IDENTITY TRANSFORMATION FOLLOWING BARIATRIC SURGERY

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ABSTRACT

Weight Loss Surgery (WLS) is considered the ‘gold standard’ treatment for individuals with ‘severe’ obesity (NICE, 2014). WLS produces rapid weight loss within the first two years as a result of the reduced size of stomach and reduced absorption of nutrients. Recent research has highlighted that WLS patients must also navigate significant internal and systemic psychosocial changes as they receive greater appreciation and respect as a result of their smaller size (Groven et al., 2013). The aim of the research reported in this thesis was to examine how patients negotiated and understood their own identity in the wake of profound social and physiological change. A critical realist epistemological position was taken in order explore these shifts from an embodied and social power perspective. A qualitative methodology involving nine semi-structured interviews, with nine participants a minimum of two years post-surgery was employed. The interviews were analysed using Thematic Analysis. The analysis focused around three themes concerning post-WLS identity: (1) A Life Worth Risking, (2) Battle of the Body, (3) A Search for Belonging. Participants described the influence of weight-based stigma on their everyday lives prior to surgery, including within close relationships and the health sector. These negative attitudes appeared to be reflected in how participants viewed themselves and treated their body. As a result, post-surgery participants described how their weight loss facilitated renewed confidence, increased personal freedom and appreciation for their body. Relief from weight-based stigma allowed participants to reflect on the impact societal discrimination had had on their lives and encouraged them to challenge these attitudes in others. This thesis discusses implications for further research, practice and policy to support the long-term outcomes of individuals post- WLS.

CHAPTER 1: INTRODUCTION

1.1. Overview

This chapter outlines terminology used within weight loss surgery (WLS) and describes the current UK context for obesity and WLS, highlighting the costs to society and the individual. The role of the psychologist within the WLS pathway is discussed, highlighting the current gaps in provision. A scoping review of recent literature is carried out, the results of which reveal a number of paradoxes between the pre- and post-WLS identity, feelings of having personal control over the body and eating behaviour despite being physically restricted, and profound social changes. Experiences of stigma within the health sector, the importance of integrated psychological services and long-term follow up are highlighted. The focus for the present research and research questions are also presented.

1.2. Terminology

1.2.1. Identity

The concept of identity is dependent on historical and cultural context, thereby creating definitional difficulties (Baumeister, 1995). Within Western cultures, identity is framed in intra-psychic terms comprising the values, ethics and relational roles a person takes up (Erikson, 1968). This is a dynamic process, shaped throughout our early development through to later life transitions. We develop a sense of who we are through social interactions, our interpretive frame and the wider social, historical and cultural contexts which facilitate and limit our language and actions (Cerulo, 1997). Individuals therefore, contain a multiplicity of identities: – cultural, political, gendered, national, ethnic, sexual – all of which are influenced reflexively through social context across the lifespan (Kroger, 2008).

1.2.2. Obesity

‘Obesity’ is defined by Body Mass Index (BMI), which is the sum of an adult’s weight in kilograms divided by their height in meters squared. Individuals with a BMI over 30 are considered ‘obese’. Under the current NHS guidelines individuals with a BMI above 35 with a weight-related health condition or BMI over 40 with or without any weight-related conditions qualify for weight loss surgery (NHS, 2020).

Obesity in itself is a problematic term. Patients often report that they find this word pejorative and demeaning with ‘weight’ or ‘BMI’ a more preferred, objective parameter (Lydecker et al., 2016). However, counterarguments suggest that the term ‘obesity’ may be beneficial in reducing weight-based stigma by positioning it as a disease with biological components rather than a moral failing (Allison et al., 2008). At the same time, it could also be argued that disease-based narratives, similar to issues of mental health diagnoses, centre the problem within the individual, obscuring the role of societal discrimination in widening health inequalities for people of higher weights (Throsby, 2009). No alternatives to ‘obesity’ were identified within the literature and a majority of participants within this study referred to themselves as being ‘obese’. For clarity ‘obesity’ has been used alongside ‘person first’ language (i.e., ‘people/person with obesity’ as opposed to ‘obese person’) in order to distinguish the person from the condition.

1.2.3. Weight Loss Surgery

Several terms for the procedures discussed in this research were considered including ‘Bariatric Surgery’ and ‘Bariatric-Metabolic Surgery’ before the term ‘Weight Loss Surgery’ (WLS) was selected. The term ‘Weight Loss Surgery’ may be construed as detrimentally focussing on weight loss outcomes from surgery as opposed to improved quality of life, longevity and the treatment of weight-related comorbidities (Sogg et al., 2018). However, in the researcher’s clinical experience, participant accounts from this study and the wider literature, surgery was frequently decided upon to avert the *possibility* of future of ill health, rather than the participant showing symptoms of ‘weight-related’ disease (e.g. type II diabetes, high blood pressure) at the time. This suggests weight loss was the intended outcome of treatment. Additionally, it is the ‘weight loss’ which facilitates social change; therefore, this aspect of surgery is arguably more relevant to the study of identity than metabolic changes.

1.2.4. Types of WLS

The mechanism of weight loss following WLS relies principally on restriction of food intake through making the stomach smaller, decreasing the absorption of ingested food (through bypassing parts of the digestive tract), or a combination of the two. However, in recent years there has been increasing recognition that the mechanism may be more complex, involving alterations in nerve signalling, hormones and microbes within the gut (Mulla et al., 2018). WLS techniques have developed considerably since their first widespread use in the 1990s. Laparoscopic techniques – minimally invasive surgeries where the abdominal organs are examined with a laparoscope – in particular have reduced the risk, post-operative pain and invasiveness of the procedures. However, these operations still involve substantial alteration to the digestive tract which requires considerable surgical skill (Kaijser et al., 2018). The most commonly used surgical techniques covered in this report are described below.

1.2.4.1. Laparoscopic Roux-en-Y gastric bypass

Laparoscopic Roux-en-Y gastric bypass (referred to as ‘gastric bypass’) involves separating the upper and lower stomach to create two separate pouches. The upper part of the stomach (connected to the oesophagus) is joined directly to a lower part of the small intestine. The lower portion of the stomach is also connected to the small intestine, although it cannot receive food. The mechanism of action involves reduced food intake through reduction in size of the stomach, reduced absorption of nutrients and the development of adverse physiological reactions when high fat or high sugar foods are eaten (Mandura & Dibaise, 2012; See Figure 1 Appendix A).

1.2.4.2. Laparoscopic vertical sleeve gastrectomy

Laparoscopic vertical sleeve gastrectomy (referred to a ‘gastric sleeve’) is the most recently introduced procedure. Consequently, long-term follow-up data (i.e. more than ten years) is lacking (Mandura & Dibaise, 2012). Despite this, the gastric sleeve is now one of the most frequently performed WLS procedures, due to the high failure rate of the gastric band (see below: Lee, Nguyen & Le, 2016). With this procedure a large portion of the stomach is removed to create a ‘sleeve’, which results in restriction of food intake (See Figure 2, Appendix A).

