009) which the authors point out is designed to act as a guide when conducting IPA analysis, however acknowledging Smith et al's encouragement to be innovative in the ways they approach the process of analysis I also drew on the phenomenological perspective of Merleau-Ponty and his emphasis on the embodied nature of experience to inform my analytic focus. Aligning with Van Manen's (1990) observation that "When the body is the object of someone else's gaze, it may lose its naturalness…or instead it may happen that it grows enhanced in its modality of being" (p. 104) and consistent with my attention to the intersubjective nature of therapeutic/research encounters, I also remained curious about my impact on the interviews, the data I was able to gather and the ways in which my invitation to participants to talk about their bodies was navigated by us both.

With the intention of allowing myself space and time to commit to the analysis and writing-up of my research I organised a career break form the academic position I held at the time. Having been excited at the prospect of being able to fully commit to the research process I was surprised to find myself feeling stuck and plagued by self-doubt as to what my research had to offer despite recognising equally intense feelings of enthusiasm and belief in my research

when discussing participant accounts with my supervisor. After struggling with this ambivalence, I recognised the need to discuss this with my supervisor supporting me with my analysis.

Through these discussions I became aware of several previously unrecognised assumptions the inclusion of quantitative measure had made. Firstly, the inclusion of a measure assessing participant's close relationships implies the implicit assumption regarding the subjective meaning they might attach to close relationships as being supportive within the context of managing post-surgery which might not be the case. Secondly, considering the feelings of self-doubt I had been feeling towards my research I noticed how my decision to include quantitative measures no longer felt consistent with my epistemological position but appeared to reflect a previously unarticulated epistemological conflict within me at the time of developing my research.

Whilst developing this study I had moved from the bariatric service I had been working in to take up an academic position within a department whose research output consisted of predominantly quantitative approaches. Through discussion with my supervisor I explored my initial motivation to include quantitative measures and was able to recognise my prior need to justify my study's contribution to the area of bariatric surgery and within the broader field of psychology by establishing a way in which my research could dialogue with empirically based research. I understood my stepping away from these contexts to create space for my research resulted in a decentring of my understanding of the phenomena I was exploring, which had been embedded within previous roles where the use of mixed-methods had been applied as a way of obtaining a multidimensional assessment of an individual's suitability for surgery. As noted above, through the course of the interviews however I recognised the ways in which the categories offered by the GHQ-28 and ECR-R represented pre-determined frames of reference and conceptual categories which felt at odds within the complex and often ambiguous ways in which participants described their understanding of both their health and

relationships postoperatively. Acknowledging the potentially limiting impact of the quantitative measures on my attempts to "give voice" (Larkin et al, 2006: p.102) to my participants' experiences, I made the decision to remove the quantitative measures from my analysis and present only data from the interviews.

Returning to Ellingson's (2006) abovementioned notion of embodied understanding, I recognise how my decision to adopt a mixed-method approach possibly reinforced a difference between my participants and I. Acknowledging this during the early stages of my analysis enabled me to attune to the interjectively situatedness of the interview transcripts and the ways in which both my participant and I represented reciprocal subjects in the creation of understanding where we both created access to and limited what knowledge was produced (Engelsrud, 2005); a process acknowledged more explicitly within the results section.

Although the acknowledgment of the ways in which "disciplinary prescriptions, concerns about scientific status…and comfort with what the researcher knows best" had acted as "paradigmatic blinders" (Patton, 1990: p.71) felt deeply uncomfortable, it also highlighted for me the inherent situatedness of my participants and I within the research process in which our encounters reflect not only "local interactional contingencies" (Rapley, 2001: p.303) but also broader social norms from which we both draw on to co-construct meaning. Viewing my experience as being one of becoming within my identity as a researcher as consistent with the need to adopt an empathic stance within qualitative research where the researcher must not only acknowledge having a particular position but also be open to risk that this position might be changed as a result of engaging in the research process (Attia and Edge, 2017). Through my encounters with my participants I not only recognised my pre-reflective assumptions but was also able to engage more fully with my embodied sense of myself within my research; a perspective suggested by Attia and Edge as foregrounding 'the growth of the whole-person-who-researches' (p .34).

4.5.1 Process of analysis

The analysis process was a long and deeply analytical process which was marked by periods of intense uncertainty, doubt and frustration but also feelings of intense curiosity and insight when listening back to my participants' accounts of living with their RYGB. The process of analysis has been acknowledged as representing a daunting time for novice and experienced researchers alike and one during which tutorial, mentoring and supervision are vital (Biggerstaff and Thompson, 2008). Recognising my own need for support during this process I began working closely with a second supervisor who was experienced in IPA and who, like myself, works from an existential-phenomenological position.

Step 1: Transcription, reading and re-reading

I transcribed all interviews myself, a process which although time intensive offered me an invaluable opportunity to immerse myself in the data and pay meticulous attention to accurately capturing "indications of pauses, mis-hearings, apparent mistakes, and even speech dynamics where these are in any way remarkable" (Biggerstaff and Thompson, 2008: p.217) engaging in a multi-sensory process of reflection and noting down immediate questions, curiosities, or emotional responses I was aware of whilst listening to the interviews. An example of this is noticing my tendency to step back from enquiring further about seemingly sensitive topics mentioned above. I split the page into three columns moving from the interview commentary on the left, exploratory comments and finally emergent themes. This format felt like an intuitive layout to reflect the process of my analysis (see Appendix 6 for sample section)

Consistent with the idiographic commitment of IPA each transcript was read and coded individually before progressing to the next, a process involving both an attempt to bracket previous ideas emerging from the previous transcript whilst at the same time acknowledging that one's 'fore-structures' are changed as a result of each transcript (Smith et al, 2009: p.100). All transcripts were read twice whilst simultaneously listening to the recordings again allowing me to pay close attention to vocal intonations, pauses, and silences and gain a more thorough

understanding of the participants' accounts (Wertz, 2005). This process also allowed me to pay close attention to the intersubjective flow between my participant and I and notice 'richer and more detailed sections' as well as apparent 'contradictions and paradoxes' (Smith et al, 2009: p.82).

Step 2: Initial notes

Although I had already began making notes during transcription and whilst listening to the interviews, this stage represented more of a textual analysis. Smith et al. (2009) suggest three analytic lenses to guide commentary on the text during this stage: *descriptive* comments on content, *linguistic* exploring the participant's use of language and *conceptual* reflecting the hermeneutic of questioning where the focus may move away from the participant's words and become more interpretative. The sections of text that comments related to varied in length between a few words and an entire paragraph.

Step 3: Developing emergent themes

Using the detailed comments, thoughts and reflections developed in the aforementioned stages, this stage represented an attempt to reduce the amount of data whilst maintaining "complexity, in terms of mapping the interrelationships, connections and patterns between exploratory notes" (Smith et al, 2009: p.91). Noting my own experience in the analysis, I noticed how I was often drawn to particular words and phrases which seemed particularly poignant yet simultaneously recognised the need to maintain the length of quotes that allowed for the context to be sufficiently preserved meaning that quotes ranged from a few sentences to longer paragraphs. To ensure transparency within my audit trail I maintained a record of the line number and quote that supported my rationale for each of my emergent themes.

Step 4: Searching for connections across emergent themes

I experienced this stage of the analysis as extremely challenging and frustrating through a desire to honour my participants' experiences and found it difficult initially to select what was

most interesting and important within my participants' accounts. I found supervision enormously useful as a function of the hermeneutic circle by allowing me space to momentarily step outside of my immersion in my data to consider my participants' accounts as a whole which subsequently helped in identifying the parts which felt most prominent. Whilst maintaining a commitment to interpretative process, I also noted the iterative nature of the analysis process at this stage where I recognised revising emergent themes and of moving back and forth between the transcript and the emergent theme labels to capture more of my participants' meaning as well as condensing theme labels where these were either repeated or where themes captured similar features of my participants' experiences (Langdridge, 2007). For each participant I constructed a table showing the groupings and the superordinate theme label. Rather than discard themes that did not appear relevant at this stage I kept these in a separate document in the event they became relevant at a later stage of the analysis process.

Step 5: Moving to the next case

The process outlined above was repeated for each participant. Whilst I acknowledge that any attempt to bracket the way in which my fore-structures had been changed by my reading of my previous participant's represents a partial attempt, consistent with the idiographic foundation of IPA I found the process of reading and re-reading whilst simultaneously listening to the interview helpful in engaging with each subsequent interview by reflecting on my experience of being with each participant.

Step 6: Looking for patterns across participants

After all interviews had been analysed I began looking across my groupings for each participant looking for patterns and divergence. Smith et al. (2009) suggest three ways of looking for connections and divergences within and between interviews: *abstraction* which refers to placing like with like, *subsumption* wherein an emergent theme acquires superordinate status within the grouping process and *polarization* which seeks to identify oppositional relationships between themes. Given the size of this task I found the process of

writing themes on post-it notes the most helpful approach with each participant being assigned a distinct colour. After configuring these I was then able to construct a table for the group (Appendix 7). Having maintained a transparent audit trail, I was able to easily identify the most suitable quotes for each participant when writing my results.

I would add that although the stages outlined above have been presented in a sequential format, the analysis process occurred over a prolonged period during which I continually moved back and forth between my emergent themes and the data. Some of the analysis process continued whilst I was writing-up which felt to me appropriate that my participants' voices should remain present throughout the entire process.

4.5.2 Personal reflexivity on the analysis process

Throughout the preceding chapter I have attempted to be transparent about the challenges and methodological decisions that I have taken over the course of the analysis. Viewing the role of the researcher as integral to the research process I regard the developmental perspective offered by Attia and Edge (2017) who "emphasise the importance of the researcher consciously stepping *back* from action in order to theorise what is taking place, and also stepping *up* to be an active part of that contextualised action" (p. 33) as reflecting my experience during my research. By allowing myself time I was able to step *back* and recognise the epistemological tensions which arose during my encounters with my participants and engagement with the data. Reflexivity represents a foundation within Counselling Psychology trainings where affect and physicality are utilised to understand the realities of oneself and others and has represented a central tenet of my efforts as a researcher in attempting to ensure both epistemological and methodological rigour during each stage of this study (Cooper-White, 2004). Most notably reflecting on the tension between wanting to remain methodologically true in the mixed-method approach I had originally chosen and my discomfort with this approach when sitting with my participants, I came to see how such an approach represented a potential "intersubjective correlate" (Murray and Holmes, 2014: p.25)

of the power imbalance experienced within the bariatric process. I recognised that in order to remain "intellectually honest" (Sharma et al, 2009: p.1643) I needed to move away from the position that I had become familiar with where I was looked to for opinion and judgement, reflected in my initial inclusion of quantitative measures, to one that openly acknowledged the intersubjective nature of the research process and truly prioritised my participants' voices in conveying their lived experience to hear the ways in which they establish meaning within their experience as they lived it. To do this, I made the decision not to include quantitative data in the analysis and report only the analysis carried out using IPA on participants interview transcripts.

4.6 Evidencing Rigour and Trustworthiness

In assessing the rigour and quality of themes identified within the data, I find Yardley's (2000) four principles of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance a helpful foundation upon which to consider the issues of rigour and trustworthiness. The notion of intentionality referred to above has been suggested as having a significant role within qualitative research both as an interpretative method (Smith et al, 2009) and as an important ethical principle within phenomenological research for researchers to consider their own connections to the phenomena they are studying (Drew, 2001).

Sensitivity to context

I recognised the need to do a comprehensive literature review to do justice to the work that preceded and influenced this study. I also recognised the importance of gaining a thorough understanding of IPA, and its appropriateness for this study compared to other qualitative approaches, as well as ways in which the functionality of IPA could be extended to fully acknowledge the embodied nature of the phenomenon being studied. Acknowledging the existence of social discourses regarding obesity I remained vigilant for ways in which these might emerge within the research process. In addition, recognising that my participants and I

had both a shared and unshared understanding of the surgical procedure that they had undergone was important to ensure that I remained sensitive to ways in which our differences might emerge, as was noted above when recognising the implicit power imbalance of including quantitative measures within this study.

Commitment, rigour, transparency and coherence

Smith et al (2009) point out how a commitment to rigour might be understood through the adherence to the phenomenological principle of recruiting an appropriate sample. Recruiting only individuals who had undergone RYGB surgery ensured that my sample was able to provide rich data (Cresswell, 1997). Being extremely passionate about the area of weight management and bariatric surgery and counselling psychologists' contributions to this, I was rigorous in my analysis so as ensure my data respectfully and accurately reflected my participants' commitment to the process.

Recognising the centrality of the researcher's subjectivity within IPA, and qualitative research generally (Murray and Holmes, 2014), I regarded an integral part of my commitment to conducting a rigorous analysis was to ensure that my results were supported through a 'grounding in examples' (Elliott et al, 1999: p.222) evidenced by the use of participants' quotes to support my themes. Furthermore, I also recorded my experience of and possible impact on the research process using a reflective journal throughout the entire process to support my reflective practice (Finlay, 2005).

Impact and importance

I regard the impact and importance of this study being its attention to participants' voices to gain an understanding of the lived experience of RYBG surgery. In hearing individuals' accounts of their lived experience, I regard this research as not only being important for counselling psychologists working within the area of bariatric surgery but is also consistent

with the increased interest within healthcare services around patient-centred care and research (Brocki and Wearden, 2006).

In addition to the principles outlined above, I also aligned with the suggestion of Elliott et al (1999) who suggest the inclusion of "credibility checks' such as the use of an 'additional analytical 'auditor" (p. 222). As previously mentioned, I worked closely with my supervisor who was experienced in IPA and offered analytical opinion and reflective space within which to discuss my analysis. Overall, I feel my adherence to the principles proposed by the above authors provided me with a sufficient framework within which to validate my research.

4.7 Ethical considerations

Murray and Holmes (2014) suggest the interview becomes a "site of ethical intersubjectivity" (p. 25). Congruent with my practice as a psychotherapist and counselling psychologist in training, I adhered to the ethical guidelines proposed by the British Psychological Society which advocates the four components of respect, competence, responsibility, and integrity (BPS, 2009). Applying these to practice I align with the feminist ideal where ethics are based in caring rather than justice and are therefore seen as emphasising responsibilities and relationships as opposed to rights and rules (Jackson et al, 2004). Bond (2004) identifies four major ethical challenges within research namely inequality, difference, risk, and uncertainty. Viewing these four areas within the ideal proposed by Jackson, the following reflects how I understood each of these relating to my study and how these were addressed.

Inequality

Murray and Holmes (2014) highlight how the "scene of the research interview might itself act as an interpretative correlate or metaphor for the event that was originally experienced as individual" (p.25). Acknowledging the existence of powerful stigmatising discourses surrounding obesity (Puhl and Brownell, 2003; Hooper et al, 2011) there existed the potential for participants to experience the research as either pathologizing, stigmatising or for feelings

of guilt or shame regarding their decision to undergo surgery. Acknowledging the ethical principle of transparency (BPS, 2014), I hoped that by acknowledging my prior experience of working with the area of bariatric surgery at the start of the interview would establish a respect for the challenges that some people can encounter and establish the scene for a collaborative exploration of the research issues (Puhl and Brownell, 2003; Ballinger, 2006).

I also regard issues relating to confidentiality and participants' right to withdraw from the research as relating to the area of inequality as both, if not addressed appropriately, can be considered as reflecting the researcher's implicit position of power in the process. Conscious of my participants' involvement with the bariatric service, I emphasised the confidential nature of the interviews and their right to withdraw from the research at any stage up until the point of potential publication; explicitly stating that should they wish to terminate their involvement with the study this would in no way effect their involvement with the bariatric support team or any other support they may be receiving. All participants were informed that the research may be published and that to enable this data would be kept for five years after the point of collection but that all identifying information would be anonymised. Information was securely stored and was identifiable only by a number indicating their order in the data collection process. This number was used throughout the analysis process however pseudonyms were assigned during the writing-up of results.