1.2.4.3. Laparoscopic biliopancreatic diversion with a duodenal switch

Laparoscopic biliopancreatic diversion with a duodenal switch (referred to as ‘duodenal switch’) is less commonly performed due to its complexity and the increased risk of complications, including severe nutritional deficiency and death (Moon et al., 2019). It involves the creation of a ‘gastric sleeve’ (as above), this is then connected to the bowel to facilitate reduced absorption of nutrients alongside the restriction of food intake (Mandura & Dibaise, 2012). An additional intestinal ‘limb’ is connected from the pancreas to the bowel to facilitate digestion. (See Figure 3, Appendix A).

1.2.4.4. Laparoscopic adjustable gastric band

Laparoscopic adjustable gastric band (referred to as ‘gastric band’) is the least invasive procedure. Restriction of food take is achieved through the insertion of a silicone band around the top portion of the stomach. This can then be inflated or deflated through the injection of silicone into a port under the skin. (See Figure 4 Appendix A). This procedure also carries high failure rates, with a significant proportion of patients requiring second surgeries. As a result, this technique is gradually losing favour with surgeons and being replaced with the gastric sleeve (Mandura & Dibaise, 2012). For this reason, and the fact this surgery represents a qualitatively different procedure in being ‘reversible’ the gastric band is not examined in this study.

1.3. Obesity: Disease or Risk Factor?

Obesity was recognised officially as a disease in 2013, following the publication of a statement by the American Medical Association (2013). Prior to this, obesity was regarded as a condition or potentially an illness. This is an important distinction as illness is a *subjective* state in which difficulties: “result from undesirable changes in social or personal function. How an individual perceives these problems, explains or labels them, and seeks remedy originates from a cultural context” (Jutel, 2011, p.64). In contrast, disease is framed by notions of *objective biological dysfunction*: “categories of clinical taxonomy… extrapolated from an aggregate of similar illnesses on the basis of what is thought to be common to the illnesses so classified" (Fleischman, 1999, p. 5).

By giving obesity a disease label, advocates state this will contribute towards lessening the stigma of obesity, assuage blame of the individual, improve access to treatment options and encourage a productive socio-cultural and political dialogue; however, there is no evidence to support this at present (Puhl & Liu, 2015). Stoner and Cornwall (2014) argue if the same classification was applied to other risk factors, then cigarette smoking should in fact also be labelled a disease. Additionally, in line with cigarette smoking, there are significant differences in the prevalence of obesity according to income, with 37% of women living in the most deprived areas in England in 2016 classified as obese compared to just 21% of women living in the least deprived (HSE, 2019). As a result, a number of researchers have raised concerns that the disease label may in fact lead to a shift in focus away from these social and environmental contributors towards emphasis on medications and surgery (Tomiyama et al., 2018).

1.4. Evidence Based Policy or Policy Based Evidence?

According to the Health Survey for England (HSE, 2019), in 2018 the prevalence of adults with obesity was 28%, almost double the figure of 15% in 1993 (Nuffield Trust, 2020). Higher weights are often accompanied by an increased risk of multiple health problems, including elevated risk of cancer, heart disease, liver disease and stroke (Public Health England, 2019). Living with obesity has also been found to contribute to significant adverse psychological consequences, including lower self-esteem and self-confidence, depression and anxiety which serves to further exacerbate pre-existing socio-economic and health inequalities (Borgès Da Silva et al., 2018; Tomiyama et al., 2018; Puhl & Suh, 2015). In 2014 The Institute of Economic Affairs (2017) estimated the cost of individuals being overweight and obese to the economy at almost £2.47 billion.

WLS is considered the gold standard and most cost-effective treatment for severe obesity (National Institute of Clinical Excellence [NICE], 2014). Weight loss within the first two years is substantial, with most individuals losing between half and two thirds of their excess body weight (Mechanik et al., 2013). WLS has been demonstrated repeatedly to be both cost and clinically effective intervention in comparison to lifestyle interventions (strategies to support changes in diet and exercise) alone to reduce weight and weight-related comorbidities (Hofsø et al., 2010; Ikramuddin et al., 2018). A recent randomised controlled trial (RCT) found mean reduction in percentage body weight lost after five years was 25% for patients who underwent a gastric bypass with 30% enjoying full or partial remission of type II diabetes, compared to only 5% reduction in weight lost and no remission of type II diabetes following a year-long intensive lifestyle treatment (Courcoulas et al., 2020). Lifestyle interventions, as well as appearing less effective in terms of weight reduction, are resource intensive both for commissioners and for the participants themselves in terms of time commitment and resources necessary to implement these changes (Avenell et al., 2018).

The success of WLS – in respect of the scale of weight loss, alleviation in weight-based comorbidities and lower cost and time burden– has led to the assertion that more procedures should be performed (Mingrone et al., 2015). However, in order to maintain WLS outcomes lifestyle changes, such as improved eating patterns and physical activity, must be adhered to throughout the patient's lifetime (Ogden et al., 2019). The feasibility of adopting these changes in individuals who have struggled throughout their lives (often as a result of circumstances beyond their control including early life experiences, low income, poor availability of healthy food options, environmental toxicities within the water, air and electromagnetic frequencies) is often variable. Although metabolic and nutritional complications such as herniation, nutritional deficiencies and internal bleeding are rare for gastric bypass (around 5%) as is mortality (0.1%), the long-term complications of newer operations such as the gastric sleeve remain unknown (Uittenbogaart et al., 2017).

For the proponents, the evidence supporting further expansion of WLS provision is very strong. They point to systematic reviews of evidence collected across RCTs that demonstrate significant, unparalleled weight loss and remission of chronic disease (O'Brien et al., 2019). However, debate surrounding the sustainability of these benefits long-term continues to linger. The concern is that individuals cannot maintain the substantial changes in eating pattern across their lifetime and therefore, gradually restore their normal eating habits (Boswell, 2018). WLS may then inadvertently become a cause of new, complex, and costly chronic conditions owing to the poor absorption of nutrients as a result of alteration in the gastro-intestinal structure (Lammers et al., 2018). This raises concerns, as many WLS patients are young and are expected to have a long life ahead of them.

The evidence supporting or contradicting WLS outcomes also involves epistemological difficulties over what types of knowledge, experience and research is valued within society. WLS is invasive and fundamentally changes the individual's experience and interaction with food, which generates a form of experiential knowledge (from patients and their networks) and professional expertise that is poorly represented by evidence-based guidelines (Douglass & Calnan, 2016). This applied wisdom associated with the experience of the intervention often contradicts the scientific evidence (Boswell, 2018). This knowledge comes in the form of highly emotive accounts of the difficulties and indignities associated with the intervention, particularly the intensity of the physical, social, and psychological side effects (Sogg & Gorman, 2008).