Difference

Considering the issue of difference, I am neither overweight nor have I undergone bariatric surgery and therefore, despite my respect for diversity and difference in body size and shape, I embody something different to that of my participants. Warin and Gunson (2013) highlight the "embodied privileged position" (p.1692) of the researcher when exploring the experience of undergoing bariatric surgery which as a result was perceived as them lacking the ability to understand what it is like to be obese or have had to cope post WLS. Acknowledging my participants' otherness and the myriad of ways in which this could emerge I ensured that their

experiences and personal values were respected at each stage of the study. As noted above, by viewing the interview as a potential interpretative correlate for the psychological assessment participants underwent ahead of surgery, I drew on my own senses, including implicit bodily knowledge, throughout the course of the study so as to be as sensitive as possible in framing my questioning during interviews and remain vigilant during the moment-to-moment intersubjective dynamics for the emergence of power dynamics between my participants and I.

Risk

Related to the issue of risk, there always exists an element of uncertainty as to the impact of the research on participants and researchers themselves. Considering the issue of risk referred to by Bond (2004), the research focused on the exploration of the individual's experience including the social relationships that exist within their lives. As a result, there existed an obvious risk that through discussion of material that may have previously been out of conscious awareness there was the possibility that either these relationships may be disrupted, or participants may become emotionally disturbed by issues that might arise. At each stage of the research I remained alert to the impact of the material upon my participants. The debriefing carried out at the end of each interview was designed to attend to the well-being of the individual and ensure they were not left with concerns or uncertainties regarding their involvement in the research. I provided contact details to all participants and encouraged them to contact me directly should they experience any distress or concerns so as we could discuss these and if necessary offer them support engaging with services. Although this is an important ethical issue to consider, my experience aligned with that reported by Goodspeed and Boersma (2005) who found that most participants involved in their research described the experience as having been a positive one providing them with the opportunity to share stories within a safe and supportive environment.

Chapter 5. RESULTS

Analysis using Interpretative Phenomenological Analysis (IPA) resulted in four major themes being identified within my participants' accounts of living with their RYGB; i) managing change and uncertainty, ii) the affective experience of change, iii) the post-operative body within its relational context and iv) the presence and absence of appropriate support. These four major themes were comprised of thirteen sub-themes outlined below.

Table 2: Table of major and emergent themes

Major themes and related sub-themes	Interviews containing this theme							
	1	2	3	4	5	6	7	8
1. managing change and uncertainty								
1.1 renegotiating the body postoperatively		•	•	•	•	•		•
1.2 experience of adjusting to imposed restriction	•		•	•	•	•	•	•
1.3 redefining relationship to food	•		•	•	•	•	•	
1.4 putting surgery into perspective		•	•	•	•	•	•	•
2. the affective experience of the body postoperatively								
2.1 disillusionment with hoped for transformation	•	•	•	•	•	•		•
2.2 living in a state of limbo	•		•	•	•	•	•	•
2.3 enduring sense of self as overweight	•			•	•	•	•	
3. the post-operative body within its relational context								
3.1 feeling of becoming normal		•		•	•	•	•	
3.2 managing others reactions to transformed body		•	•	•	•	•	•	•
3.3 the solitary burden of the post-operative body	•			•	•	•		•
4. The presence and absence of appropriate support								
4.1 the absence of appropriate professional support	•	•	•		•	•	•	•
4.2 the privileging of the body in post-operative support	•	•				•	•	•
4.3 the importance of peer support	•	•		•	•	•		•

5.1 Major Theme 1. Managing change and uncertainty

The essence of this theme relates to the ways in which participants notice their bodies having changed following surgery and the ways in which they were now being required to respond to these changes at cognitive, behavioural and emotional levels. Whilst a sense of loss around food preferences and eating practises characterised some participants' experiences, others also identified ways in which their lives had been enriched through the process of adapting. Whilst participants identified changes that they sometimes found difficult to negotiate, the sense of uncertainty many experienced in the present was set against a belief in a certain future that would have awaited them had they not undergone bariatric surgery.

5.1.1 Renegotiating the body postoperatively

Participants acknowledged ways in which their bodies were no longer the same and now required attention and consideration in ways that they had not previously required; particularly with regards to their bodies capacity to accept food. For some these changes represented a challenge whereas for others they resulted in a sense of frustration and realisation of the responsibility that undergoing gastric by-pass surgery involves. Participants' statements within this theme capture a relational quality where they find themselves having to negotiate not only what their bodies will accept but also with the demands it makes on their time and attention. For Stephen, despite sometimes feeling despondent towards his efforts to understand why he is unable to accept certain foods, he prided himself on adopting a pragmatic approach to gaining mastery over his body.

> I mean that's what the dietician did turn round and say, she said well you seem to be trying things whereas some people just sit there and go 'Oh I don't know what to do'. You know I will try. You know, it's the same problem if you've got a problem with a car you've got to try certain things until you get it right you know and that's what I try to do. [Stephen]

Stephen's comparison of his body to a car needing to be fixed appeared to offer him a familiar context within which to relate to difficulties which seemed helpful. Similarly, Tony adopted a creative and *playful* approach to the changes that he was noticing in the types of foods he was able to eat, an approach that was reflected elsewhere in his narrative where the willingness to continually try different foods appeared in keeping with his prior training as a chef.

> But it's quite interesting playing with different foods. What can you eat, what can't you eat. [Tony]

The use of metaphor also appeared to offer Joyce a way of expressing the newness of her post-operative body and her sense of uncertainty regarding its needs.

> Because you come out of hospital, that's it you just get maybe one or two bits of paper basically telling you about what meds you've got to take your multi-vitamins and you know your lifelong calcium and all the rest of it for your bones. But there's really you don't come out with, I suppose it's like coming home with a baby. You don't get a manual on how to look after a baby. It's a bit like that. [Joyce]

Joyce's use of the metaphor of "coming home with a baby" to describe her experience of leaving hospital following surgery was striking. Considering this within the wider context of her narrative, a tentative interpretation could be offered that this metaphor captures the fragility of her post-operative body and her sense of not knowing what her body needs or wants but of having to find this out through a process of negotiation.

For others, changes were recognised via the impact they had on their usual routines and the need to now consider their body's needs within their hectic schedule. For Jenny and Bronwyn, their experiences capture the temporal nature of change, acknowledging the ways in which

their bodies have become more demanding since having surgery and now requires them to slow down, plan and think about eating; practices that did not exist before surgery.

> But the time, it's the time limit on eating that I found really difficult because I'm so busy at work to actually sit down and eat slowly. Just didn't happen before, usually on the go, in the car stuffing something in erm so that, that I found difficult [Jenny]

> It reminds me actually that [*pause*] food is my life now. Everything has be planned around sort of eating as where prior to surgery if I was hungry I'd eat, if I wasn't hungry I wouldn't eat […] I didn't have to think about it, it was just there. [Bronwyn]

Bronwyn's statement vividly captures the relational nature of this negotiation referring to how the necessary conditions required for her body to now accept food means that eating now has to be '*planned around'* and now dominates her life.

Sophie's experience of having to overcome the unfamiliarity of her body differs somewhat to the others and relates to changes in her emotional rather than physical experiences that have occurred following surgery.

> I get sort of, I don't get the hunger pains but I get like, not hangry but emotional. Just annoyed, annoying, annoyed. And I didn't realise it was because I was hungry, or I needed food. […] You know what I mean, you don't realise that that was the problem [Sophie]

Sophie's use of the adjective '*hangry*' in describing how she now recognises the need to eat highlights the way in which she recognises being required to develop a new emotional repertoire for relating to and understanding her physical body and its needs.

5.1.2 Experience of adjusting to imposed restriction

The second sub-theme captures participants' responses to the physical change that appeared to be experienced as *imposed* on their bodies by the surgical procedure. The use of the verb *adjusting* expresses the idiographic nature of these responses in the form of emotional, cognitive and practical reactions. What is interesting in this theme is the ways in which most participants refer, either explicitly or implicitly, to a desire to revert to a relationship with food that existed prior to surgery that they wish to escape from yet also crave.

Robert recalls the sense of containment he felt from the restriction which had been imposed immediately following surgery but how over time this has lessened, resulting in him struggling to sustain this sense of containment for himself.

> I mean the first three or four weeks you just had liquid food then you went on to a little dish then you went on to a tea plate and it was good because after that you think 'I'm full up' and you couldn't eat no more. But now you sort of think 'oh I could eat a bit more' you know 'I need some more' but I don't, but you could do. The mind says you could do but it's awkward it is really hard". [Robert]

Robert's struggle comprises an apparent dichotomy between his desire to be restricted and his minds desire to eat more. The tension he refers to between his desire for containment and his minds contradictory stance is shared by Bronwyn who, despite recognising the benefit of being controlled by the surgical procedure, describes being *angry* and *battling* against the restriction imposed by the gastric by-pass.

> I get quite angry with it then because it's, my Bypass is still in control not me. Which is a good thing! In hindsight it is a good thing because if I had total control over it, but I do battle it. I do battle it. [Bronwyn]

The ambivalence expressed in the previous statements highlights the struggle participants experience between both desiring change yet experiencing resistance over the ways in which they feel this is imposed on them. For Sophie, this struggle emerges in her awareness of how her motivation oscillates and how she regards herself as '*her own worst enemy*'.

> I [*hesitates*] it was difficult coz [*pause*] I'm like my own worst enemy, it's like well I shall eat these things then if or I shall have these things then if [*sigh*]. It's hard, it's, on one hand I can really try and then the next time, next sort of things I completely give up it's like well I'll have what I want then and [*pause*] eat the wrong things and drink the wrong things. [Sophie]

For Tony, the imposed restriction is through the unforeseen impact on his ability to taste foods. He refers to his taste buds having '*gone to pot*' and is angry at the loss of enjoyment in foods as a result.

> Erm one of the things that did change that really pissed me off, I mean virtually all my life I have lived off things like jellied eels, whelks, cockles, prawns, shrimps erm we used to go and catch it all, dig it all, scrape it all pick it all. Crab for instance, I always loved crab err and then after the operation I found that after the operation my taste buds had changed and, I not so much didn't want it, I didn't like it. [Tony]

The loss Tony refers to here has a quality of mourning, not only for foods he previously enjoyed, but also for the context within which these foods were enjoyed. I experienced his nostalgic recollection of the way in which he used to enjoy these foods as conveying not only a sense of imposed physical restriction but also experiential as to the experiences he now sees as being available to him.

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Unlike Tony, Joyce is adamant that surgery will not restrict her from enjoying activities that she enjoyed prior to surgery and instead adopts a position of defiance in relation to the prospect of her life being changed by surgery.

> ...a couple of times we've gone out for dinner. Because I said, I promised myself when I had the operation I wouldn't change [Joyce]

Jenny recognizes that her use of food as a method of self-regulating remains however the restriction imposed by surgery means that she has had to adapt her behaviours.

> I still use food as comfort. Erm the types of food that I use as comfort have changed because I can't tolerate some foods, so I can't binge on chocolate in the way that I used to, but I can have rich tea biscuits because they crumble down and they just go through and I don't have a reaction to them [Jenny]

My tentative interpretation of Jenny's pragmatic response to the threat of losing a method of self-regulation is that it reflects a determination to maintain a sense of personal autonomy following surgery by finding a way to overcome the loss of this familiar way of Being.

Helen's experience of adjusting differed to other participants in that, instead of resisting or resenting the restriction imposed, she appears to have internalised a belief in the restrictive power of surgery and the potential to experience adverse reactions should she deviate from this.

> …to me it feels as though there's something there and I'd rather go along with that thought process of thinking if I did over eat then this could happen. I don't wanna go there. I've been on this eating merry-go-round for too long now. [Helen]

Although Helen also acknowledges the possibility of reverting to a previous way of relating to food, her willingness to '*go along with*' the '*thought process*', to me, conveys a willingness to commit and work with the surgery as opposed to resisting what it potentially offers her.

5.1.3 Redefining relationship to food

A closely associated experience to participants' abovementioned accounts of loss and their need to adjust was observable in the ways they made sense of their altered eating behaviours. Most notably, participants described how they recognised their relationship to food having changed; both in terms of the way they perceived it and in its meaning within their life.

For Robert and Joyce, they described how foods that they had previously enjoyed now appeared grotesque and overwhelming.

> Well the other day I cooked, we had one of these side of pork erm I cooked it for six hours slow and when you sort of cut it you've got this thick layer of fat, put it on a plate. You know, Christ I used to eat all that. Why! [Robert]

> I laughed to myself coz I walk in there and I say a small portion and they put this small potion and it looks huge to me. [Joyce]

These statements acknowledge the way in which both these participants relate to food on a visual level and how their perceptual experience of food was now different and more sensitive to the implications of their food choices for their weight and health. Robert's description goes a step further in not only expressing shock at his previous behaviour but also posing a question to himself, asking '*why!*' he had eaten in the way he had prior to having surgery.

For some, the ways in which they described having noticed their relationship with food changing was more pragmatic, acknowledging the fact that they were unable to enjoy food in

the same ways as before and so looking for ways to minimise this loss. Tony explicitly acknowledges the dilemma he faces and the options that he sees as being available to him.

> I try because the thing is, I can no longer physically enjoy it. What do I do? Do you carry on moaning about that or do you take a different route you know. And that's what I've done. [Tony]

Jenny on the other hand takes a more compassionate stance towards her experience of losing her ability to tolerate meat, something she describes as previously *loving* when eating out, and through this process has been forced to open up to new opportunities that she finds herself enjoying.

> Because I don't say to myself I'm not allowed to eat anything erm I will have it occasionally […] But I find myself enjoying other things that are much much better for me. [Jenny]

Similarly, Helen describes how, whilst not denying herself the occasional digression from her post-operative plan, '*the by-pass'* has enabled her to '*get it all into* perspective'.

> You know you are what you put into your body and I think particularly because of the By-pass and I always make sure I'm getting all the vitamins and I try and make whatever I eat count. For the goodness of my body. It's not to say that I don't have the odd little square of chocolate now and again, you know, very rarely and erm but it doesn't bother me and I do enjoy food more now and what I'm eating. […] I can certainly get it all into perspective and erm it's not a problem. [Helen]

I understood Helen's paraphrasing of the adage 'you are what you eat' as reflecting a shift in her relationship to food where she is not only more conscious of what she puts in her body but

of how her choices now feel as though they quite literally define her. Whereas the other participants refer to the ways in which they have been able to identify new opportunities and greater enjoyment from food, Bronwyn's experience of how her relationship to food has changed relates to the function she now assigns to it as opposed to the act of eating itself.

> Now I eat because I need to survive whereas before I eat because it was there [Bronwyn]

Whereas before surgery she noticed eating out of impulse, food has now taken on greater meaning for her as a *need* for her survival. Considering Bronwyn's wider interview, I would offer a tentative interpretation of her reference to the '*need to survive*' as reflecting, at one level, a sense of being burdened through surgery with a '*lifelong commitment*' which she is now responsible for.

5.1.4 Putting surgery into perspective

The final sub-theme captures the ways in which alongside the uncertainty that comes with changes to their bodies and their relationships to food, there exists a certainty that without surgery their lives would have been much worse. Adopting Helen's use of the word *perspective* from the previous subtheme felt appropriate here as participants' statements appear to reflect a process of positioning the RYGB within the wider contexts of their lives. A number of explicit commonalities existed within this theme which I have represented through the grouping of participants' themes below.

For Stephen and Joyce, surgery was regarded as quite literally saving their lives. Both convey a firm belief that without it they would not be here now.

> I say well without it, I say it time and time again, without it I think I was on a one-way ticket you know. [Stephen]

I don't regret one minute of having it done. Best thing *ever*. I don't think I'd be here if I hadn't had it done. I really really don't [Joyce]

Stephen's use of a journey metaphor here communicates a sense of hopelessness against which he now compares a feeling of future potential. This comparison of past versus present is further developed by Helen who, in reflecting on the experience of being interviewed, describes her experiential sense of noting the impact of surgery on her life.

It's quite nice actually, to go through it and remembering how it was because it was such a change and for the better. [Helen]

For some, the comparison with their pre-surgery life involved a desperate image of themselves where the future was either non-existent or one of marked decline both physically and experientially. For Bronwyn and Tony, their contextualisation of surgery within their lives occurs through the identification of what it has made possible for them to achieve.

I don't regret it. I've had my children out of having gastric surgery. I would never of had my children. Had I of not had my children then I couldn't see a future anyway. [Bronwyn]

I've got my life back. I can go fishing again. […] Without the surgery, like I said I would have been in a wheelchair and on the downward slope. [Tony]

The achievements they acknowledge, having children and being able to fish again, appear to represent life fulfilling pursuits without which life, for them, would not have been worth living. Similarly, although noticing ways in which surgery has not fulfilled her expectations, Sophie also notices ways in which without it her situation could have been much worse.

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But you just, I don't know I was just desperately hoping for change and thinking this is the best way. I mean it has helped, it has, I have lost enough weight to be able to do more physically which [*long pause*] is great. Because, you know otherwise I could have been getting worse and worse and worse. [Sophie]

The process of gaining perspective on the impact of surgery within participants' lives at the heart of this subtheme was directly addressed by Jenny.

It's not cosmetic surgery at all […] I actually feel, although there's been massive health improvements my idea of what I look like, I'm worse off now erm but, for cosmetic reasons it has not done me any favours at all in that respect, but it's been such a positive thing health wise I couldn't, I just feel so much better for having the surgery, for losing that weight. [Jenny]

Not dissimilarly to Sophie, Jenny recognises how changes she has noticed postoperatively have resulted in her being '*worse off*'. Jenny's explicit evaluation of the benefits and consequences of undergoing surgery offers, I believe, a way of understanding my other participants' experiences of this process of contextualising surgery within their lives. Despite the negative changes Jenny acknowledges, her view of surgery as a positive experience is based on its impact on her health. From an interpretative position, her evaluation appears to reflect the identification of needs (Maslow, 1943) based on her life values which she refers to elsewhere in her interview when describing how the fact that her children now '*feel safer*' as a result of not being '*at risk of losing me*' results in her view of her decision to have surgery '*feel worthwhile*'.

5.2 Major Theme 2. The affective experience of the body postoperatively.

Whereas the first major-theme addressed the ways in which my participants noticed responding to bodily changes brought about by surgery on cognitive, behavioural and emotional levels, the second major theme captures participants' descriptions of living in their postoperative body. At its core this theme conveys the personal and often very private struggles participants experience including feelings of disappointment with their post-operative bodies and uncertainty around the future living with a physical state that feels temporary.

5.2.1 Disillusionment with hoped for transformation

My participants described varying degrees of disappointment following surgery and the disparity between what they had hoped for and the situation they now found themselves in. For most, the sense of disillusionment centred around their physical appearance and the ways in which this now affects their sense of their bodies on intrapersonal and interpersonal levels. Robert expressed a considerable amount of disappointment and disgust towards his body throughout his interview describing how all he sees when looking at his reflection is a *'big bulge'* and how in his mind *"I'm massive. I'm still big"*. For him, his physical appearance featured prominently in his disillusionment with how his body had failed to *adjust* in the way he had hoped for following surgery.

> Erm according to the doc […] what happens he says is after about three-year period
> is the honeymoon period. And after three year it's as if your body adjusts. But that don't
> adjust (pointing to apron of skin). [Robert]

I understood Robert's repeated reference to the *three-year period* and the acknowledgement of the apparent imbalance between his body's visual and physiological *adjustment* as highlighting his awareness of time and how this appeared to signify a loss of hope for the possibility of improvement.

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Similarly, Tony also refers to a temporal sense of his weight loss journey and how, after regaining some weight, he now finds himself *stuck.*

> I've got down to this weight and they said you get down so far and stop and you put a bit on. And that occurred. Err I didn't get down as far as I was hoping […] I'm stuck around the seventeen and a half stone mark. [Tony]

Interestingly, both Robert and Tony base their expectations, to some extent, on information provided by the medical team about the expected weight loss and adjustments. Within their descriptions of their actual experiences, the disparity and accuracy respectively of these predictions appear to feed into a disillusionment of their prior hopes following surgery.

Whereas Robert and Tony's evaluations of their current situation include comments from professionals, Sophie describes holding herself responsible for her failure to '*make it work*' and ensuing disappointment which seems grounded in this perspective.

> Erm [*pause*], yeah I just, just so disappointed in myself and my body erm that I couldn't make the most of it or it didn't just; my body didn't make it work [*laughs*]. [Sophie]

Here Sophie introduces a self-body split by differentiating between her and her body when attempting to make sense of her disappointment. This mind-body split appears frequently in participants' accounts of how they recognise struggling to manage as well as in their experiences of their post-operative bodies described within subtheme 5.2.3 below.

For Bronwyn and Joyce, their experience of disappointment emerged through a persistently critical self-reflective consciousness around their physical appearances. Bronwyn's description below perhaps captures most explicitly the sense of disillusionment with the ways

in which her body's failure to change in a way that was hoped for means that she is now required to *adjust* the way in which she views herself.

> It does play a massive role to you've come this far erm (*pause*) and no you're never going to be perfect but you still don't like what you see. You don't like what you see when you're fat and you still don't like what you see when you're healthy. So it's, it's the adjustment of how you see yourself. [Bronwyn]

> I'm still conscious of erm how I look I suppose. Still thinking like the summers going to come when I put a skirt on or dress on am I going to look, you know, with no tights is my skin going to look OK and yeah all those sort of things are crossing my mind I have to say. [Joyce]

Both these statements highlight the way in which their bodies remain a source of dissatisfaction that weighs heavily on their minds. In addition to acknowledging the temporal dimension of change as others did, Bronwyn also highlights the way in which although she never expected to be *perfect*, her pre-surgery dissatisfaction with her physical appearance has persisted. I understood her use of the word '*adjustment*' as relating to her realisation that in the absence of anticipated positive changes to her physical appearance, she now has to attempt to look elsewhere to see the benefits of the gastric by-pass; a process captured within my first major theme where participants described the ways in which they gain perspective by evaluating the impact of surgery within the wider context of their lives.

Whereas the statements above relate to a sense of disillusionment arising from the feeling that their bodies had not adjusted in the way they might have hoped, for Stephen his disappointment related to the limitations he now experienced on his independence resulting from his body's unpredictability in accepting food.

That is the only problem. Erm because I can't just turn round and say to meself right that's breakfast and go out which […] I'd, you know, like to do go back to work for somebody again. Erm if I go back to work I couldn't turn round and say yeah I'll be there at eight-thirty unless I got up about five o'clock in the morning. [Stephen]

Stephen's acknowledgement that he is not free to pursue employment as he'd hoped to but instead now must consider what he is physically capable of, felt as though it clearly contrasted with the anticipated hopes for life postoperatively and the current situation in which he finds himself in two years after surgery.

Joyce's description of how concerns about her appearance are still "crossing my mind" is consistent with Jenny's acknowledgment within major theme one of how, in some ways, she feels '*worse off*' in terms of her appearance since losing weight and the way in which she considers her body against societal standards of acceptability.

I felt sexier when I was bigger. Erm, just because it's normal. It's, you know fat is actually quite normal in our society isn't it. Whereas saggy skin is not normal in our society. Not to the extent that I think you get it after surgery. [Jenny]

Jenny's repetition of the word '*normal*' highlights how the ambiguity of one's own view of our physical body and that which is influenced by others view of it. Whilst the ways in which participants acknowledge feelings of disappointment with the results of surgery, at its core, this sub-theme illustrates the ways in which the cognitive, emotional and physical consequences of undergoing the RYGB procedure remain unknown until they are experienced when participants, as Robert stated, have '*to learn to live with it*'.

5.2.2 Living in state of Limbo

The use of the word *limbo* within this sub-theme was used to convey the sense, evident within participants' dialogues, of existing within a transitional state, the outcome of which felt uncertain. Of interest within this theme are the ways in which participants convey their experience of living within a body that feels temporary and not entirely their own, which for some results in an increased vigilance towards their current physical state through fear of it changing and for others a sense of futility that embodied change is not possible.

Although Robert expressed relief that having the by-pass had meant his weight had not continued to increase, this relief was tinged with a fear of losing this achievement and of his weight increasing.

> I mean I'm pleased to a degree that I'm not sort of thirty-stone now which if I had carried on I would have been but my next, fear now is that my weights going up. This is my next fear. [Robert]

His repeated reference to his '*next fear*' succinctly captures where Robert now found himself, referring elsewhere in his interview to feeling powerless to continue losing weight now the restrictive impact of the by-pass had worn off and his fears should he begin to regain weight. The fear of change Robert refers to is expanded upon by Tony and Joyce who both describe how, having successfully lost weight, they have become vigilant for threats to the position they now find themselves in.

> Erm I keep a check on it because, I've heard stories about people creeping up. They start drink or eat sweeties or whatever. If you're aware of what's happening you can keep a check on it. […] I have no intention of getting worse. [Tony]

But erm the thing I would say that I have noticed is if I'm sitting down […] I find I can eat more than if I'm here on my own […] I tend to get down more. So, that's quite strange and I'm quite *aware* of that. [Joyce]

Within both Tony and Joyce's statements I sensed an underlying feeling of anxiety over losing what they have achieved from losing weight. My sense of this emerged at different points of the analysis for each, in which with Tony it was in the immediacy and certainty of his tone during the interview which seemed almost defiant of any suggestion that his monitoring was unnecessary whereas for Joyce it was during the process of transcribing when I heard her emphasis and slight pause when saying how "aware" she is of her bodies receptivity to food in different contexts. In response to this fear of loss they both describe explicitly and implicitly how they now *keep a check* and are *aware* of different ways in which they perceive potential threats to their current physical states.

The feeling of uncertainty surrounding the future captured in the statements above contrast with those offered by Jenny and Bronwyn who both explicitly acknowledge the struggle they experience on a day-to-day basis.

Erm I suppose I'm eating less [*pause*] sort of emotionally but I still do from time to time. It has, it's not changed, it's not completely, my psychological issues are still there but I think I'm just managing them a bit better. [Jenny]

For Jenny, she openly acknowledges how her tendency to eat in response to emotions continues to exist and how despite the physical weight loss, psychologically she remains unchanged.

it's always going to be a fight. I suppose, I, I try and look at it on the side of an addict

that a drinker is always going to be an alcoholic until the end. And I'm always going to

be a [*pause*] impulsive food eater. That's never gonna change. [Bronwyn]

Similarly, Bronwyn's use of the term *addict* here captures a sense of a stable and

unchangeable sense of self, in this case as an *impulsive food eater*, however rather than being

regarded as necessarily problematic, this appears to offer a sense of containment by providing

a goal upon which to focus her energy. Whereas Bronwyn describes how her sense of herself

as essentially unchangeable offers a resource she can draw on, for Sophie her doubts

regarding her ability to change clearly undermines her efforts.

But I was sort of waiting for it to stop working and [*sigh*]. Sort of the defeatist or the

pessimist in me thinking you know you're not lucky for it to, you're not one of these

people it'll work for because you're [*pause*]. You've had quite a bit of bad luck in your

life so why should this be. […] I don't want to say poor me but things don't happen for

me as they do for other people. It seems. Or that's the conclusion I've come to after

all this time. [Sophie]

Here Sophie explicitly acknowledges how the *defeatist* and *pessimist* within her are regarded

as sabotaging her efforts by creating doubt and ultimately discouraging her from the potential

for change. In offering a tentative interpretation, I regard Bronwyn and Sophie's statements as

capturing the ways in which, despite recognising changes brought about by the gastric by-

pass, there continues to exist a sense of self that threatens to undermine their hopes for

change, but which can either be embraced within a wider motivation for change or feel

overwhelming.

Helen's awareness of the uncertainty regarding the future emerged from her reflection on her

experience of being interviewed and how she recognised it offering the opportunity to

acknowledge the impact of the by-pass and the importance of this for maintaining her weight loss.

> It's quite nice actually to go through it and remembering how it was because it was such a change and for the better. And I never want to lose sight of that because I don't wanna be someone who then has to have another one a few years down the line because it's all gone back on. [Helen].

Not unlike Bronwyn, Helen's desire to maintain her memory of *how it was* for her prior to surgery appears to act as a way of sustaining the determination to maintain the changes that she has achieved following surgery alongside the awareness of the potential to return to *how it was*.

5.2.3 Enduring sense of self as overweight

Sharing the sense of process like experience captured in the previous sub-theme where participants described a sense of being between states, the final sub-theme relating to participants' affective experience of their bodies postoperatively highlights the ways in which many of my participants acknowledged feeling that, despite noticeable physical changes, their perception of their bodies remains unchanged from before surgery. Within all their statements, what felt striking was the apparent existence of an underlying split between mind and body that seemed to form a central part of their experience of relating to the changes that have occurred to their bodies postoperatively.

On several occasions during his interview, Robert conveyed his dissatisfaction with his physical condition through objectifying descriptions of his physical body referring to his *big bulge* and how he believed the surgeons could simply remove the *layer of fat* that was causing his distress. This apparent objectification of his physical body appears to be explicitly

acknowledged within this sub-theme where Robert describes how his visual perception conflicts with the physical reality of his body.

>   Erm yeah that's how I feel. I look at myself and I think 'I'm no different, I'm the same size'. I'm not obviously but. [Robert]

Robert's paradoxical acknowledgment of how his body has *obviously* changed yet he is unable to visually register this change explicitly refers to the split I observed in participants' dialogues of how their mind and bodies are referred to as separate entities.

Both Jenny and Helen acknowledged an intriguing disconnection in their perceptual experiences of their physical bodies, describing how despite noticing objective indicators of their bodies becoming smaller, their perception of their bodies as large bodies remained unchanged.

>   I mean I was losing a stone a month. It was just really falling off. I can't remember when it kicked in. But it was, I still felt I looked fat even when I'd lost like seven stone I still felt I looked fat. [Jenny]

>   I don't think I realised how much my shape had changed. Although I knew it was changing because you get excess skin […] and you can see it's going in and so you know it's changing. But in my brain I didn't register how much my body had changed. [Helen]

The terminology used in the statements above such as *falling off* and the acknowledgement of *excess skin* clearly communicate an awareness of the extent to which their bodies were changing however at a perceptual level their sense of their bodies remained unchanged. In

trying to understand this dichotomy, I found Joyce's naming of the part of herself that endures despite her weight loss helpful.

> But, I still walk into a shop, and this is really strange because I still then, got my fat head on as I call it, I can still walk into a shop and go straight up to the twenty-two rails instead of going down to an eight [Joyce]

Drawing on Joyce's naming of her "*fat head*" which she recognises guides not only her decision making at times but also her own view of her body, I got a sense that, following surgery, participants' bodies altered at a disproportionate rate to their innate sense of their physical Being resulting in a disjunction between their cognitive and affective sense of their bodies. My interpretation appears to receive some support from Bronwyn's statement that eloquently captures the dilemma she encounters in relating to her post-operative body.

> I don't feel that I'm eight stone lighter […] And I don't think there is anything to take that bit away because that was there longer than this has been here. [Bronwyn]

Bronwyn's unambiguous reference to time and how her sense of herself as overweight represents a more familiar, and enduring, embodied experience in comparison to her new and unfamiliar physical body led me to consider the impact of such rapid weight loss experienced by my participants within the temporal nature of their lives and how such rapid weight loss, as is experienced following the gastric by-pass, creates a significant challenge to the individuals attempts to redefine their embodied sense of self.

5.3. Major Theme 3. The post-operative body within its relational context

Although the themes have dealt with my participant's experience of their bodies on cognitive, emotional and behavioural levels including the ways in which they both experience and manage the uncertainty that has arisen following their weight loss, what was evident in the

data was the way in which the body exists within a relational world which the third major theme addresses. Within this theme, participants describe how they now evaluate their bodies against social categories of *normality*, how they recognise others relating to their physical transformations and the ways in which, individually, they all experience feelings of isolation arising from their sense of their physical bodies.

5.3.1 Feeling of becoming normal.

The first sub-theme captures the implicit and explicit ways in which my participants evaluate their success against constructions of *normality*. For some this is experienced through the recognition of their body being able to do every day and sometimes seemingly mundane things that they were unable to do before having surgery, whereas for others they notice the way in which, following weight loss, their interactions with others feel distinctly different. An interesting phenomenon within this theme are the frequent references to time and how, like within previous themes, my participants' experience of life now positions itself in contrast to life pre-surgery.

For Stephen, the act of being able to choose regular size clothing represented a positive advantage of being smaller.

> But what is nice is that I can go in and buy clothes off, you know, just straight go in there and say oh I need a large in that size and I just go yeah that'll fit. I know that'll fit. [Stephen]

I understood the ease he refers to within the interaction he describes, where he can *just go in there,* as reflecting how he no longer experiences his body as something requiring special attention making his experience of buying clothes a less arduous task. I interpreted his use of the phrase *know that'll fit* as further evidence of how Stephen now sees his body as reflecting a standard rather than exception within society. Similarly, Jenny recalled a humiliating memory

of her body being subjected to a public evaluation resulting in her being excluded from enjoying activities with her children.