However, NICE's response to these epistemic challenges has been a policy of incremental expansion, with the latest re-assessment of guidelines in 2014 to include adolescents and those with comorbidities with a BMI over 35. The voluntary nature of these commissioning guidelines informed by the Guideline Development Group (an organisation which replaced the Health Technology Assessment in 2006 which enforced mandatory guidelines) has freed proponents of the surgery and NICE to employ stronger rhetoric about the efficacy of WLS despite well-documented uncertainty. NICE officials, to forge short-term compromise, have subsequently produced guidelines that suitably reflect the evidence-based arguments of proponents of WLS, with ample 'room for manoeuvre' for service providers, commissioners, and clinicians less convinced by this evidence (Boswell, 2018). The impact on the guidelines for obesity has therefore, strengthened proponents of surgeries, whilst at the same time allowing greater space for non-compliance by those who feel the research base is more ambiguous.

1.5. Patient Pathway

1.5.1 Screening

There is no formal screening programme for adult obesity in the UK (NICE, 2014). Weight may be measured in routine clinical appointments with a General Practitioner (GP). Obesity may also be highlighted through other generic screening programmes such as the NHS Health Check programme, which aims to identify individuals aged 40-74 with elevated risk of cardiovascular difficulties through Primary Care registers (NHS, 2014). Individual Primary Care practices may also run specific clinics for other conditions associated with obesity such as hypertension and diabetes. Raising the issue of weight management as a medical issue at these clinics offers the opportunity to direct the patient towards appropriate interventions and is congruent with constructions of obesity as a disease (Dewhurst et al., 2017; American Medical Association, 2013).

1.5.2 Diagnosis

The diagnosis of adult obesity does not involve the sophisticated equipment, training or investigative procedures which may be needed to diagnose other chronic conditions such as diabetes or chronic pain; the process relies on scales and a BMI chart alone. Following the confirmation of the obese status through BMI, this diagnosis may automatically implicate increased risk of other related conditions such as type II diabetes and hypertension, which may then necessitate additional diagnostic tests to assess these. Overall, sophisticated technology is more apparent in the ways weight is managed, such as mobile applications to monitor levels of physical activity or calories consumed.

1.5.3 The Tiered System

Although there is an acknowledged lack of consistency of provision (Royal College of Surgeons, 2014), the biomedical management of obesity in the UK operates under a tiered system (Welbourn et al., 2014). Patients will typically progress through tiers 1 to 4 starting at the community level at tier 1 and moving to WLS at tier 4. However, patients may enter the pathway at any tier, with NICE guidelines (2014) recommending surgical intervention as the first line option where an individual's BMI is above 50.

Tier 1 refers to universal interventions at the community level including the re-enforcement of healthy eating messages and the importance of physical activity (often through government advertising; Stegenga et al., 2014). Tier 2 is usually delivered in primary care settings and offers educational classes and lifestyle changes. These involve behavioural techniques such as self-monitoring, prescribed diet programmes and/or physical activity programmes, meal replacements, access to facilities for physical activity and individual counselling (Sutcliffe et al., 2016). These services are commissioned by the local authority in collaboration with the NHS and Clinical Commissioning Groups (CCGs) (NHS England, 2014b).

Tier 3 is offered at a combination of community and hospital settings. These are clinically focused services led by multi-disciplinary teams (MDTs) which include nurse specialists, dietitians, GPs and psychologists (NHS England, 2014b). Tier 3 services offer more specialist professional input surrounding diet and exercise as well as pharmacological methods of weight loss (prescribed medications which prevent the absorption of dietary fats; Alkharaiji et al., 2019). Patients referred into Tier 4 have usually not achieved significant weight loss through the interventions offered in the other tiers, such as diet, exercise and pharmacotherapy. Tier 4 therefore, positions WLS as a last resort option, when other methods have not worked (NICE, 2014).

1.5.4 Multi-Disciplinary Team Decision Making

The recommendation of a specific surgical procedure is made following consideration of existing physiological factors which may impact the success of the surgery (e.g. gastric sleeve may exacerbate existing reflux difficulties). Psychological considerations are also taken into account by the MDT which generally comprises of surgeons, psychologists, dieticians and nurses who collectively make decisions with regards to patient selection (NICE, 2014). Although psychological input is a requirement of WLS providers, operational definitions regarding the purpose and scope of this are lacking resulting in significant variation in the interpretation of these guidelines (Ogden et al., 2019; Ratcliffe et al., 2014).

1.6. Psychology Provision in WLS

Whilst guidelines exist within the UK for psychology provision within WLS services (Stegenga et al., 2014), these merely state that psychologists should be part of the multidisciplinary team (MDT). Consequently, there is a lack of information about how psychology should operate within these services. Psychological interventions for people with obesity have to date largely focussed on weight as an outcome, for which psychological interventions, on their own, have consistently been unable to yield clinically significant results (Castelnuovo et al., 2017). Difficulties with weight do not occur in isolation but are a result of a complex interaction between physiological, psychological and social factors (Bagnall et al., 2019). However, often this is over-simplified and results in a narrow focus on behaviour change.

Although there is no recommended guidance on use of a specific psychological model, a survey by Ratcliffe at al. (2014) of psychologists within UK WLS services described respondents as implementing individual and group interventions which focused on binge eating, emotional eating and night eating. One of the most frequently used models for these types of difficulties is Cognitive Behavioural Therapy which has been adapted to highlight thinking errors and cognitive distortions (e.g. believing that maintaining the same weight for a week despite dieting means the person is useless and should give up) which may sabotage weight loss attempts (Beaulac & Sandre, 2015). Other studies have highlighted the potential of different models for addressing salient factors in eating and weight management, such as Compassion Focussed Therapy to address the negative impact of internalised weight stigma (Hilbert et al., 2015) and Dialectical Behavioural Therapy to develop alternative strategies for managing difficult emotions which may have previously been addressed with food (Mushquash & McMahan, 2015);

1.6.1 Pre-Surgery

1.6.1.1 Difficulties

Some authors have pointed towards the complex psychological histories of many WLS candidates pre-surgery, including higher rates of depression, anxiety, eating disorder symptoms, addictions, trauma and abuse than the general population (Sokol et al., 2019; Koball et al., 2016; Kalarchian et al., 2007). Higher weight individuals may develop these conditions as a result of the high levels of weight-based stigma and discrimination within society, others may use food to cope with difficult emotions as a result of unrelated traumas and subsequently gain weight (which may then, in turn, attract further discrimination). However, no consistent pre-operative psychiatric predictors of weight loss outcomes have been identified (Sockalingam et al., 2020). Approximately a quarter of individuals undergoing WLS carry a diagnosis of Binge Eating Disorder. Although this does not exclude people from surgery, it has been found to contribute to less weight loss and to weight regain (White et al., 2010).

Regardless of pre-operative mental health vulnerabilities, preparation for WLS requires major changes to eating behaviour and development of new skills, such as managing difficult emotions or novel situations which, given the individual's weight loss history, may be challenging to maintain. Difficulties such as anxiety and depression may also reduce executive function, making it harder to plan and implement the complex, pervasive lifestyle changes required following surgery (Tomiyama et al., 2018). It is therefore, important that underlying emotional difficulties are addressed, and alternative coping mechanisms are found to weaken the association between food and comfort to ensure the success of the surgery (Wedin et al., 2014).