> I can remember going to Thorpe Park before the surgery with the children and I couldn't get on any big rides. I was too big to get on any of them and it was *awful*. The kids were *desperate* for me to go on so they made me sit in that chair outside the que to try it […] For *every* one I had to get into and for *every* one I had to turn round and say I can't fit [*laughs*]. Which was awful. So to be able to do stuff like that with the children now is, you know. *That* was one of my goals. [Jenny]

Jenny's repetition of the word *awful* and her emphasis on her children's *desperation* for her to join them spoke of a sense of her being ostracised because of her size and that this feeling of exclusion formed a prominent goal for her body to fit with what society requires. Jenny's desire for her body to be an accepted size highlights an interesting paradox of the contextual nature of acceptability as within my sub-theme 5.1.1 she explicitly states that, within intimate settings, her body now feels unacceptable as a result of *not* being normal within society.

Whereas Stephen and Jenny's experience of becoming normal emerged in relation to social indicators of normality and acceptability, Bronwyn and Helen recognised the ways in which their experience of encounters with others differed since losing weight.

> I feel a lot more confident, I don't worry about, I don't worry about how I look anymore as in meeting people or going out in the street or going to the pub […] I feel normal in that way now which I never felt before. [Bronwyn]

> I feel as though people take me more serious, not more seriously that's wrong […] I don't know just being, I hate the word normal, but just being seen as a normal person who has the right to be listened to. [Helen]

The quotes above explicate in my understanding how the term *normal* relates to a sense of being acceptable and accepted by others. Whereas Bronwyn refers implicitly to the feeling of previously being judged by others and how she no longer *worries* when entering social situations, Helen explicitly notes how she now not only feels worthy of being acknowledged by others but, importantly, that others now also regard her as a *normal person*.

It seems my participants' acknowledgement of how they now feel *normal* so far have been directly related to social cues and indicators that, subtly or not so subtly, have highlighted their physical difference in the past but now no longer do so. For Joyce, whilst social approval of her appearance was important, the way in which she experienced *normal/normality* postoperatively related to a time before she had become overweight.

> And he went to me mum it's just amazing to see you back to your normal self
>
> [Joyce]

Although the statement above conveys her son's acknowledgement of her return to normality, by relating to a previous *version* of herself rather than a societal standard, the context this statement occurred in related to her own acknowledgment of the ways in which her physical ability had improved since losing weight.

5.3.2 Managing others reactions to transformed body

Whilst the first sub-theme addressed my participants' cognitive and affective experiences of feeling normal within social and relational contexts, this sub-theme relates to the way in which participants experienced other's reactions to their physical changes. Whilst exercising caution in my observation, within this sub-theme there appeared to exist a gender difference in ways in which participants described the nature of other's reactions to their post-operative body and the ways in which they managed these. Whereas female participants described ways in which

they noticed their smaller bodies being related to on intimate and sexual levels the men, with the exception of those closest to them, were somewhat dismissive of other's opinions on their appearance and instead appeared to base their understanding of the changes they experienced on what their bodies were capable of doing.

Whilst he described how his weight loss and improved health had been greeted positively by his partner and father, elsewhere in his interview, Stephen also referred to how others expressed concern at his dramatic weight loss.

A few people turn round and say 'ooh you don't want to lose anymore' and I know why that is but I'm not worried […] it's because I look so thin compared to what I used to. That's why it is. I mean, that's all it is. […] I can understand what they're saying but it don't affect me in the slightest. [Stephen]

People are impressed with the results […] I'm not sufficiently vein that it affects me that much. [*laughs*]. If you don't like it tough shit. You know [*laughs*]. [Tony]

Stephen's acknowledgment but disregard of others' opinions is shared by Tony who, whilst acknowledging that others are *impressed*, vehemently rejects the possibility that this *affects* him. The explicit dismissal expressed in the men's statements contrasts markedly with most of the female participants who describe how others reactions to their significantly changed bodies required them to redefine their understanding of themselves in relationships.

I think people perhaps talk to, I mean certainly with the dating erm that became easier. Erm, easier to get to know people on that initial bit [Jenny]

I definitely notice around the men […] And that's a real hard thing to deal with when you've never had that before […] to almost feel I suppose sexually wanted in a way is a whole new experience to deal with. [Bronwyn]

Bronwyn and Jenny both notice how men now approach and admire them more since they have lost weight. Considering these statements together I understood Jenny's reference to the *initial bit* of a relationship as expanding upon the difficulties Bronwyn describes and the ways in which their smaller bodies presented both opportunities and challenges in different contexts.

Similarly, Joyce also recognised how, because of her partner's reaction to her weight loss, she was now having deal with new dynamics within her relationship.

he [partner] like never left my side. And he's not like that again at all. But he never left my side and he said I saw when you went up to the bar I saw those guys over there looking at you. And it's things like that. He never would say things like that before. So it's quite, that's a new thing for me. So I find that quite strange to deal with [Joyce]

Joyce's acknowledgment of how, since losing weight, she now notices her partner behaving towards her in ways that are quite different to before surgery appears to present her with a challenge and yet another form of uncertainty.

As was the case within my second major theme where the experience of being interviewed appeared to prompt Helen to adopt a reflective position to her weight loss journey, here she questions her role in the co-creation of differences she notices in others reactions to her.

it just occurred to me that it's happening more that people were more happy to open the door for me […] I'm thinking perhaps that could have been me. Perhaps because I didn't want to be noticed I didn't take any notice of what people were doing. [Helen]

Despite initially suggesting others were more obliging to her, Helen's consideration of the extent to which she had previously avoided others gaze appeared to result in a consideration of the differences she now noticed in others as actually reflecting ways in which she was now different within these contexts; a reflective process that was also evident within other participants' references to how they also notice changes in their encounters with others.

I'm a lot more easier to talk to, a lot more approachable because I haven't got the defences up because I know I look normal like everyone else [Bronwyn]

Bronwyn's description of how she now recognises being "more approachable" links closely with the way in which participants recognised feeling *normal* following surgery in sub-theme 5.3.1 above. Viewed in this way these statements offer a poignant view of the ways in which changes to my participants' embodied sense of themselves can impact upon their experience in relation to others.

Sophie's experience of others reactions to her weight loss differed markedly from others. Rather than recognising the need to adjust to a new form of encounter with others, she described the gaze of others, even when positive, as adding to her concerns around maintaining her weight loss.

I suppose, I mean I was getting positive comments from my boyfriend's parents. They were saying 'Oh you're looking really well' and 'You're doing really well' and; it was, you know that's sort of nice to, to hear that people notice but then, in a way it sort of [*short pause*] when you stop losing weight you're worried that they'll notice that as well. […] So

you sort of, it's the way my mind works it's like 'Oh no they're going to realise I'm not losing weight and I've failed and I've erm they're going to think less of me or whatever'. [Sophie]

Offering a tentative conceptualisation of Sophie's ambivalence over receiving attention from others I was struck by some similarities between her ambivalence of others attention and her own ambivalence towards her post-operative process described above as manifesting in her oscillating between really trying and giving up. Listening to the way in which Sophie described her dilemma I had an acute sense of her loneliness in struggling to regain control of her eating behaviours, whilst simultaneously feeling the need to manage others hopes and expectations of her.

5.3.3 The solitary burden of the post-operative body

The final quote in my last sub-theme links closely to the essence of my final sub-theme relating to my participants' experience of their post-operative bodies within the relational context. A common theme referred to by my participants described ways in which they now feel alone in dealing with their body and how this sense of aloneness now resides as a burden they are required to bare.

Robert expressed openly his dissatisfaction with his body following surgery appearing to focus extensively on discrete parts of his body such as the *bulge* referred to below which persisted despite him losing a considerable amount of weight.

Erm I mentioned it to the doctor and unfortunately, we can't remove it on the National Health and well there's no way that I can afford what they want to afford; eight, nine thousand pound to have the operation but. So, you have to live with it. [Robert]

I heard Robert's statement as conveying his frustration at the unattainability of having a skin removal procedure. Attending to his language within this statement, I consider his use of the pronouns *we* and *I* as reflecting a division between himself and the medical profession with regards to how best to manage his dissatisfaction with his body. Developing the impact of this sense of division one step further I understood Robert's assertion *you have to live with it* as expressing a feeling of hopelessness around the possibility of obtaining the help he so desperately wants and of resigning himself to living with his dissatisfaction.

For Jenny, a prominent impact of the physical changes that occurred postoperatively centred on her confidence in dating and intimacy and the way in which she now felt the need to maintain a distance within these relationships.

> I have dated a couple of times since I've lost the weight, but because I look slim but I've got saggy skin and all the other things that come with the WLS erm I feel, I just feel people don't, people see you differently to the way that I actually am. [Jenny]

Jenny explicitly describes here how she now experiences her body from the gaze of the Other and how she feels others do not see all the other things that accompany gastric by-pass surgery. Jenny's reference to no longer feeling her body is normal by societal standards and how she imagines men being horrified at the sight of her body if she were to reveal it, felt as though it conveyed a deep dis-ease around the acceptability of her body. Considered alongside her feeling described elsewhere in her interview that her clothed body represented "false advertising" because of its slim appearance, Jenny's intentional concealment of her body which she viewed as being deceptive to others represented for me a burden she endured alone.

Similarly, Joyce and Sophie also described how they now conceal certain parts of their post-operative experience from others, albeit for distinct reasons.

I think erm, erm my children are a bit concerned sometimes. Erm I think they worry, […] so it worries me that they're thinking that. So I think I try to erm not tell them anything, you know like with these sugar levels and things, it's part and parcel of the operation but to them it's quite drastic [Joyce]

Joyce acknowledges the impact on her adult children of post-operative complications that she experiences and how, in wanting to protect them from this, she conceals her true experience of her body. Although she negates the significance of her low blood sugars describing them as *part and parcel of the operation*, elsewhere she describes the concern the medical team have regarding the extent of her weight loss and her difficulties managing her blood sugars*.*

I'm happy to try and maintain where I am. But they wanna see me back, usually it's six months, but they wanna see me back in three because of my blood sugars [Joyce]

Considered together, I understood her desire to conceal difficulties she was experiencing from her children as also potentially serving at a personal level, by enabling her to maintain her view of surgery as being the '*best thing ever',* by supporting her to return to her *normal self*, without this image being tarnished by complications she now experiences. The way in which Joyce permits certain aspects of her embodied experience into awareness, both others and to some extent her own, highlighted a deeply personal and solitary process.

Whereas Joyce conceals the difficulties she experiences postoperatively, Sophie's difficulties maintaining and continuing her weight loss and the fear she has around others noticing this results in her withdrawing completely from encounters with others to avoid potential judgement and their disappointment.

And it sort of makes me want to not see people as much again so they don't, they're not there, they can't see that if you see what I mean. They don't notice that or [*pause*]. Yeah. So, I mean I didn't see many people anyway and you sort of right ok well I won't see anybody then they can't notice anything. [Sophie]

Sophie acknowledges how her existing social isolation is further compounded by the fear of others noticing that she is struggling to '*make the most of it [surgery]'*. Sophie's statement links closely with Helen's earlier consideration of the intersubjective nature of social encounters and the role she has in avoiding and engaging in connection with others. Here, Sophie openly notices how, to avoid disappointing others, she withdraws her very presence from social encounters leaving her alone with her struggle.

So far this sub-theme has highlighted the ways in which my participants describe feeling alone in managing their post-operative bodies whether as a result of feeling others are unwilling to help, with the aim of protecting others, through a fear of revealing their body with its signs of weight loss or in an attempt to avoid others judgement. Bronwyn captures a somewhat distinct experience in which she feels others are unable to understand the gravity of what it is like for her day-to-day life following gastric by-pass surgery.

I've always been honest and people do ask questions but I don't think they totally understand and no one's looking at it from a psychological view like you are. So, it's just a bit like 'yeah that's sounds awful' or 'yeah that sounds', you know 'that sounds hard'. And then they don't have to think about it again because it's not affecting their life so. [Bronwyn]

Her acknowledgment of having *'always been honest'* sits in stark contrast with the ways in which other participants have felt the need to conceal aspects of their postoperative experience above. Bronwyn's observation of how our meeting contrasted with her usual

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experience of talking about surgery, by adopting *a psychological view*, speaks of her sense that others are unable to fully understand or appreciate the full impact of undergoing surgery which are not necessarily visible. Allowing myself a level of interpretation in considering Bronwyn's description of how others *'don't need to think about it again'*, I wonder whether the *it* might be seen as referring to *her* as it appears to relate to her lived experience. Viewed in this way, I wonder whether participants' attempts to fully express the challenges they encounter go unheard, conveying a deep sense of isolation within her relational context.

5.4 Major Theme 4. The presence and absence of appropriate support

Building upon my participants' experiences of their post-operative bodies within their relational contexts, my final major theme captures the various ways in which they experienced support throughout their bariatric journeys. Although my participants' accounts of support occur within relational encounters, such as family, partners, medical professionals, and peers, their statements differ from those referred to within the previous sub-theme in that their statements relate to the ways in which support, and the absence of, impacts upon their experience of adjustment following surgery and their ability to renegotiate their sense of themselves, others and the world.

5.4.1 The absence of appropriate professional support

With the exception of Jenny, all participants expressed the view that there exists a dearth of appropriate support from the medical profession following surgery. For some, this related directly to a lack of support in helping them manage new and unfamiliar physical symptoms resulting from the gastric by-pass, whereas for others there was felt to be an absence of support helping them adjust to the psychological impacts of the physical changes experienced following such rapid weight loss.

Robert described feeling as though, in hindsight, he could have been provided with more information regarding the way in which the gastric by-pass facilitates as opposed to guarantees weight loss.

> I think they could be a bit more explanatory. Erm and say what the side-effects will be. They didn't sort of say, only recently has the surgeon said to me that well the three-year honeymoon periods over it's now down to you to carry on losing the weight. Ok. How? [Robert]

The dismay Robert expressed at the suggestion that he now needs to take responsibility for further weight loss highlights the misconception he entered his surgery journey with and how this has contributed to his unique sense of disillusionment referred to within major theme two. Robert's reference to the honeymoon period relates closely to Stephen's experience of feeling unsupported at a particular juncture in his post-operative journey.

> They signed me off this visit just gone but they changed all my erm calcium and they're putting me on vitamin B injections and stuff like that to try and help this malabsorption problem. Even when I was you know telling them about the problem, now they've done something about it. [raised voice] Just as I'm leaving! [Stephen].

I heard Stephen's prosodic intonations as expressing a frustration at what he regards as a delayed response by the medical team to deal with his body's difficulties absorbing nutrients by introducing new treatments at a time when he is being *signed off* parallels that of Robert, with both men alluding to a sense of feeling abandoned by the medical profession. The sense of being left to manage alone was also captured by Joyce who drew an interesting parallel with bringing a baby home to describe her sense of bewilderment and aloneness when leaving hospital following surgery.

Because you come out of hospital, that's it you just get maybe one or two bits of paper basically telling you about what meds you've got to take your multi-vitamins and you know your lifelong calcium and all the rest of it for your bones. But there's really, you don't come out with, I suppose it's like coming home with a baby. You don't get a manual on how to look after a baby. It's a bit like that. You come home and you've, you do feel a bit like you know [Joyce]

Joyce's use of the metaphor of bringing a baby home and her feeling that the information she was provided with when leaving hospital felt inadequate for dealing with this new, fragile and unfamiliar Being felt to me as though it conveyed a deeply felt sense of being left alone. Although Joyce does not explicitly say what it was like for her to *come home*, I found Bronwyn and Sophie's accounts of this experience helpful in expanding my understanding of the deep level of uncertainty and sense of being on one's own that accompanies the process of being discharged following surgery.

…that is all a real big learning curve. You're given paperwork, you're given a sheet about calcium and about protein but unless you totally understand what that means and what the concept of not having that means [Bronwyn]

So far, the absence of support has manifested within participants' accounts through their concerns relating to their ability to manage their physiological functioning of their post-operative bodies. For others, an absence of support was also felt to exist around the physical and psychological impacts of weight loss following surgery.

Because there is no, with the, you know surgery sort of ok you've done now and that's it for. And for quite a few people I suppose that's fine. But erm, you know if you've got that within you anyway I suppose they knew that there wasn't sort of any aftercare in that respect. [Sophie]

In her quote above, Sophie's reference to her mental health difficulties as having *that within you* represents another way in which she differentiates herself from others undergoing surgery. Picking up on Sophie's differentiation between the physical act of surgery being *done now* and the absence of aftercare for her underlying psychological needs relates closely to my second sub-theme below where participants openly acknowledge ways in which they recognise their physical bodies appear to take a precedence over their affective experience of post-operative change.

> With what I've got there I would imagine there's a couple of stone, probably a stone and a half two stone that would probably make a big impact on my knees. But the fact of the matter is they're not doing it as a follow-up to the operation which I think is wrong. Erm I can't afford to have it done so why think about it. [Tony]

Tony's unambiguous disapproval at the lack of follow-up support to remove his loose skin at first glance appears pragmatic, acknowledging the *fact* that follow-up surgery is not available on the NHS and therefore why consider it. Adopting a broader perspective however, his disapproval with the support available to him and the way in which he feels this prevents him from further improving his situation appears to align closely with other participants' accounts within major theme two, where this absence of support can be seen as contributing significantly to an enduring sense of disillusionment postoperatively with the transformation they had hoped to achieve. This view receives some support from Bronwyn who not only differentiates what support she feels is needed from what might be classed as cosmetic approaches but also how additional support to manage the loose skin resulting from such rapid weight loss feels the only hope to *deal with* her view of her body.

I don't think I'm entitled on the NHS to have a boob job and a tunny tuck. Not at all […] but there isn't anything in place to make you mentally deal with that other than correcting it. [Bronwyn]

Developing the hypothesis that a perceived absence of support features prominently in participants' disillusionment with their bodies, I wondered whether Bronwyn's use of the term *correcting it* to refer to her post-operative body reveals her experience of her body as now being in some way *wrong*. This view would align with Jenny's opinion expressed in major theme three where she questions the *normality* of her *saggy skin* within society. The connection between available support and the dissatisfaction and disillusionment referred to by participants both within this theme and major theme two is eloquently described by Helen.

It's funny the psychological testing I've done when I went into the room and then the woman said have a look at these and it was the excess skin pictures […] I do wonder perhaps at the time, no now sorry should there be more, not more counselling because perhaps people don't necessarily need the counselling before surgery but it's just preparing people for the excess skin and asking a few questions that people can't just sit there and think well I want the surgery done so I'll just say yes yes yes. You know it really was a quick, a quick test to see if you're alright sort of thing. [Helen]

Here Helen reflects on her experience of the pre-surgery assessment and how, with hindsight, this offered only a superficial opportunity to consider the physical implications of having surgery. Concluding this sub-theme, Sophie succinctly describes her view of the lack of appropriate support available to her.

Yeah, there isn't enough out there and it's only what they've got not what you need sort of thing. [Sophie]

I understood her succinct yet poignant sentence as capturing my participants' feelings of needing something different to what was available. Adopting a more interpretative stance, I wonder if my participants' existence between what is available and what they feel they need to fully realise their hoped-for transformation contributes, at least to some extent, to their experience of being in limbo referred to within major theme two.

5.4.2 The privileging of the body in post-operative support

Developing my participants' experience of the professional support available to them the second sub-theme captures their experience when in contact with medical professionals and how within these encounters they describe their psychological wellbeing remaining unaddressed. Instead, participants described experiencing the nature of encounters with bariatric support as largely impersonal experiences in which they regarded support as too generic or where their weight loss forms the focus of attention as opposed to their experience of post-operative weight loss.

An example of how postoperative support was perceived as being too generic was described by Robert who, whilst acknowledging the dietetic support he'd received, questioned its relevance for the particular difficulties he was encountering.

> it's like putting weight on you know erm ok I've seen a dietician […] but I feel what could they do for me if I had any more support. What sort of support would they do? All they'd do is sit there and say well you've got to cut your food and a bit more to me that's not support [Robert]

Although he does not explicitly say what support he would want, he clearly expresses that merely receiving dietetic advice feels unsatisfactory and misses the issues he feels he needs support with. Whilst Stephen's experience doesn't relate directly to the support he feels he

has received, the language he uses to describe his meeting with the surgeon portrays a vivid sense of his understanding of the motivation behind this encounter.

> I saw the surgeon I think post-op, six months after it was. Yeah something like that where he turned round and said everything's OK blah blah and I think he ticked he's boxes like you know but every time you go there they say have you been into hospital, have you had any problems blah blah any of this any of that... [Stephen]

The *box ticking* nature of the follow-up support captured in Stephen's description is echoed by Bronwyn who also highlights the way in which an objective focus on her weight overshadows the complex nature of her embodied experience of her weight loss.

> it's the same thing every time. So we weigh you then you, it's the receptionist that weighs you which I find really bizarre erm. So you get weighed so initially straight away before you've even seen who you're there to see it's about your weight [Bronwyn]

In attempting to understand further the abovementioned experiences, I found Bronwyn's reflection on her encounter during follow-ups helpful in gaining a deeper insight into participants' subjective experiences during consultations.

> at the beginning it's made an issue about your psychological well-being but as soon as surgery's done, it's no longer an issue because it's never mentioned again. And maybe that's why you wouldn't bring it up because it's not, it's not there. It's not one of the tick boxes 'how are you feeling emotionally?' 'How are relationships?' It's not, it's not there. It's not a question that's asked [Bronwyn]

Bronwyn's use of the same terminology as Stephen in describing how her psychological well-being no longer seemed relevant postoperatively alongside her feeling that the process was

about her weight suggests consultations are experienced by her as comprising implicit boundaries beyond which she, and perhaps others, felt unable to venture resulting in the overlooking of the subjective experience of losing weight by focusing instead on the objectively measurable weight lost.

Addressing directly the ways in which the experience of post-operative support was felt to overlook her individual needs, Sophie articulately describes her experience of depersonalisation resulting from what she views an over generalisation by health professionals.

[*sighs*] It's quite dire really, especially the NHS. They don't really, they sort of class everyone as the same and everyone's an individual that's got their own unique ways, you know problems […] And I think lots of people have got lots of issues that they carry around with them and it just, just have to keep carrying around with them. [Sophie]

The use of the phrase "*keep carrying*" felt as though it captured the experience described in the second major theme where participants not only spoke of their disillusionment from not achieving the level of transformation they had hoped but also to the enduring sense of themselves as being overweight despite having lost considerable amounts of weight. Remaining with the overgeneralisation referred to by Sophie, Helen also recognised how information provided by health professionals overlooked the idiosyncratic nature of the post-operative journey.

I think probably because you're, for me I was certainly told that by the end of a year you'll be able to eat the size of a child's meal […] it was all general whereas you know it'll take a year, it can take up to two years for the weight to come off […] And I think all that was in my mind, but for me erm my weight was off. To me it was all done and dusted in three months. [Helen]

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The uncertainty alluded to here by Helen as to whether her *progress* was appropriate was also noted by Stephen describing the type of support he felt would have helped him.

…somebody whose there, even the surgeon being in there saying you're not all going to be the same. I don't think I would have been trying too hard […] I thought I was meeting, I had to meet I should be on that by now, why am I not on it? You know why can't I cope with that? [Stephen]

The abovementioned statements highlight the various ways in which participants experienced feelings of depersonalisation, whether implicitly within the post-operative process or explicitly within the forms of support made available to them. Considered alongside participants' accounts of the various ways in which they felt the need to renegotiate their post-operative bodies referred to within major theme one and their uncertainty of existing within a state of limbo referred to in major theme two, it could be suggested that the post-operative stage of the bariatric journey represents a potentially destabilising time where support looking beyond the objectively measurable aspects of dietetic monitoring and weight loss is needed.

5.4.3 The importance of peer support

In contrast to participants' accounts of feeling overlooked within professional services, there existed a clear acknowledgement of the ways in which support from WLS peers had been utilised by my participants in managing postoperatively. Considered alongside my participants' accounts of their bodies within the relational context described in major theme three, there existed a strong emphasis on the importance of mutual understanding that only others who had undergone gastric by-pass surgery could provide.

For Stephen and Sophie peer support was regarded as offering a source of information from others who had undergone gastric by-pass surgery.

When your six months to eight months down the line you don't really need to go back to the support group if everything's running smoothly. The only time you might want a support group is if it's not running smoothly you know to find out if anybody else has got any issues. [Stephen]

That was quite supportive and helpful and just hearing other people that had gone through it recently saying what they found difficult or what they were having problems with [Sophie]

Both the quotes above explicitly refer to the usefulness of hearing what others have found challenging as a way of developing their own coping strategies, a process which links closely with my participants' recognition of the ways in which they had been required to renegotiate their altered bodies following surgery. Alongside the opportunity to hear others experiences as a way of managing one's own postoperative journey, the importance of mutual understanding found within peer support featured prominently within other participants' accounts.

I don't think if you've never had the weight problem you don't understand. Erm [*pause*] so that's really good and it's really nice as well to be able to support them so you've got the two-way thing [Jenny]

After having it done it wasn't too bad because the girls who had it done the same time we do like once a month or once every six weeks […] And obviously they've gone through it so they know what you're going through so I suppose it's hard for people [Joyce]

Both Jenny and Joyce acknowledge the unique sense of understanding they gain from peer support which they do not believe is possible to get from those who have not experience

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gastric by-pass surgery themselves. Reflecting briefly on my own experience within the interview with Jenny, I was aware of a shift in our contact during the interview when she made this statement however only on hearing her pause when transcribing the interview did I wonder whether this momentary rupture in our contact offered an insight into the sense of distance that some participants described experiencing within professional support above.

Interestingly, Sophie also differentiates the experience of losing weight following RYGB surgery with that of non-surgical weight loss highlighting the distinctly unique *need* of those choosing to undergo surgery which others are unable to fully understand.

> Because they'd been through it themselves rather than, if you talk to somebody 'oh yeah you've lost weight' or whatever but because they haven't done it themselves it's not really, they don't see it in the same way as someone that has. Basically, and that's quite important because they don't feel the same [*pause*] erm sort of need of it if you see, the sort of. If you've done it yourself, you know all the things that you've expected from it and other people do who've been through it but if you haven't been through it [Sophie]

Whilst Joyce and Jenny recognise the unique form of support weight loss peers offer, Bronwyn explicitly addresses the dichotomy that exists between peer and professional support.

> …when I get with the girls that have had it done we, you know, we sit round and have a coffee and then we'll jokingly start about things like how big do your knickers have to be now to tuck your belly in and those sort of things you don't get through the medical side as yet. [Bronwyn]

Bronwyn furthers the differentiation experienced between peer and professional support described by my participants by drawing comparison with peer led weight loss approaches before expressing her opinion of the professional support offered.

> when you think about the years of going to slimming clubs. The, the talking aspect of slimming clubs and the promotion that they give you […] That prompting bit, that encouragement bit isn't there in this. [Bronwyn]

> it's very textbook medical. Which they're doing their job. You know they are. It's impersonal, it is. [Bronwyn]

Participants' experiences of support postoperatively acknowledge a gap between the medical and the personal experience of weight-loss and management of the physical body postoperatively. Occupying the space between the two perspectives of post-operative care participants describe how they experience feelings of depersonalisation through the prioritisation and objectification of their physical body over their emotional well-being by the medical profession, as well as the ways in which their experience of undergoing surgery forms a bond with peers who share the unique challenges seen as differentiating weight loss post-gastric by-pass to that of non-surgical weight loss.

Chapter 6. DISCUSSION

The purpose of this study was to gain an in-depth understanding of the long-term lived experience of those who have undergone RYGB surgery in the U.K. In total eight men and women took part in semi-structured interviews which were analysed using Interpretative Phenomenological Analysis (IPA). Through a deep and sustained engagement with my participants' accounts characterised by double hermeneutic engagement four major themes comprising 13 subthemes were developed.

This section will begin by considering the findings of this study in relation to the empirical and theoretical findings and concepts introduced in the literature review as well as drawing on other material that I view as relevant in contextualising the findings. The introduction of additional material is consistent with the analytic approach adopted which acknowledges the way in which "it is in the nature of IPA that the interview and analysis will have taken you into new and unanticipated territory." (Smith et al, 2009: p.113).

6.1 Findings in relation to the literature

Consistent with findings reported elsewhere (Epiphaniou and Ogden, 2010; Carvalho et al, 2014; Warholm et al, 2014; Groven et al, 2015, 2016; Lier et al, 2015), none of the participants in the current study reported regretting their decision to have RYGB surgery with some describing the procedure as having been lifesaving either through its impact on health or by improving their emotional well-being from feeling hopeless prior to undergoing surgery.

Four principal areas are identified within participants' accounts of living with RYGB surgery i) managing change and uncertainty, ii) the affective experience of change, iii) the post-operative body within its relational context and iv) The presence and absence of appropriate support. Whilst supporting some of what has already been reported in the literature the ways in which the findings contribute to the current understanding of the lived experience following RYGB surgery are acknowledged.

6.1.1 Change and uncertainty following surgery

All participants noticed how their physiologies had changed following surgery and how they were now being required to respond to these changes at cognitive, behavioural and emotional levels. Whilst each participant's experience of change differed markedly, all described how they had had to renegotiate their relationship with their body, either practically or through the identification and attunement to affective sensations which they had not been aware of before. Rather than representing a linear process as suggested in some studies (e.g. Engström and Forsberg, 2011), participants' experience of adjusting to these changes were characterised by ambivalent feelings of new opportunities but also feelings of loss and resentment towards the ways in which the imposed restriction from the bypass meant they were unable to enjoy foods in the same way as before and how their freedom to respond to the changes was constrained by their altered physiological bodies. Natvik et al (2014) offers some support for this finding from their study exploring the meanings attached to eating within a sample of individuals who had undergone bariatric surgery five years prior. Based on their findings Natvik et al. concluded that changes to eating habits following surgery represented an alteration to the experiential dimension of eating including the enjoyment and satisfaction that their participants previously associated with food, an experience echoed by participants in this study.

A prominent feature of participants' experiences of change was the way in which they described noticing how their bodies were no longer docile when it came to eating practices and instead required considerable thought and attention. For some this was process represented a pragmatic process of deduction or a "playful" process of trial and error as to what their altered anatomy could tolerate, whereas for others the adjustments they were required to make represented disruptions with habitual routines and their hectic schedules reminding them that "food is my life now" [Bronwyn].

Studies acknowledging the experience of adjustment following bariatric surgery have referred to it as a "phase" (Ogden et al, 2006: p.282) and process (Warholm et al, 2014) noting the ways in which, through necessary changes to meal frequency and nutritional requirements food becomes a focus of participants' daily lives (Lier et al, 2015). Whilst the findings from this study are in line with those acknowledging the process of adjustment following surgery, the previously mentioned studies looked at change over shorter periods of time than the current study. Whilst studies looking at the longer-term have described the way in which eating can continue to be a "deeply problematic" (Natvik et al, 2014: p. 8) the current study suggests the process of ambivalence towards imposed restriction can be an ongoing experience for some in which food and eating continue to represent a major focus.

Proposing a paradoxical view of control following bariatric surgery, Ogden et al (2006) proposed two ways in which control was experienced by their participants; either as a benevolent external force or as something that they were able to internalise, resulting in a changed psychological state of control. Within the current study the issue of control emerged within participants' descriptions of the ways in which they attempted to adjust to the restriction imposed by surgery. Whilst consistent with Ogden et al in so far as restriction was generally regarded as being a positive consequence of surgery it emerged as a more complex phenomenon resulting in highly ambivalent feelings including confusion, anger, frustration and reassurance. Whereas for some the presence of the gastric bypass provided a benevolent reminder that prevented them from considering food choices that could result in a return to the "merry-go-round" of weight loss and regain for others they recognised how they continued to "battle against it".

In attempting to understand the ambivalence reported within the current study, Robertson's (2007) use of the term "edgework" to describe risk-taking behaviours as attempts "to transcend the banality of everyday existence" (p. 49) provides a helpful perspective. Although Robertson uses this term within the context of men and masculinity, the current study highlights the

diverse ways in which participants attempted to transcend the restriction imposed on them by the RYGB in attempts to reaffirm a sense of personal autonomy and social identity. Despite participants differing markedly in the ways they related to the control imposed on them, the sense of control appeared fragile and appeared to exist against a fear of losing control.