1.6.1.2 Pre-Surgery Assessment

Pre-operative psychological assessments offer the opportunity to identify and assist individuals with preparedness for WLS, highlighting any psychosocial challenges that may impair their weight loss or quality of life. Psychological practice within WLS settings has historically focused on pre-surgery psychological assessments and a number of studies have highlighted the lack of standardisation and wide variation in assessment methods, outcome decisions and recommendations (Sogg et al., 2016).

In a national survey of 22 UK WLS psychology services by Ratcliffe et al. (2014), all services reported carrying out pre-surgery psychological assessments. However, only a third of those services routinely assessed all new patients, with the remainder relying on identification of psychological difficulties by another member of the MDT. This suggests a reliance on a team member who may not have the skill level, confidence or sensitivity to identify individuals who may benefit from psychological assessment and also that psychological services exist in silo away from the main patient pathway. Given the wide-ranging implications of this surgery it has been argued that psychologists would be well placed to routinely support WLS-patients to ensure adequate informed consent (Ogden et al., 2019).

1.6.1.3 Pre-Surgery Intervention

Pre-surgery interventions typically involve behavioural lifestyle interventions, usually individual or group sessions designed to increase the patient's preparedness and readiness for WLS through psychoeducation and strategies for the management of emotional eating. Group programmes in particular, have been associated with increased weight loss prior to surgery (compared to no intervention) and increased ability to implement and adhere to post-operative changes and greater weight loss one year following surgery (Brandenberg & Kotlowski, 2005; Kalarchian et al., 2016; Livhits et al., 2012). Despite this evidence base for group interventions and over ninety-one percent of UK WLS services reporting to offer individual interventions pre-surgery, only forty-one percent offered pre-operative groups for WLS candidates, which varied in length between one and twelve sessions (Ratcliffe et al., 2014). No further information on structure, models or outcome measures used was available.

1.6.2 Post-Surgery

1.6.2.1 Post-Surgery Difficulties

Following WLS, individuals can only eat pureed food for several months. In the longer term, patients can eat only very small amounts multiple times a day. Additionally, they must eat slowly, avoiding any high fat foods and liquids with meals

(Ogden et al., 2011). If WLS patients overeat or eat foods that their body cannot tolerate – particularly in the first two years – they may endure ‘dumping syndrome’, which involves sweating, hypoglycaemia, gastro-intestinal pain, vomiting, diarrhoea and nausea (NICE, 2014; Overs et al., 2012). However, after two years their weight plateaus and the sensations which limit food intake and choices reduce. From that point, the maintenance of weight loss is highly dependent on the individual’s capacity to maintain dietary and lifestyle changes (Watson et al., 2020). As a result, the issue of weight regain following WLS is being increasingly recognised. Cooper et al. (2015), in a study of 300 WLS patients, observed significant weight regain (regain of over 25% total weight initially lost) in 38% of patients who underwent gastric bypass surgery over an average of 6.9 years. This study also highlighted that patients who lost the most significant amount of weight within the first year maintained, on average, the greatest losses long term, highlighting the potential role of post-surgery support in maximising patient outcomes.

In terms of psychological adjustment following WLS, many patients describe improved self-confidence and self-esteem, a decrease in their preoccupation with food and a reduction in depressive symptoms (Strain et al., 2014; Benson-Davies et al., 2013; Wood & Ogden, 2015). However, a significant proportion of WLS patients also report distress at excess skin, as well as poorly understood complications from surgery such as hypoglycaemia and chronic pain (Groven et al., 2013). A number of studies have also highlighted poorer psychological outcomes in some patients including recurrence of binge eating and higher rates of drug and alcohol misuse and suicidality than the general population (Backman et al., 2016; Ivezaj et al., 2019; King et al., 2012; Li & Wu, 2016; Lydecker et al., 2019; Müller et al., 2019).

As a result of alterations in appearance, routine and mood swings (due to fluctuations in blood sugar), WLS patients are also more likely to experience changes in their relationships. A recent Swedish cohort study found patients who underwent WLS were more likely either to get divorced if they were in a relationship at the time of surgery or to marry if they were single at the time of surgery, compared to weight-matched controls and the general population (Bruze et al., 2018). WLS patients may find themselves in situations they have never or rarely encountered before (such as feeling listened to) or negotiate a disrupted equilibrium within their work, friendships or families, as the social stigma of their weight is lifted and they receive more positive attention (Sogg & Gorman, 2008). This experience may be perceived as painful for some individuals who then reflect on the way their former self was overlooked (Lynch, 2016). The psychological difficulties that individuals experience following surgery may not be attributable to an existing mental health problem, but a consequence of the stress evoked through a significant physiological and life transition. This suggests a key role for psychologists in supporting post- WLS patients in managing these shifts.

1.6.2.2 Post-Operative Assessment

Two-thirds of services were found to offer post-operative assessments and follow up appointments, but these were not routine for all patients in any service surveyed (Ratcliffe et al., 2014). As with pre-operative assessment the impetus for identifying psychological difficulties rested upon members of the MDT. The lack of post-operative psychological follow up appointments (in contrast to those carried out by the rest of the MDT) highlights the division between psychological and physiological approaches to weight loss. Given the serious post-operative difficulties highlighted as a result of the significant life changes brought about by WLS, it could be argued that it should be routine to enable early intervention.

1.6.2.3 Post-Operative Interventions

Of the services surveyed by Ratcliffe et al. (2014), although a majority of WLS services offered individual support post WLS (following identification from another MDT member), none offered post-WLS intervention groups. Again, meta-analysis of post-operative psychological group interventions alongside WLS are associated with more sustained weight loss than WLS alone (Beck et al., 2012). Additional research is required to establish whether it is more efficacious to provide psychological support before or after surgery, and which models of treatment are most effective for which individuals.

1.7. Relevance to Psychology

Owing to the complex physical and psychosocial changes reported by individuals who have undergone WLS, appropriate psychological assessment, preparation and follow-up support are therefore, an integral part of the WLS process. Although a quality statement by NICE emphasises the importance of postoperative follow-up and multidisciplinary team decision-making, no guidelines currently exist for the provision of psychological services support pre- and post-WLS (Ogden et al., 2019).

This has led to a lack of standardisation and wide variation in provision and practice as well as a limited understanding of how to support individuals in managing the complex physiological and social outcomes of surgery. The limited role of psychology within WLS services in the UK appears to suggest services which are focussed on short-term economic gain (through alleviation of costly comorbidities), rather than a considered approach structured according to the long-term sustainability of physiological and psychological health outcomes. Most psychological resources appear to be focused on pre-operative assessment and intervention rather than post-operative input, despite considerable evidence in support of the in latter maintaining long term quality of life as well as weight loss.