Closely associated with participants' experience of adjusting to the restriction imposed by the bypass were acknowledgements of ways in which they recognised the meaning and role attached to food having changed following surgery. Whilst changes in food preferences have been widely acknowledged as occurring following surgery, the processes through which this occurs remains largely unclear (Gero et al, 2017). Qualitative studies have reported that following surgery individuals often report discovering new foods that they enjoy through their attempts to avoid unpleasant side-effects (Ogden et al, 2006; Groven et al, 2012) which can result in a newfound interest in food (Engstrom and Forsberg, 2011). A less commonly acknowledged change was reported by Natvik et al (2014) who described how their participants inhabited new eating practices characterised by perceptual, bodily and emotional experiences reflecting past and present eating practices. Consistent with Natvik et al.'s findings, some participants in the current study described changes in their relationship with food occurring less in relation to what their body was able to tolerate but via changes in their visual perception of foods that they had previously enjoyed as appearing grotesque or "enormous".

Whilst participants identified changes that they sometimes found difficult to negotiate, the sense of uncertainty many experienced in the present was set against a belief in a certain future that would have awaited them had they not undergone bariatric surgery. This strategy would seem comparable to the strategy referred to by Engstrom and Forsberg (2011) where their participants described reflecting on their previous condition of being obese as enabling them to both obtain and maintain control postoperatively. Similarly, Alegria and Larson (2014)

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also emphasised the strategy of purposely acknowledging improvements on their "former self" as a way through which to cope with the uncertainty brought about following surgery.

The experience of change and uncertainty that participants encountered supports the notion proposed by Boccieri et al (2002) who suggest that whilst not necessarily viewed as being negative, changes experienced following surgery present the individual with various tensions that they are required to negotiate. Whilst Boccieri et al view the changes reported by participants as representing a clear dichotomy between pre and post-surgery life in so far as previous ways of dealing with situations were no longer suitable and instead require the person to develop new ways of being, the findings within the current study illustrate the diverse ways in which the "daily struggle" between pre-surgery behaviours and desires appear to continue to threaten both the establishment of new behaviours and a sense of control participants attempt to maintain.

Participants' descriptions of the ways in which they attempt to manage change and uncertainty following gastric bypass surgery appear consistent with the dilemma described by Groven et al (2012) in which whilst gastric bypass surgery results in irreversible physiological changes, desires and eating practices are imbued with personal, social and cultural meanings and therefore cannot be reduced to one organ. As is evident within the participants' experiences of change captured within this study, eating represents a primarily pleasurable experience, the loss of which results in confusion, anger and loss. Viewed in this way it seems essential that any attempt to support individuals in changing habitual practices must acknowledge the meanings food and eating practices are imbued with and take them into account (Vandamme and van de Vathorst, 2010).

6.1.2 The affective experience of change

Alongside the ways in which participants in this study acknowledged their experience of living *through* their bodies had been altered and now required attention they also referred to ways

in which their affective experience of living *in* their bodies had changed postoperatively. Nearly all participants recognised feelings of disappointment at the disparity between what they hoped for following weight loss and the situation they now found themselves in. Some described now feeling "stuck" or that parts of their body had not "adjusted" suggesting that the changes that they had experienced had stopped short of what they had hoped for, whereas others acknowledged ways in which ongoing episodes of dumping restricted opportunities for self-actualisation by preventing a return to work (Moss, 1992).

Participants' disappointment with body image is consistent with other studies that have highlighted the impact of loose skin experienced by many after undergoing bariatric surgery (Boccieri et al, 2002; Groven et al, 2013; Warholm et al, 2014). In their study exploring the experience of living with excess skin, Groven et al (2013) highlighted the discrepancy that arose between the "public body", which was noticeable to others, and the "private body" which only the women saw. Exploring this discrepancy within the current study, Murray (2016) highlights the "fat body is a site where numerous discourses intersect, including those concerning normative feminine beauty and sexuality…anxieties about excess, and the centrality of the individual in the project of self-governance" (pp.4-5). Although all participants in the current study had lost considerable amounts of weight their experience of disappointment with their postoperative bodies continued to incorporate the perspective of the Other, for example in Jenny's declaration that "I felt sexier when I was bigger […] just because it's normal […] fat is actually quite normal in our society […] Whereas saggy skin is not normal in our society.".

The impact of loose skin reported in the current study might seem unsurprising when considered alongside research looking at individuals' expectations prior to surgery. In a study by Homer et al (2015), exploring individuals' experiences and expectations prior to undergoing bariatric surgery, participants reported that despite being told of the risks of loose skin following surgery by the multi-disciplinary team, they were unconcerned about the

consequence of this happening to them and instead believed that achieving a smaller size would outweigh the potential negative impact from this. Interpreting their findings, Homer et al. acknowledge the way in which preoperative factors exacerbate "unrealistic aspirations" reported by individuals and call for greater attention by preoperative (Tier 3) services in addressing the potential side-effects from surgery. Drawing on the existential phenomenological notion of intentionality I would propose an alternative perspective. Research looking at individuals' experience prior to surgery has consistently reported feelings of inferiority (Forsberg et al, 2013), limitations on physical mobility (Warholm et al, 2014), as well as stigmatisation of the obese body (Groven et al, 2015; Homer et al, 2015). Considered within the context of these highly stigmatising circumstances and the widely reported view of surgery as representing a "re-birth date" (Throsby, 2008: p.118) this perspective could equally be regarded as an intentional mindset rather than a misconception that is modifiable during the pre-operative phase. Support for this perspective could be taken from the current study where some participants recounted their experience of the assessment process.

> "You're not listening…your main focus is getting agreed for that surgery…you're ticking boxes in your own head to get to the surgery you're not, you're not exploring it, you're not discussing it you're just agreeing with what's being said. Because you don't wanna disagree in case it looks like you're not ready for surgery" [Bronwyn].

This perspective would appear to receive some support from studies highlighting how individuals report not remembering information on potential complications mentioned prior to undergoing surgery and how individuals attempt to present themselves in favourable ways during the assessment process (Ambwani et al, 2009; Maden et al, 2007).

In attempting to deal with the disappointment experienced, some participants alluded to a split between their body and self in attributing responsibility for the perceived failure, such as was the case in Sophie's description of how "my body didn't make it work". Considering the

possible function of this splitting, Moss (1982) described the way in which individuals can sometimes "present" themselves in ways that attempt to avoid owning their visible appearance. In addition to presenting themselves to others, Moss (1992) described how the obese women within his study described encountering their body as a thing and something from which they were estranged. Whilst Moss's view would seem consistent with the split between body and self which is observed in the current study, R. D. Laing's theory of "unembodiment" offers a more dynamic account of the intrapersonal experience in which the "individual experiences his self as being more or less divorced or detached from his body. *The body is felt more as one object among other objects in the world than as the core of the individual's own being…*which a detached, disembodied, 'inner', 'true' self looks on at with tenderness, amusement, or hatred" (1965: p.69). Viewed in this way, the "detaching" of oneself from the source of the disappointment, in this case the body, might offer a way of managing the tension between competing attributions individuals encounter when trying to understand their failure to lose weight.

An experience which further characterised participants' experiences of living *in* their body was the ways in which they recognised, despite noticeable physical changes, continuing to perceive their bodies as large. Within their descriptions there once again appeared an underlying mind-body split that seemed to form a central part of their experience which was most articulately captured by Joyce describing having her "fat head" on; a notion consistent with Annis et al's (2014) "phantom fat" to describe the ways in which individuals who have previously been overweight continue to perceive themselves as such despite no longer being so. From a phenomenological perspective body image has been defined as "a system of perception, attitudes and beliefs pertaining to one's own body" (Gallagher, 2005: p.25) and has been suggested as being sensitive to cultural and social influences as well as one's own emotional reactions towards their body (Gallagher, 2005). Given the influence of one's own sense of embodiment on their perception of body-image, participants' uncertainty over their current physical state might act as an obstacle to assimilating their smaller bodies into their

view of self. This perspective would seem to receive some support from Natvik et al (2013) who noted how despite having achieved major weight loss for some time, their participants recognised ways in which their posture and body in movement appeared stuck between the past and the present, suggesting the embodied experience of becoming smaller and the rate of weight loss experienced following surgery do not occur simultaneously.

Phenomenologically the "lived body" has been suggested as existing on two layers, the "habit body" comprising embodied knowledge and dispositions and the "body at this moment" which acts and perceives in response to persons current bodily based experiences (Merleau-Ponty, 1962/2005: p.95). Interpreting the state of being in-between described by participants and their persistent view of themselves as overweight, the maintenance of a view of themselves as overweight, a more familiar *habitual* state, might be seen as offering a more stable sense of embodiment than their current, and somewhat tenuous, sense of their lived body. Support for this might be taken from Bronwyn's acknowledgment of the relatively brief temporal nature of change following surgery and how her view of herself as overweight "was there longer than this has been here" [Bronwyn].

6.1.3 The body in its relational context

Consistent with the phenomenological view of the body as "that which enables one to be seen by the Other" (Moss, 1992: p.184) all participants referred to ways in which encounters with others following surgery offered both opportunities to develop new views of themselves but also challenges to their previous views of self, others and the world. Explicit within these experiences were acknowledgments of how participants evaluated their bodies against social categories of normality, either in terms of size or in what they were able to participate in because of their smaller bodies. Although allowing them to blend into social contexts more easily their broadening social engagements resulted in them being confronted with challenging questions about the extent to which they had potentially contributed to their experience of being excluded and ignored by others prior to undergoing surgery. This reflexive process was

referred to by Boccieri et al (2002b) who noted how their participants described recognising the impact of their weight on their self-definition prior to surgery and now had to re-evaluate the responsibility they had previously allocated to others for excluding them and instead consider their own unwillingness to engage with the world.

Despite recognising ways in which they enjoyed feelings of inclusion within social contexts, the process of adjustment was not free of challenges and presented "tensions" (Boccieri et al, 2002) through reflections on their experiences in relationships prior to surgery (Natvik et al, 2013). Some participants recognised how encounters with others, particularly people who hadn't known them prior to surgery, triggered feelings of sadness for how they had felt treated before surgery and resentment that others now related to them differently as a result of their smaller appearance. Merleau-Ponty (1962/2005) describes how body memory represents "our permanent means of 'taking up attitudes' and thus constructing pseudo-presents" (p.210) referring to the way in which by actualising past experiences we are able to feel at home in the present. Participants' descriptions of the tensions they experienced therefore would seem to represent a discrepancy between past and present resulting in a form of "residual stigmatisation" (Lier et al, 2015: p.5) which continued to exist alongside feeling more accepted. Highlighting the struggle identified in his study of obese women to be seen as more than their body and situation, Moss (1992) describes the protest expressed towards others that "I am more than what you see here" (p. 191), an experience poignantly captured by Joyce in stating "I'm still the same person inside…I was no different when I was size twenty-two. I was still that same caring person inside".

Within participants' descriptions of their relational contexts there also appeared apparent gender differences, evident in their understanding of other's reactions to their post-operative body and the impact these views had on their experience of redefining their sense of themselves around others. Whereas female participants described other's reactions to their smaller bodies as reflecting intimate and sexual intentions male participants appeared to

negate the opinion of others regarding their physical changes and appearance. Considering this difference within the wider context of feminist literature addressing the body, in her feminist critique of the gendered nature of obesity Murray (2016) argues that within western society 'fatness' does not represent a singular category but is established and re-established along a continuum of what represents a normative body informed by rules relating to gender, class and race and how "A fat woman is always under medical and cultural scrutiny" (p.24). Similarly, drawing on Simone de Beauvoir's view of the gendered body, Leder (1990) argues that women within Western culture learn to be more conscious of their bodies than is the case with men and are therefore required to deal with expectations of being preoccupied with their appearance, including their weight and physical shape. Within the current study, the difference emerging between the male and female accounts appeared to capture the way in which, for the women, the gaze of others was central to their ongoing project of redefining themselves amongst others whereas for the men their descriptions of the ways in which they experienced their changed bodies within social contexts captured what could be considered a more "pragmatic mode of embodiment" (Watson, 2000: p.118) in which their ability to carry out tasks and activities appeared more central to their understanding of their changed bodies.

Despite describing ways in which they noticed their smaller bodies conforming more to normative social markers which for many opened possibilities to redefine their sense of themselves as social beings, in other ways the body remained a source of ongoing distress which limited the extent to which they felt able to fully realise their smaller bodies and appeared to reinforce a sense of isolation from others. Interestingly the experience of isolation experienced by participants comprised a quality of not being seen by others either by their own design, to avoid anticipated shame or concern, or through others not understanding the challenges involved in adjusting following bariatric surgery.

Acknowledging the way in which all experience of one's own body is situated within an intersubjective context, Leder (1990) extends his notion of "dys-appearance" referred to above

to include the way in which when we perceive the gaze of the other as critical, judgmental or objectifying the body can become thematised in an experience he terms "social dys-appearance" (p. 96). Whilst this offers a helpful lens through which to understand some of the participants' experiences such as Jenny who described avoiding physical intimacy because of her loose skin, feeling that people "see you differently to the way that I actually am" [Jenny], for others the sense aloneness emerged through feeling that others failed to acknowledge the struggle they experienced following surgery. In their study exploring the perceptions and attitudes of eating and exercise behaviours associated with weight maintenance following RYGB surgery Benson-Davies et al (2013) identified a number of factors associated with social support which are consistent with those reported in the current study including the gradual decline of social support from friends and family and the inability of others who are not overweight to understand, a feeling expressed explicitly by Jenny who openly stated "I don't think if you've never had the weight problem you don't understand".

6.1.4 The presence and absence of available support

Given the emphasis placed on the bariatric services to provide follow-up care for two-years postoperatively (NICE, 2016), participants were invited to talk about their experience of support and whether they recognised receiving support from others outside of the surgery team. In relation to support, two principal areas emerged highlighting their experience of professional support and the ways in which participants recognised utilising support from weight-loss peers. Explicit within their accounts was how support impacted upon their experience of adjusting following surgery and their ability to renegotiate their sense of themselves, others and the world.

Nearly all participants described how they felt the professional support available failed to meet their individual needs, either through a lack of clarity at the assessment stage regarding what to expect postoperatively or feeling that the information provided regarding their new altered bodies nutritional needs when leaving hospital was too generalised resulting in the experience

of leaving hospital as being "a real big learning curve" and like bringing home a new baby. A theme that characterised participants' accounts of the perceived absence of support, concerned the failure to address the emotional and psychological impacts of surgery. For some, the lack of support centred on the unavailability of support to remove loose skin for those who have undergone WLS. The dilemma was captured most explicitly by Bronwyn, who despite not feeling "entitled" to plastic surgery, acknowledged how "there isn't anything in place to make you mentally deal with that other than correcting it". That many of the participants continued to regard their bodies as in need of *correcting* aligns with studies looking explicitly at the experience of individuals undergoing plastic surgery following WLS (e.g. Smith and Farrants, 2012).

Another way in which participants regarded professional support as lacking, manifested within the procedures characterising the follow-up process which some experienced as representing a "box ticking" process and which appeared in distinct contrast to the preoperative screening they were required to go through. The qualitative shift between pre- and postoperative support appeared to reinforce a body-mind split in which despite emotional wellbeing being "made an issue about" prior to surgery the absence of any follow-up regarding their emotional wellbeing was understood as indicating its lack of importance within the postoperative support they received. Because of this most participants described how they did not feel the support that was offered aligned with the challenges they encountered, but instead prioritised the physical aspects of weight loss through the practices of weighing and measuring as opposed to enquiring about their emotional well-being and relationships, an implicit focus which some felt inhibited their willingness to raise the issues they were experiencing during consultations. Returning to Leder's (1990) notion of "social dys-appearance" (p.96), he emphasises a number of ways in which "social dys-appearance" can occur including through a discrepancy in power such as that enacted during doctor-patient encounters. Whilst supporting the view that follow-up consultations can represent a form of "record-keeping" (Groven and Glen, 2016: p.14), the descriptions of the clinical encounter captured in the current study highlight the

intersubjective nature of the consultation process and the importance of acknowledging the impact of implicit medicalized discourses on the extent to which individuals feel able to utilise the support available to them to meet their needs.

Interpreting the perceived discrepancy participants described between professional support and their lived experience following surgery, Moss (1992) suggests that the medical clinic offers a context of vocabulary and interventions for understanding the obese body. Viewed in this way, the participants' accounts would appear to suggest that whilst this might have offered a form of understanding prior to surgery the complex and individual nature of the changes that they have experienced postoperatively appear to transcend a medicalized understanding of their body as being defined merely by weight, restriction and control.

Despite current guidelines emphasising the need for services to offer psychological support both pre- and postoperatively (NICE, 2014) there continues to appear an absence of this, reflected both within the current study as well by Ogden et al's (2011) reference to the "neglected mind". In a more recent study Sharman et al (2015) explored the support needs and experiences of patients who had received funding for bariatric surgery, highlighting how peer, dietetic and psychological support were all regarded as key factors for both weight loss and improved health as well as the experience of bariatric surgery more generally. In line with the current study and other research looking at support (e.g. Ogden et al, 2011), Sharman et al highlighted how participants regarded psychological support as a commonly overlooked component of care and that despite some regarding it as more important than dietetic input following surgery few had had the opportunity to access it.

In contrast to their experiences with healthcare professionals most participants in the current study identified ways in which they experienced support from WLS peers, a distinction captured by Bronwyn in her comparison of how the support offered by the bariatric service felt "impersonal" and "textbook" compared to "the talking aspect of slimming clubs and the

promotion that they give you". Although some participants also recognised family members being supportive, the support identified from WLS peers appeared distinct in its role of helping them in areas of postoperative adjustment and self-management. The differentiation found within this study would appear consistent with the findings reported by Livhits et al (2011) who carried out a systematic review looking at whether social support is associated with greater weight loss after bariatric surgery. Based on their findings Livhits et al. reported that in contrast to studies exploring social relationships with peers and family members, all studies looking at post-operative support groups reported a positive association between support group attendance and weight loss.

A prominent theme that emerged within participants' experiences of peer support related to the shared understanding WLS peers had of the challenges and struggles that characterise the postoperative experience and the feeling that others who had not undergone surgery were unable to understand the unique challenges that the participants faced, a finding echoed by others (Groven et al, 2012, 2013; Jones et al, 2016). Interestingly the experience of peer support was described by participants as representing a "two-way thing" through which they not only received support, advice and understanding but also discovered a sense of "role-based purpose" (Thoits, 2011: p.145) through sharing their experiences with others. Considering the abovementioned ways in which weight loss achieved through surgery has been reported as being susceptible to its own forms of stigma (Throsby, 2008), I wonder whether the role participants recognise adopting within their WLS peer groups represents a way through which they are able to validate and vouch for their post-operative body through the identification and affirmation of their experiences as being both meaningful and of benefit to others.

6.2 Summary of findings

Previous qualitative studies exploring long-term psychosocial outcomes following gastric bypass surgery have described how, despite not regretting the decision to undergo gastric

bypass surgery, participants recognise "tensions" and challenges following surgery including at an existential level of self, identity and appearance; within social and relational contexts; and within daily behavioural practices (Boccieri et al, 2002; Lier et al, 2015). The four major themes identified in the current study would appear to support the view of multiple changes and challenges identified by these studies, yet they also extend beyond them by offering insight into the deeply personal nature of changes and struggles experienced after undergoing gastric bypass surgery and the ways in which these are inextricably intertwined with the persons social, cultural and personal histories.

Change following surgery was inextricably linked with a deep sense of uncertainty regarding participants' "new body" with its altered physiology and the ways in which they recognised previous ways of relating to their body and its needs were no longer feasible. Despite the transformation being a long awaited one, the process of change and adjustment did not represent a smooth transition from pre- to postoperative life but instead was characterised by ambivalent feelings towards the imposed restrictions participants now recognised as constraining their freedom and choices.

Alongside the changes participants noticed making in adjusting to their altered physiologies, they recognised the affective experience of living *in* their bodies postoperatively. Intertwined with feelings of disappointment that surgery had failed to result in the transformations they had hoped for was a sense of themselves as being in a transitional state characterised by a residual sense of embodiment in which they continued to view themselves as being overweight despite having lost considerable amount of weight. The discrepancy described by participants between their embodied sense of themselves as overweight and the smaller body they now saw captured the asynchronous experience of rapid weight loss and the persons attempts to redefine their embodied sense of self.

The changes and adjustments participants noticed making did not occur in a vacuum but were intertwined their social relationships requiring them to renegotiate the way in which they both understood others and themselves within social encounters. Within the relational context participants' experiences highlighted the intersubjective nature of physical changes and the ways in which they experienced their bodies not from their own view of it but through the view of it as seen by others imbued with social judgements of normality, attractiveness and functionality.

Consistent with the literature suggesting a dearth of appropriate support for individuals dealing with the emotional and psychological impacts of surgery (Ogden et al, 2011; Sharman et al, 2015) the current study also raises questions regarding the extent to which follow-up support provided by health professionals currently aligns with the idiosyncratic nature of the challenges encountered by individuals postoperatively. Furthermore, this study highlights the potential value of weight loss peers in offering a safe and non-judgemental context in which individuals can share their experiences.

6.3 Strengths and Limitations of the current study

6.3.1 Strengths

As mentioned previously IPA was the methodology adopted within this study as it aligned closely with my own grounding within existential psychotherapy which draws on a phenomenological approach to enable the person to explore their meaning and understanding within the context of their own lives. Furthermore, the scope offered within IPA to draw on phenomenology and existential philosophy enabled me to acknowledge the intersubjective nature of both the research interview and the person's lived experiences and the role of interpretation within the sense making process. Working at an idiographic level also felt most appropriate for this study as it allowed for a detailed exploration of participants' unique lived experience remaining sensitive to the complexity and novelty that characterised their experience of adjusting postoperatively (Smith and Osbourne, 2008).

A strength of this study was in the focus on individuals who had undergone the RYGB procedure only. Most qualitative studies looking at postoperative outcomes have tended to include samples who have undergone different surgical procedures. Research looking into individuals' reasons for and against different bariatric procedures has reported the perceived invasiveness, irreversibility and risks of complications associated with the RYGB as contributing to a person's decision to undergo alternative procedures (Opozda et al, 2017). Given the potential significance of these factors in a person's experience of postoperative adjustment and the limitations they regard being imposed on them, the current studies focus on one procedure reflects a strength through its focus on a surgically homogenous group.

Focusing on participants who had undergone surgery a minimum of 12-months previously also enabled an exploration of the longer-term experiences of change postoperatively. With the

exception of Jones, Cleator and Yorke (2016) most studies in the UK have tended to include participants who have undergone RYGB surgery within the past 12-months. On average participants in the current study had undergone surgery 24-months prior to taking part in the interviews a point at which the initial restriction imposed by the bypass would have reduced and participants would have been reaching the end of the two-year follow-up recommended for postoperative care (Elkins et al, 2005; NICE, 2016). Interviewing participants who were no longer experiencing the restriction imposed by the surgical procedure meant that they were able to reflect on the process of change and offered the possibility of considering what had been helpful throughout their postoperative journey.

Regarding the validity of the findings of this study, I would argue that this study adheres to each of Yardley's (2000) four principles: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance.

From the start of this study I sought to remain sensitive to the context. Drawing on my experience as both a clinician and supervisor within the area of psychological support for individuals undergoing bariatric surgery I immersed myself in the empirical literature, both quantitative and qualitative, looking at outcomes postoperatively which provided me with a grounding in the "intellectual history" (Yardley, 2000: p.220) of bariatric surgery and the different perspectives and arguments that have been adopted within research focusing on the psychosocial outcomes following RYGB surgery. Having worked closely within the multi-disciplinary team I was also aware of challenges individuals faced with aspects of post-operative adjustment that might have fallen outside of the issues that usually arose within psychologically focused sessions, allowing me to gain a much broader and in-depth awareness of the challenges that might arise following surgery. I have acknowledged elsewhere the ways in which my embeddedness in the field of bariatric surgery presented both challenges and opportunities for unique insight throughout the research process,

however, overall, I regard my understanding of bariatric surgery and the journey individuals go through, including the challenges they can face, was an advantage in researching individuals lived experience following surgery.

Whilst regarding my prior experience of the area of bariatric surgery an advantage, I remained sensitive to the power imbalance that might occur within interviews where I was either seen as 'expert' or as a 'professional' who was regarded as approaching the topic from academic position which might be experienced as an "intersubjective correlate" (Murray and Holmes, 2014: p.25) for the psychological assessment participants underwent prior to surgery. I therefore spent time ahead of each interview getting to know my participants and informing them of my previous work with the bariatric services and my understanding of how the experience of undergoing surgery can vary dramatically from person to person and that I was interested to hear their experience. Whilst acknowledging the potential for this self-disclosure to reinforce a power imbalance I hoped it would facilitate a rapport through the establishment of trust and enable them to feel comfortable talking openly about their experiences. I also agreed with participants that we would allow time after each interview to discuss the experience and have a debriefing including providing contact details should they wish to contact me following the interview to discuss any aspects of their experience.

I attempted to remain sensitive to the data at each stage of the analysis. Both during the development of the interview schedule and during the interviews I attempted to remain respectful of the participants' individual experiences and therefore attempted to remain open and flexible in my interviewing style to allow participants to discuss what they regarded as most important and relevant for them. I attempted to show understanding and empathy for the experiences participants shared with me and where necessary checked in with them as to how they were finding the interview. Throughout the analytic process I attempted to remain as

close as possible to my participants' experiences by attuning to my experience of being with them during the interview.

Turning to Yardley's second commitment of rigour which she defines as "prolonged engagement with the topic… the development of competence and skill in the methods used, and immersion in the relevant data." (2000: p.221) I attempted to align with this commitment in several ways. Firstly, by working closely with the bariatric service with which participants were actively engaged, ensured the recruitment of participants who met the inclusion criteria regarding surgical procedure and time since surgery. Yardley (2000) refers to rigour within the analytic process as "the use of a prolonged contemplative and empathic exploration of the topic together with sophisticated theorising" (p. 222). I believe I have met this commitment by maintaining a close engagement with my participants' narratives, a process supported by working closely with a supervisor experienced in using IPA.

Since completing the interviews this study has taken more than two years to complete allowing me time to embrace IPA as an analytic process and myself time to ensure I am able to be suitably respectful to my participants' experiences described during the interviews. Working closely with my supervisors also helped me sustain an intentional and methodical reflexive stance throughout the duration of the research process which enabled me to acknowledge and make sense of personal biases and how these are imbedded in the double hermeneutic. In their methodological review of qualitative studies of obesity Brown and Gould (2013) acknowledged the lack of attention to researcher characteristics and how these influenced the data collection. By adopting a reflexive stance, I have attempted to acknowledge the challenges that emerged throughout the research process acknowledging both the ways in which my own biases and fore structures influence the data collection process as well as ways my own embodied experience of the interview process and the ways in which I drew on this to inform the analysis.

In adhering to Yardley's third principle of transparency and coherence, I maintained a meticulous audit trail throughout the data collection and analysis process, samples of which are included in the appendices. In addition, I have embedded excerpts from the interviews in the findings section to allow readers to determine for themselves the themes I developed. Consistent with Gadamer's view that "interpretation begins with fore-conceptions that are replaced by more suitable ones. This constant process of new projection constitutes the movement of understanding and interpretation" (2006: p.269) regular contact with my supervisor also enabled me to identify my own assumptions and biases and the potential impact of these on my findings which I have explicitly acknowledged throughout my writing.

I believe this study also adheres to Yardley's last principle of impact and importance. Here Yardley (2000) suggests the "decisive criterion" (p. 223) of any research is its ability to describe something important and of interest as well as being useful. This study emerged from my own experience of working within bariatric services and therefore it has been my intention to meet the aim set out by Yardley. While I feel satisfied with the results and their value and relevance within the broader context of bariatric services, ultimately the utility of my findings is best judged by the reader.

6.3.2 Limitations

It is important to note that the current study was based on a relatively small sample of self-selected participants from one bariatric centre in the South of England who had remained in contact for on average 24-months. Relying on the process of self-selection after receiving information during routine dietetic consultations meant that there was no way of knowing any information regarding those who decided against taking part. Whilst some diversity existed within my sample in terms of gender, age, relationship status and levels of education all my participants identified their ethnicity as White British and therefore the extent to which the findings reflect a particular socio-cultural phenomenon should be considered. Responding to this possible limitation, future research might seek to recruit participants from various

geographical locations across the UK. Whilst the issue of self-selection is difficult to avoid, consideration might also be given to the recruitment of individuals who have stopped attending follow-up care offered by the bariatric service.

Although consistent with a phenomenological approach, the findings from this study are based on my interpretations of participants' accounts and are therefore not necessarily transferable to the wider group of individuals who have undergone RYGB surgery. However, given that the purpose of this study was to explore the lived experience of individuals who were 12-months post-RYGB surgery, the intention was never to achieve transferability and generalisability of its findings. Instead, it sought to understand the lived experience of a specific group of men and women following RYGB and how it was encountered within the context of their lives which I believe it has achieved.

Whilst I have previous experience of conducting qualitative research this study represents my first endeavour adopting a hermeneutic approach and as such represents an area for future development. A further area that warrants consideration when interpreting the findings from this study is the decision to adopt a mixed-methodology and the potential impact of this on the research interview. Considering as I do the interview to represent an intersubjective encounter and, to coin Murray and Holmes's (2014) term a site of "ethical intersubjectivity" (p.25) by adopting a reflexive position throughout the study I became aware during the interviews that the use of quantitative measures felt at odds with my intention for the interview to be a collaborative endeavour and instead represented a possible "intersubjective correlate" (Murray and Holmes's, 2014: p.25) for the assessment process participants had experienced prior to surgery. The ways in which the researcher's embodied presence both "creates access to, and can comprise a limit, to the knowledge that is produced" (Engelsrud, 2005: p.267) has become an increasingly important area of

study. Emphasising the inherently social nature of the research interview Rapley (2001) highlights the way in which the "'data' obtained are highly dependent on and emerge from the local interactional contingencies in which the speakers draw from, and co-construct, broader social norms" (p. 303). Viewed in this way it could be suggested that the use of a methodology which so closely mirrored that adopted in the pre-surgery assessment could have resulted in an "enforced subjectivation" (Murray and Holmes, 2014: p.24) where the methodology adopted invited participants to take on a 'role' ascribed by broader social norms. Whilst I acknowledge the way this inevitably shaped the interview process and the data collected, I regard my acknowledgement of the way this intersubjective phenomenon emerged within some interviews offered new perspectives on the research topic being studied during the analytic process and highlights the unique value that interpretative approaches can offer the area of healthcare research (Galdas, 2017).

6.4 Possible future directions

The current study expands upon the literature by highlighting the day-to-day challenges faced by individuals following Roux-en-Y gastric bypass surgery two-years postoperatively. Whilst previous research exploring postoperative experience within UK samples has tended to focus on the initial 12-months postoperatively, a phase characterised by a level of enforced restriction (Elkins et al, 2005), the current study highlights the way in which individuals continue to experience challenges over the longer term in their adjustment to their altered physiology and their embodied sense of themselves within the wider contexts of their lives.

Building on the issue of representation and the current study's recruitment of individuals accessing one bariatric centre, there remains little known about those who stop attending formal follow-up support and the ways in which they manage their postoperative adjustment. Given the difficulties that individuals can experience therefore there exists considerable scope

for exploring the experience of those who have chosen to opt out of the postoperative care offered by bariatric services.

The role of peer support also featured prominently in participants' descriptions of the support networks they established postoperatively which they described as providing not only a safe and non-judgemental space in which to discuss the challenges they faced, but also its potential to offer a sense of identity amongst weight-loss peers. Whilst research has suggested involvement in weight loss support groups is positively associated with successful weight loss postoperatively (Beck et al, 2012), future research could explore the particular features of this resource and the possibility for it to form a more integral part of individuals bariatric journey.

In summary, while the current study adds to the current understanding of individuals' experience following RYGB surgery, there is considerable scope for future research into the ways in which individuals can be supported throughout the postoperative journey and the types of services that might be best suited to this.