Given the significant range and complexity of psychological issues that may impact on, and arise from, WLS it is important to develop an understanding of how patients adjust psychologically to embodied and social postsurgical changes in the long term. This experiential knowledge generated by service users is crucial to ensure appropriate commissioning of WLS psychology services to support people at all stages of the patient pathway.

1.8. Scoping Review

To inform the research for this thesis a scoping review was performed. Scoping reviews, as described by Arksey and O'Malley (2005), aim to examine the extent, breadth and nature of existing research into a topic, clarify central concepts and identify any gaps in the existing literature (Peters et al., 2015).

1.9. Objective

The objective of the scoping review was to explore the current literature on psychosocial adjustment following WLS.

1.9.1. Inclusion Criteria

The search criteria for the review was developed by defining inclusion and exclusion criteria for participants, interventions, study design and outcomes (Peters et al., 2015).

1.9.1.1. Participants

Studies were included if they focused on individuals for which a majority had undergone WLS a minimum of two years previously. This was to ensure that the maximum weight loss had been achieved and participants weight was stable for a period long enough to adjust and reflect on.

1.9.1.2. Interventions

‘Reversible’ procedures such as the adjustable gastric band are declining in popularity owing to their high failure rate. Therefore, ‘irreversible’ WLS, particularly the gastric bypass and gastric sleeve have become preferred amongst surgeons. These procedures will also likely lead to a qualitatively different experience than a procedure that can be relatively easily reversed. Therefore, only those studies that included a majority of participants with gastric bypass, gastric sleeve or duodenal switch were included.

1.9.1.3. Study Designs

All qualitative study designs were included.

1.9.1.4. Outcomes

The relevance of research outcomes to the concept of identity was developed in line with a previous systematic review by Coulman et al. (2017) which focussed on literature published before 2015 examining psychosocial outcomes in post- WLS patients (including short-term). The outcomes listed included improvements in psychosocial functioning, including body satisfaction, confidence, self-esteem, relationships (intimate, family, work), quality of life and wellbeing.

1.10. Search Strategy

An initial search was performed across several databases to refine search terms. Using the keywords, published work was searched for across nine electronic databases (PsycInfo, PsycArticles, PsycNet, Scopus, Web of Science, The Cochrane Library, Google Scholar, PubMed, and Medline). Finally, reference lists of the identified papers were searched to identify relevant studies.

Given the rising rate of obesity, range of bariatric interventions, and advancement in techniques of WLS (Chang et al., 2014), only articles written in English published between January 2010 and January 2020 were included in this review.

List of search terms can be found in Appendix B.

1.11. Extracting and Charting the Results

All papers identified by the search were downloaded using Zotero reference management software and duplicates were removed. The titles and abstracts were screened for relevance and potential inclusion in the review using the inclusion and exclusion criteria.

1.12. Summary of Database Search

All articles were checked for relevance. Only those which were relevant to the themes of identity and WLS were included. In all, 2378 unique articles were initially identified through EBSCO search. See Appendix C for diagram.

Of the 2378 articles found through the EBSCO search and including 4 additional papers found through reference checking, 320 study titles appeared to be potentially relevant. Screening of the abstracts for these records excluded a further 258. Of the remaining 62 full-text articles, 47 were excluded for the following reasons: 24 studies interviewed a majority of participants who were less than two years post-surgery; 20 interviewed a majority of participants who had had the adjustable gastric band or another reversible procedure; three did not provide information on type of procedure undertaken: two qualitative studies focussed largely on food and dietary intake; and one qualitative study focussed narrowly on physical activity following surgery.

Table 1 (below) lists the research papers selected for the scoping review.

Table 1: Summary of research papers identified

Study ***Country***	**Focus of Investigation**	**Sample size, Gender, Age, Ethnicity**	**Type of Surgery and Time since surgery**	**Data Collection Method** **Method/Approach** ***Themes***
Groven, Råheim & Engelsrud (2010) ***Norway***	Chronic problems following WLS	5 female; Aged 22-55 'Norwegian'	Gastric bypass; within the last 6 years 'vast majority' more than 2 years post-surgery	Interviews Phenomenological *Healthy, but worried; Positively life-transforming; Unexpected pain and loss of energy; Change of bodily appearance; Feeling damaged on the "inside"; Comparing one's old life with the "new" life*
LePage (2010) ***US***	Psychosocial adjustment following surgery	12 (8 women) Aged 30-57; 9 'Caucasian'; 1 'Caucasian-Jewish'; 1 African American; 1 'Hispanic'.	Gastric bypass 2-9 years post-surgery	Interviews Phenomenological *Surgery as renewed hope, finding balance, filling the void, and transformation of self-image*

Engström & Forsberg (2011) ***Sweden***	Psychosocial adjustment	16 (12 women)	Gastric bypass and Duodenal switch, 2 years post-surgery	Longitudinal Interviews (pre-op, 1 year, 2 years post-op) Grounded Theory *Hoping for de-burdening and control through surgery; Feeling de-burdened; Practising control through physical restriction*
Ogden, Avenell & Ellis (2011) ***UK***	Experience of revision procedures	10 (8 female); 9 'white British', 1 'Black-British Caribbean'	10 Gastric bypass 1-10 years (mean 4.6 years) post-surgery	Interviews Interpretive Phenomenological Analysis *Mind / body relationship; Control*
Groven, Råheim & Engelsrud, (2013) ***Norway***	Living with excess skin and intestinal changes	22 female; 'Norwegian'	22 gastric bypass; within the last 6 years 'vast majority' more than 2 years post-surgery	Interviews Phenomenological *The felt "inner" body versus the visible "surface" body; The "old" body versus the "new" body*

Stolzenberger, Meaney, Marteka, Korpak & Morello (2013) ***US***	Post-surgery health related quality of life	61 (48 women)	44 Gastric bypass, 17 Gastric band; 2–9 years post-surgery	Focus Groups Phenomenological *Eating to live, getting healthy, acting normally, discovering the new me, fitting in, taking control, relating differently*
Geraci, Brunt & Marihart (2014) ***US***	Psychosocial adjustment	9 Females; aged 27-57 age (Mean= 42). Self-identified ethnicities of participants were 5 ‘Caucasian’, 2 ‘Hispanic’, 2 ‘African-American’.	7 Gastric sleeve; 2 Gastric bypass. 2-7 years (Mean =3) post-surgery	Interviews Phenomenological *Food after the first year post-surgery; bariatric surgery is not a magic pill.*
Natvik, Gjengedal, Moltu & Råheim (2014) ***Norway***	Meaning of eating following WLS	14 (7 female)	Duodenal switch; 5-7 years post-surgery	Interviews Phenomenological *Negotiating Flexibility Within a Forced Structure; At the Mercy of the Altering Body.*

Groven, Galdas,& Solbrække, (2015) ***Norway***	Men's experiences of complications following WLS	5 Males; 'Norwegian'	Gastric bypass; Over 4 years post-surgery	Interviews Phenomenological *Episodes of hypoglycaemia; severe pain and internal herniation; the significance of physical activity and exercise.*
Lier, Aastrom, & Rørtveit (2015) ***Norway***	Psychosocial/ lifestyle adjustment	10 patients (7 female) aged 33-57	Gastric bypass; Over 5 years post-surgery	Interviews Qualitative Content Analysis *Relational aspects related to weight loss; The new body; changes in self esteem*
Heidmann & Grønkjær (2015) ***Denmark***	Health Related Quality of Life	12 (8 female)	Gastric bypass; 6 years post-surgery	Focus Groups Qualitative- Not specified *Changed personality; social challenges; physical possibilities and limitations; a constant focus on food.*

Lynch (2016) ***US***	Relationship with food pre and post-surgery	16 patients (13 female); Aged 32-63	Gastric bypass; 11 months- 10 years post-surgery (5 patients <2 years)	Interviews Grounded Theory *Pre-surgery; honeymoon; Work begins.*
Bylund, Benzeina & Sandgren (2017) ***Sweden***	Family adjustment following surgery	12 patients with 1-3 family members; 11 male and 17 female in total	Gastric bypass; Over 2 years post-surgery	Interviews Grounded Theory *Attaining unity, returning to old patterns, or disconnecting to find stability.*
Griauzde, Ibrahim, Fisher, Stricklen, Ross & Ghaferi (2018) *US*	Psychosocial outcomes following WLS	77 (69 female); age 26-72 (mean= 48); 50 ‘White’, 16 ‘African American’, 11 ‘Other’	25 Sleeve gastrectomy; 22 Gastric Bypass; 20 Lap Band; 10 Duodenal Switch; 1 month- >5 years (63% over 2 years) post-surgery	Focus Groups Grounded Theory *Change in self-perception; change in perception by others; change in relationships.*

1.12.1. Characteristics of the Studies

Of the 14 studies retrieved, five originated from Norway, five from the United States, two from Sweden, one from Denmark and one from the UK. The greater representation of Scandinavian countries can be attributed to the recognition of the gaps in knowledge regarding the long-term implications of WLS and the request of Norwegian and Danish health authorities for more long-term qualitative research in this area (Groven et al., 2015). The commitment to understanding long-term health outcomes may also be a reflection of the greater accountability inherent in publicly funded healthcare systems (in Scandinavian countries) as opposed to privately funded (U.S.). Two of the Norwegian studies (Groven et al., 2010 and Groven et al., 2013) interviewed the same sample of 22 women, with the 2010 paper focussing only on the 5 women from the larger sample who had experienced complications. A majority of respondents were white females. Only one study focussed exclusively on males (Groven, et al., 2015). The most common procedure performed among participants was the gastric bypass.

The focus of studies varied: five studies focussed broadly on psychosocial adjustment, three on experiences of revision surgery and complications, two on changed relationship with food, two on health-related quality of life, two on living with embodied changes and one on family adjustment. The most common analytic approach was phenomenological carried out by eight studies, followed by Grounded Theory. One research paper described their approach as ‘qualitative content analysis’ and one did not specify the approach.

1.12.2. From a Restricted Life to Normality

A theme or subtheme of ‘normality’ emerged within a number of papers (Engström & Forsberg, 2011; Groven et al., 2010; Groven et al., 2015; Lier et al., 2015; Stolzenberger et al., 2013). ‘Normality’ or ‘a normal life’ involved the alleviation of the psychosocial burden of obesity which had defined the participant prior to surgery. As a person living with obesity, participants described building a ‘restricted life’ (Engström & Forsberg, 2011, p. 5) at work, socially and romantically. Ideas of ‘normality’ related to being able to be seen for who they were and fulfil roles like ‘normal people’. As one participant describes: “I feel that I can go out and nobody is going to look at me unless I want to be looked at. I can go about my business being a human being and not be a freak” (Stolzenberger et al., 2013, p. 34).

1.12.2.1. Work and social life

Within workplace settings, participants described repetitive experiences of being bullied, excluded, overlooked and stigmatised as a result of their weight prior to surgery. In Groven et al.’s (2015) study focussing on post-surgery males, one participant described being referred to consistently as the “fat guy” (p. 6) in the office. Others were repeatedly passed up for promotions (Stolzenberger et al., 2013). Participants described exclusion even from friends: one described how his friend refused to include him on a hunting trip, fearing that he would not be able to cope with the physical demands. Women similarly described experiencing verbal abuse in public. In one of countless examples, a participant who attended a disco was told by a stranger “you are the ugliest person I have ever seen” (Groven et al., 2010, p.6). Participants limited their social contact describing feelings of shame, anxiety and isolation as a result (Groven et al., 2012; Natvik et al., 2014; Stonlenberger et al., 2013).

Post-surgery participants described their delight in being seen for something other than their weight. One participant was referred to as the “exercise guy” owing to their continued interest in physical activity (Groven et al., 2015 p. 7). Women post-surgery found that they were consulted and listened to more at work. They described colleagues appearing more helpful and obliging, alongside comments which praised their appearance (Groven et al., 2012). However, participants typically limited the number of people who knew about the surgery, owing to feelings of shame that they had not been able to lose weight themselves, which created a feeling of discrepancy between public and private life (LePage, 2010).

1.12.2.2. Romantic Relationships

Romantic relationships post-surgery created additional dichotomies between the compliments people received on their clothed and unclothed appearance. Women in Groven et al.’s (2012) study described their appearance in denigrating, objectifying terms (e.g., having “batwing arms, thick flabby thighs and sagging breasts”, p. 515) at odds with the positive responses they received in public. As a result, many described vulnerability when having to reveal their bodies (Lier et al., 2015). Additionally, participants who had been single prior to weight loss also disclosed being in uncharted territory when negotiating new relationships: “friends will say “you have five guys looking at you.’’ And I don’t know how to handle it. I never had those alerts up. I never knew anything. Now I think so if a guy wants to buy me a drink I’m like ‘‘yes!’’ But then, I can freak about what’s next.” (Stolzenberger et al., 2013, p. 34).

Participants instituted a variety of clothing strategies to conceal loose skin and often avoided intimacy with partners. Participants also described feelings of shame and frustration that, although their partners were supportive, they could not supress negative feelings towards their own bodies (Lier et al., 2015). Other participants, while considering having the skin removed, decided to prioritise their health over the risk of further surgery (Groven et al., 2012).

1.12.2.3. Family Life

Prior to surgery, participants described not being able to perform in their roles as partners or parents (e.g., tiring easily playing with children). Others reported needing support from family members with simple tasks such as washing, dressing or standing up (Bylund et al., 2017). Participants with children described fearing not being around to see their children grow up, even though many of these participants experienced no comorbidities at the time of interview (Engström & Forsberg, 2011). Following surgery, a significant number of participants were able to conceive much longed-for children. ‘Participant 1’ (who gave birth to a daughter following WLS) discussed the devastating impact infertility had on her mental health: ‘‘That was such a dark time. I was a mess and wanted to die. I was a failure as a wife. I wanted to kill myself’’ (LePage, 2010, p. 59).