6.5 Value of the research and its implications for practice

As previously mentioned, individuals requesting bariatric surgery are required to complete a pre-surgery assessment by a multi-disciplinary team (MDT) who assess not only their suitability for surgery and readiness to proceed but also offers a chance to identify psychological or clinical factors that may affect adherence to postoperative care (NICE, 2014). In addition to the evaluative function of this process, others have suggested the potential for the psychological assessment to act as an opportunity for individuals to familiarise themselves with the psychologist should they encounter difficulties adjusting or adhering to lifestyle and behavioural changes post-surgery (Sogg and Friedman, 2015). Despite these intended functions however the psychological assessment represents a complex intersubjective encounter which is imbued with socially normative roles and expectations as well as the

persons desires and hopes for "normality" (Homer et al, 2015: p. 1). Based on these findings it is perhaps understandable that most studies suggest the improvement in pre-operative education around expectations and the necessary nutritional and behavioural changes that will be expected of the person following surgery as a focus for attention (Alegria and Larson, 2014; Homer et al, 2015).

Considering the contribution counselling psychology can have within healthcare services, Karademas (2009) highlights their ability to "evaluate and assess the psychological functioning of the patients; act as advisors for the treatment team…provide counselling or other types of psychosocial interventions to the patients and their families" (p.20). Whilst the educative role of the pre-operative assessment appears an important feature, the effectiveness of assessing psychological functioning seems to me to be more tenuous. The findings from the current study suggest that preoperatively the person's hopes for surgery outweigh concerns over postoperative complications, a perspective which emerged both in participants' sense of disillusionment and their experience of assimilating their sense of themselves as smaller and 'normal' within social contexts. Drawing on the phenomenological notion of intentionality, it could be argued that any assessment of a person's suitability for surgery preoperatively might bare little relation to their postoperative experience of change. It might therefore be suggested that the availability of postoperative support addressing the individuals' experience of adjustment might be better placed.

The premise of this however would mean a shift away from a sole focus on weight loss as a marker of success to a more holistic view of the person's psychological and emotional wellbeing postoperatively. Despite current guidelines recommending follow-up care, including "psychological support if needed" (NICE, 2016: p.34), the findings from this study would suggest that the identification of *need* might be hindered by the procedural practices that currently characterise the follow-up process. Furthermore, and in line with previous research, the focus of aftercare on establishing appropriate behaviours, whilst useful for some, risks

overlooking the uniquely personal struggles individuals encounter in assimilating their needs and embodied sense of themselves into their lives. Although the need for more psychologically informed care postoperatively has been mentioned previously (e.g. Ogden et al, 2011; Sharman et al, 2015), all the participants in this study acknowledged ways in which the support they received either overlooked or was regarded as inhibiting requests for support in dealing with the psychological and emotional impact of postoperative change and adjustment.

From this perspective, the findings from this study align closely with Throsby's (2012) view of bariatric surgery as an "uncertain cure" (White, 2009) which she describes as:

> "one that, while having some success in relation to specific medically defined goals and practices, intersects with (and contributes to the enactment of) other obesities in ways that have to be negotiated, physically and socially, long after the end of the surgical treatment pathway." (2012: p.3)

Consistent with this view, participants within this study described the ways in which following surgery they were required to renegotiate a multitude of day-to-day practices as well as the ways in which they related to themselves, others and the world from their new and unfamiliar sense of embodiment. Within their descriptions of their experience of change and uncertainty existed a broad discrepancy between the "impersonal" care offered by healthcare providers contrasted against a sense of belonging and identity amongst weight-loss peers. It has been my intention within this research to 'give voice' to my participants. In doing this, I hope this research can contribute to the understanding of the experience of individuals following Roux-en-Y gastric bypass surgery and development of appropriate ways in which to the support individuals who have made the decision to undergo bariatric surgery.

6.6 Personal reflections on this study

During the two years since completing my interviews I have felt both energised by the analytic process and overwhelmed with the prospect of writing the dissertation, anxious at the thought of others reading it and the need for me to 'get it right'. The topic of obesity research understandably has been the focus of studies highlighting the inequalities experienced by those who are overweight or obese, including those who have undergone bariatric surgery (Raves et al, 2016; Throsby, 2008), as well as the ways in which research can further contribute to the stigmatisation of individuals within healthcare research (Ellingson, 2006; Murray and Holmes, 2014; Warin and Gunson, 2013). Through my immersion in this literature from the early stages of this study and the wanting to 'give voice' to my participants' stories, having never been overweight or obese myself, I became self-conscious venturing into this area of research and recognised a hypervigilance for ways in which I might be overlooking the role of my own embodied presence within the research process and as such unintentionally reinscribing "the power of scholars to speak without reflexive consideration of their positionality" (Ellingson, 2006: p.301). Throughout the analytic process and writing of this dissertation I have felt the pressure of these perspectives which alongside my desire to do justice to my participants' accounts have at times resulted in a feeling of moral paralysis in which my progress has ground to a halt. On reflection these times, whilst fraught with self-doubt and frustration at being unable to move forward, have been fertile junctures which, through the use of supervision, enabled me to think more creatively about my sense of stuckness and anxiety within the wider context of the research process.

The experience of conducting this research has led me to reflect deeply on my own role as a clinician working within weight management and bariatric services. In my own practice as a psychological therapist I have integrated aspects of what I have learnt from this research into my work with families whose children had been diagnosed as morbidly obese. Conducting the analysis alongside this role I shared insights with colleagues regarding practices which formed routine procedure within the service, but which appeared to be based on little other than time

efficiency and usual practice. An example was weighing young people as a first 'task' during consultations upon which discussion could then take place depending on whether they had lost weight or not. Through meeting with my participants, I heard the ways in which such procedures were experienced as objectifying through a privileging of weight loss over the experience of trying to lose weight. As a result this insight led to discussion regarding our responsibility to be mindful of the ways in which whether successful or unsuccessful the young person's engagement with the service contributed to their already forming cultural milieu in which their body was being defined through medicalized terminology and represented a potential further form of socialisation into being overweight and become part of their "personal career out of being fat" (Moss, 1992: p.188), a view reinforced by Murray (2016) who, as "a fat woman", describes how her "her life has been mapped by control for as long as she can remember" (p. 4).

In summary, the experience of conducting this research has influenced my practice in far-reaching ways. I have a far greater appreciation for the ways in which the power dynamic can exist within clinical contexts and the myriad of ways in which this can potentially impact the person within the healthcare system. As mentioned above, I have gained an increased appreciation for ways in which the clinical encounter represents a site of ethical intersubjectivity which acknowledges and values the person's wider social and historical context and the ways in which the person is always socially and intersubjectively situated.

Chapter 7. REFERENCES

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Chapter 8. APPENDICES

Appendix 1. Metanoia Ethical Approval

Nathan Faulkner
DCPsych programme
Metanoia Institute

30th July 2015

Ref: *14/14-15*

Dear Nathan

Re: The role of attachment and social support in patients' experiences post gastric by-pass surgery

I am pleased to let you know that the above project has been granted provisional ethical approval by Metanoia Institute Research Ethics Committee (MREC). Full approval for the project can be provided by MREC once you have obtained ethical permission from the NHS. Please contact me gain once you have obtained NHS approval so that I can grant full ethical approval on behalf of the MREC.

If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the MREC.

Yours sincerely,

Dr Patricia Moran
Research Subject Specialist, DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Appendix 2. NHS Ethical Approval

NHS

Sussex NHS Research Consortium

Research Consortium Office
Worthing Hospital
Lyndhurst Road
Worthing
West Sussex
BN11 2DH

Tel: 01903 285027
Fax: 01903 209884
www.sxrc.nhs.uk

Mr Nathan Faulkner
Doctoral Student in Counselling Psychology
NF Counselling
58A Marsham Street
Maidstone
Kent
ME14 1EW

15/01/2016

Dear Mr Faulkner,

Our ID: 1637/NOCI/2015
TITLE: The Role of Attachment and Social Support in Patients' Experiences Post Gastric By-Pass Surgery

Thank you for your submission of the above project to access Participant Identification Centres (PICs) in our area.

All the mandatory governance checks have been satisfied, and I am therefore pleased to confirm that you now have our agreement for the following sites to act as PICs:

- **Western Sussex Hospitals NHS Foundation Trust**

Please note that the above PIC sites do not indemnify the main research site, the organisation managing the research or the participants in relation to the conduct or management of the research – this responsibility rests with the study sponsor.

Your research governance approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application.
2. You notify the Consortium Office should you deviate or make changes to the approved documents.
3. You alert the Consortium Office by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of research governance approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.
6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the

NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Good luck with your work.

Yours sincerely,

Ms Indra Chadbourn
Research Governance Officer

Email: indra.chadbourn@wsht.nhs.uk
Tel: 01903 285 222 x84609
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cc: Vivienne Colleran, Director of Clinical Excellence, Research & Innovation, Western Sussex Hospitals NHS Foundation Trust

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| Date | 27 November 2015 |

| Direct line | 0141 211 2102 |
| E-mail | WoSREC5@ggc.scot.nhs.uk |

Dear Mr Faulkner

Study title:	**The Role of Attachment and Social Support in Patients' Experiences Post Gastric By-Pass Surgery**
REC reference:	15/WS/0273
Protocol number:	N/A
IRAS project ID:	182083

Thank you for your email of 27 November 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 24 November 2015.

Documents received

The documents received were as follows:

Document	Version	Date
Other [Email reply]		27 November 2015
Participant consent form	2	27 November 2015
Participant information sheet (PIS)	2	27 November 2015

Approved documents

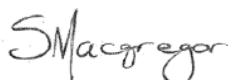The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering letter on headed paper [Covering Letter]		02 October 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 September 2015
GP/consultant information sheets or letters [Consultant Information Sheet]	1	02 October 2015
Interview schedules or topic guides for participants [Interview Schedule]	1	21 August 2015

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Letters of invitation to participant [Request for Research Participants]	1	02 October 2015
Other [Participant Demographic Information]	1	02 October 2015
Other [Email reply]		27 November 2015
Participant consent form	2	27 November 2015
Participant information sheet (PIS)	2	27 November 2015
REC Application Form [REC_Form_05112015]		05 November 2015
Referee's report or other scientific critique report [Metanoia and Middlesex University Ethical Approval]		30 July 2015
Research protocol or project proposal [Nathan Faulkner Research Proposal]	1	02 October 2015
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	02 October 2015
Summary CV for supervisor (student research) [Professor Julia Buckroyd Biography and CV]		02 October 2015
Validated questionnaire [General Health Questionnaire (GHQ-28)]	1	28 August 2015
Validated questionnaire [The Experiences in Close Relationships Questionnaire]	1	28 August 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/WS/0273	**Please quote this number on all correspondence**

Yours sincerely

SMacgregor

Sharon Macgregor
Committee Co-ordinator

Copy to: Ms Kate Fromant, Metanoia
             Mrs Clare Meachin, Lead Research Manager, Worthing Hospital

Appendix 3. Interview Schedule

Interview Schedule

Introduction

Please could you tell me a little about you weight history? (How was it for you living with this weight?)

Can you recall your expectations for surgery before you had it?

Experience post WLS

What was the actual experience of surgery and the period straight afterwards like for you?

How successful do you feel the gastric by-pass surgery has been for you?

What has been your experience of losing weight following surgery?

How do you think it has effected your:

[PROMPTS]   Eating behaviours

Physical activity behaviours

Social

Psychological aspects

Overall what do you consider the most positive aspects of having the surgery?

And what aspects do you consider the most negative?

Support

Can you tell me about what psychological support did you receive prior to and following your surgical procedure?

Have you been able to get support from others, not related to the team at the hospital?

How have you found the level of support and contact with the surgery team throughout your weight loss surgery journey?

Considering your journey so far do you have any suggestions or ideas about what might improve the patient experience of having weight loss surgery?

Appendix 4. Example Section of Analysis

	Interview transcript	Comment	Emergent themes
P07:	So it's making me aware of what I'm pushing over to my children (Mm) erm has been quite interesting and I do make, we sit at the table and I have to sit there with them with still food on my plate making out that I'm picking at it until they've eaten theirs (Right) sort of thing. So it, it's the things that you take for granted that you don't think they pick up on that actually they pick up on a lot more than what I realised.	Changes to own body and resultant intergenerational transfer of eating behaviours. Increased awareness of Self in relationships. Learning to manage the way in which she presents herself to others. Developing strategies to present herself socially. Deepening awareness of her role of mother.	managing pressures of others gaze .
R:	Mm Mm		
P07:	So that's, that's, that's been really hard. And the feeling, I think when you're an overeater. I suppose it's an addiction that feeling of being *absolutely* stuffed is the same as a drinker finally feeling drunk or someone taking drugs finally getting that hit. That's all of a sudden taken away from you. So I, I haven't had that sensation of knowing I've had a good meal (OK). And I, I haven't had that and I think	Change of word from 'interesting' above to 'hard' suggests a more challenging experience of managing herself in the role of mother. Self identifies as an '*overeater*' Pathological view of Self and behaviour as addict. Does she see herself as being helpless in battle with food? Experience of loss of satisfaction. Having something '*taken away*' – view of surgery as punishment/removal of pleasure Mourning sense of enjoyment in food – '*sensation of knowing I've had a good meal*' Thinks what?	Mourns loss of satiety
R:	Do you feel the fullness but you don't feel the	Interrupted her here to clarify distinction between physical and mental satiety based on comparison with alcoholic/drug addict. Could have asked her to elaborate here – what does she think?	

	Interview transcript	Comment	Emergent themes
P07:	Yeah I haven't got an appetite (Right) so that's, and my appetite still hasn't come back from surgery yet. And they keeping saying it will one day it's going to kick in and you're going to think 'Ooh I fancy that or'. I don't get that, I can go all day without eating and totally forget that I haven't eaten.	Loss of sensation of food as pleasure.

Promised return of appetite by healthcare professionals – hope, uncertainty. body as a mystery.

Relationship with food changed – food a chore rather than source of enjoyment or satisfaction. | Loss of agency over body |
R:	Wow		
P07:	Erm so I don't get that *satisfaction* around eating anymore and I find that quite hard. I find that	Loss. Emphasis on '*satisfaction*' suggestive of a loss of a previous enjoyment within current lived experience 'anymore.' **"*I don't get that satisfaction around eating anymore.*"** – the Self as being unsatisfied?	Mourns loss of satisfaction from eating
R:	Prior to surgery it sounds like food was, you describe yourself as an overeater but also food being a	Could have asked her to complete thought – she finds that…?	
P07:	It's a big social, it was a social thing for me I feel (OK) as well so. It was never a need; food was never a need as where now food to me is a *need* to survive and get through the day and give me energy levels and (Right). It's, it's almost food to me is like taking your medication now.	Change from present to past tense ('*It's a big social, it was a social thing for me*'). See's social experience as being different now.
Self as dependent – food gone from being social activity to necessary for survival.
Eating as a routine/regimen rather than experiential process. Mundanity of food as a necessity rather than an enjoyment - '*like taking your medication now.*'	Food a function
R:	OK.		
P07:	As where before it, it was great. Friends, family food	Loss of social experience and norms. Prior to surgery food viewed as existing within positive social experiences – does she need to redevelop sense of self in social encounters now?	Loss of food as social commodity
R:	Very social kind of (Yeah) relationship with it.		
P07:	Yeah. And and it was, food was my comfort. I'm, I was a big comfort	Loss of food as an emotional regulator. What replaces this now?	

	Interview transcript	Comment	Emergent themes
	eater as well (OK). Erm and I suppose work wise, because I've always worked in the care industry and stuff it was never about three meals a day, sitting down at normal times eating. A lot of the times I wouldn't eat until very late at night erm so all that has had to change because (To a more structured) my body can't process it at night time and, so yeah it's been a *massive massive* change. Erm and I don't regret it for a minute but I resent it at times.	Changes to body and eating and the impact on her lifestyle. Impact of changes viewed within wider context of her life. Acknowledgement of the magnitude of the changes to her life. <u>Resent vs. Regret</u>. "*so yeah it's been a massive massive change. Erm and I don't regret it for a minute but I resent it at times.*" Resents no longer being able to do as she likes with her body; needs to respect physical limitations e.g. digestion.	loss of source of comfort in food Resents loss of autonomy over body at times