Bylund et al.’s (2017) research which involved interviews with WLS patients and their families highlights the significance of family support in adjusting to and maintaining long-term lifestyle changes. The study outlines that the individual’s relational network had to adapt to significant changes which were often unexpected, including changes in physical appearance, physiological side effects (dumping syndrome, hypoglycaemia, cramps) and psychosocial changes (mood swings, having more energy, becoming more assertive and perceiving greater acceptance from others). These created disruptions in routines, habits and communication patterns for the entire family: “If we knew the consequences of the change, we would not have taken the decision regarding [WLS] so lightly” (p. 3).

This created dramatic systemic shifts which were not always positive. Family members reported feeling surprised and confused by their jealousy, resentment or frustration when family members who previously ignored the individual who had undergone WLS now gave them attention. For others, family members responded with derision for the individual who had undergone WLS for ‘taking the easy way out’ and ‘not trying hard enough to lose weight’ (Bylund et al., 2017). Participant four in LePage’s (2010) study described how, during the two years post-surgery, he had gained a sense of freedom and recognition of his true sexual orientation. This had led to the end of his marriage and subsequent alcohol dependence and loss of the custody of his children.

1.12.3. Control

Control – referring both to a sense of control over the body as well as not returning to pre-surgery habits – was highlighted in numerous studies (LePage, 2010; Groven et al., 2010; Groven et al., 2012; Groven et al., 2015; Stolzenberger et al., 2013; Geraci et al., 2015). Body control was seen as an essential component of autonomous authorship of identity. Autonomy or control over identity was suggested in the way participants bodies were not sanctioned by others, nor did they sanction themselves from activities that involved being in public (e.g. going to restaurants, exercising in public). Control related to a sense of victory and emerged particularly within the first 6-12 months after surgery, as participants lost significant amounts of weight. Participants described the period as a ‘honeymoon’ (Lynch, 2016) and a ‘hallelujah wave’ (Groven, et al., 2010).

Control of their bodies also required a new shift in awareness and psychological effort. Participants began to eat in response to bodily signals, noticing that eating the wrong types of food or skipping meals resulted in changes in mood, drops in heartrate, diarrhoea, fatigue and nausea (Engström & Forsberg, 2011). However, rather than describe these symptoms as negative, participants often appreciated the heightened connection with what they ate and their bodily state. Being pushed towards avoiding foods with high carbohydrate and fat content connected them with a healthier lifestyle and weight loss. One participant said: “I’ve tried to self-sabotage and I’m glad I get sick. It kind of conditioned me to not do that anymore. . .like, “hey, this is bad for you. Do not do it.” (Geraci et al., 2015, p. 4).

Participants lives prior to surgery were characterised as being controlled by hunger, resulting in participants' shifting from “living to eat” to “eating to live” following surgery (Lynch, 2016 p. 248). In the nine months to two years following surgery participants redefined the relationship with food and not only expressed that they were taking better care of themselves, but ate in a way which suggested their bodies were worth taking care of: “It made me a lot more aware of the quality of what I was eating. I think I use to eat just whatever. Not anymore. Now food nourishes my organs, not my heart.” (Stolzenberger et al., 2013 p. 35). This facilitated perspective on their relationship to food and hunger allowed participants to recognise habits that had contributed towards poor diet. Negative habits included opening the cupboards when they returned home from work, eating patterns around holidays, giving oneself celebratory meals, or using food to manage strong emotions. They described now being able to experience these situations without the need to eat (Lynch, 2016).

Several authors commented on the paradox of the attitudes towards thinking about food both pre- and post-surgery. To the outsider, participants' lives ‘revolved’ around eating and planning meals both pre- and post-surgery. The difference in whether this was perceived negatively or positively appeared related to whether participants felt in control of their cognitions and behaviours related to food and eating. Those who considered their WLS successful often viewed the surgery as a ‘tool’ that required their willingness to engage and work with it. Participants who maintained their weight loss emphasised their active participation in the process: “I have not lost weight because of the surgery. I have lost weight because of the lasting lifestyle changes I have managed to make” (‘Kristoffer’, pp. 9; Groven et al., 2015). This enhanced feelings of personal success and willpower.

Many participants simultaneously positioned the WLS both as a source of control which they aligned themselves with, as well as something they obeyed: “I need this superior person telling me what to do. I view the operation as a superior person, since the operation will make my bowel smaller, thus obliging me to eat less. It may sound strange, but somehow my stomach will set the limit.” (Engström & Forsberg, 2011, p. 6). For some in Lynch’s (2016) study, managing the ‘control’ imposed by the surgery resulted in them pushing boundaries and rebelling: ‘stretching’ the boundaries of what the stomach could accommodate, or grazing and ‘flushing’ foods through the stomach with fluid in order to eat more.

Those that had regained weight spoke about their lack of understanding of the permanence of the surgery, having expected the surgery to “do all the work” (Lynch, 2016 p. 241). Ogden et al. (2011) also found that participants who regained the weight expressed a desire for an external solution or source of control to address their difficulties managing their weight. Participants shared that the level of vigilance required to maintain post-surgery rules was also threatened over time by life circumstances beyond their control such as deaths and relationship breakdowns. This led to a relaxing of the ‘rules’ to varying degrees. Experiencing weight regain was almost ubiquitously connected with regret, shame and self-contempt (Natvik et al., 2014).

1.12.4. The Real Work

After the initial ‘honeymoon’ period where “no matter what you do, you will lose weight” (Lynch, 2016 p. 243), the physiological sensations of early satiety and the intolerance of high fat food faded, so that these foods became harder to avoid. Participants described anxiety over regaining weight and the struggle in maintaining the dramatic lifestyle changes in the absence of signals from the body. As a result, maintaining a sense of conscious control was a profound effort, particularly for those who experienced marked changes in life circumstances such as divorce or loss of significant friendships. Lynch (2016) discusses that this ‘real work’ included accepting their lowest post-surgery weight (i.e., abandoning the desire to lose more to reach an ‘ideal’ personal target), being able to tolerate small regains (e.g., a five to ten pound ‘bounce back’ from the very lowest weight) and addressing any minor weight gain beyond that through dietary changes.

However, living with profound embodied change created emotional tension and instability both internally and externally within relationships. Participants were able to see how much they had relied on food now that they were unable to use it to relieve stress and placate loneliness (LePage, 2010). Many participants recognised their underlying difficulties and went to therapy. Some participants struggled to find new ways to cope and developed difficulties with alcohol, drugs or spending. As one participant ‘Martin’ described, “I did start to substitute alcohol for food. But that got worse later on… I became an alcoholic… Post-surgery, I definitely transferred to alcohol ‘cos I couldn’t eat… It was easier and easier to drink to fulfil the need in me” (Ogden et al., 2011 p. 15).

Irrespective of weight loss, participants described the damaging impact of ideas around WLS as a ‘magic pill’ (Geraci et al., 2015, p.4) which made it difficult for them to feel understood by friends and family: “They do not realize that you cannot eat and drink at the same time or you can only eat 3 ounces of food at once. . .nobody talks about all that and all the working out and that you’ve been gutted like a fish. They just think you’re instantly skinny within a month... I do not know why people think it’s so easy… it’s harder actually. It’s life-long” (Geraci et al., 2015, p.4). Moreover, there was an intolerance for discussing the difficulties encountered by participants even within the WLS patient community. In Groven et al.’s (2010) study of patients who had developed difficulties following surgery, all participants had been part of online support groups in the first year, sharing their success as they lost weight, but left as problems with their surgery arose. Some participants had tried to discuss their ongoing pain, weight regain or complications but were told they were being ‘too negative’ (p. 10).

1.12.5. Stigma in the Health Sector

Papers focussing on unsuccessful surgery by Groven et al., (2015), Groven et al., (2010) and Ogden et al., (2011) described how severe complications and serious illness after WLS occurred as unanticipated disappointments that required considerable energy to manage and live with. Groven et al., (2010) described five previously healthy patients who qualified for surgery purely due to their BMI and unsuccessful previous weight loss attempts. Their development of chronic pain, nutritional deficiencies and vastly decreased quality of life following surgery raised questions about whether surgery was really effective in preventing future illness. Within several studies excess skin (which could only be removed through privately funded surgery) was also discussed as raising a new set of problems, resulting in ulcers and backpain. This left participants with a reduced quality of life and feelings of abandonment (Heidmann & Grønkjær, 2015).

Participants stated their fears both of a gradual decline into ill health or that their weight represented a ‘ticking time bomb’ (Groven et al., 2010, p. 6). Surgery for these participants represented a healthier, safer option than their previous weight loss attempts. Participants often described feeling their health was overshadowed by their weight within the health sector which resulted in dissatisfaction; “The only answer they give me is that if I lose weight my back will be fine. That’s my experience. And if I tell them that my arm is broken they say: lose weight and your arm will be fine. I have met that attitude both from physicians and other health care professionals” (Engström & Forsberg, 2011, p.5).

Following WLS, participants described their difficulty in having healthcare workers believe that they were suffering complications. A participant ‘Charlene’ described that her pain and fatigue was so severe she could no longer work or take care of her children. She was repeatedly told the pain was ‘all in her mind’ and offered only psychological support through the surgical team. It was only through the reinforcement of her account of her symptoms by her GP that she was able to have revision surgery, which discovered significant scar tissue. Removing this alleviated her pain and the tremors she had suffered (Groven et al., 2010).

Whereas women’s physical pain appeared to be overlooked almost as a result of stereotypical ‘female hysteria’, men were denigrated as lacking stereotypical male stoicism. Male participants who had experienced internal herniation repeatedly described the failure of medical staff to recognise the severity of their condition as emotionally scarring. Men shared that they felt reluctance to express the true intensity of their pain, but equally experienced derision from healthcare practitioners when they did. One participant ‘Sebastian’ described: “The first doctor I told you about... he just laughed at me. ‘‘You are supposed to have pain,’’ he said. Well… I can tolerate a lot of pain and manage it. Perhaps I did not manage to express how painful it really was. I recommend that everyone who experiences anything like that should roll around and play dead on the floor” (Groven et al., 2015, p. 7).

1.13. Summary of Findings

The qualitative data examining outcomes for bariatric surgery suggests that the transition between pre- and post- WLS generates numerous discrepancies in public and private life which appeared simultaneously painful and life-affirming. Post-surgery, individuals faced being visible in new ways, both physically and in terms of the relational roles they were able to fulfil. Some patients described a renewed sense of control over their preoccupation with food and overeating as their weight decreased. However, ongoing adherence to the post-surgery guidelines waned with the loss of physiological signals from the body and the emergence, or recognition of, emotional difficulties which had previously been managed by food. Some WLS patients faced the burden of problematic intestinal complications and excess skin from which they struggled to access, or were denied, adequate help from medical services.

Participants were able to create differentiated identities and find acceptance within their relationship networks as a result of their ‘normal’ body. However, for some this came at a cost. Participants also felt controlled by the physiological limitations imposed by their surgery at the same time as feeling psychologically ‘in control’ of their hunger. WLS therefore, involved substantial internal and external shifts in the physical experience of the world, with corresponding psychological changes. Issues of mind-body separation raised important questions around the interaction between mind and body and how this is mediated by the individuals lived context. This phenomenon deserves more attention.

1.14. Present Research Project

1.14.1. Approaches to the Body

Western-European psychology is founded on a separation between mind and body, exemplified by Descartes during the enlightenment period (Descartes & Kenny, 1984). Descartes asserted that the mind and the body are two distinct entities independent of one another. The conscious self and mind – the "I" or thinking substance – is distinct from the corporeal body, referred to as "me". In this paradigm, the body is external to our true self. Hence, the body is described in the context of ownership: It is described as 'my' body and I perform actions on 'it'. Cartesian dualism therefore, facilitates the privileging of the rational mind and concurrent devaluing of the body, which is constructed purely as a vehicle for the mind (McNay, 2013). In the case of WLS the rational mind, after battling with the body over its weight decides to correct the body through surgery.

However, the body is embedded within environmental and social relationships. As a result of the erosion of cultural scripts which, historically, would have largely determined our future, our bodies are now used reflexively to construct our identity, biography and future trajectory (through dress, gestures, exercise habits, hair colour, tattoos). Particularly within detraditionalised societies, the body has become a totem of the individual and their social group (Durkheim & Swain 2008; Gofman 2019). As a visible carrier of self-identity, the body is assimilated into the lifestyle decisions the person makes. The body cannot be merely accepted, fed and dressed according to a traditional custom. The body is a core and unescapable part of the reflexive project of self-identity (Crossley, 2006).

The body faces a multitude of choices and options, many of which carry moral value (e.g., veganism, hair coverings, 'modest' dress; Giddens, 1991; Trandis, 2018). Religious practices around food such as lent or Ramadan, which signify virtuosity and membership of religious orders, are also illustrations of selfhood and identity through bodily practices. Our bodies, self-identity and the social world (as well as the power structures within it) therefore, mutually shape each other. However, there is disagreement over the respective weight of each of these factors (Crossley, 2006).

In the study of obesity and WLS, researchers have differed in whether the alterations in the body and identity following surgery should be understood in terms of the individual's materiality (i.e., the changes to their physical form) or in terms of the person's altered position within social power structures. Nevertheless, consideration of these factors appears to be overlooked within WLS services with psychological services only intermittently requested by the MDT where it is felt necessary. This dualism is emphasised through the positioning of psychology as separate from the patient pathway, as opposed to offering routine assessments and interventions in the same way as surgeons or the dietetic team.

1.14.1.1 Phenomenological Approaches

Phenomenological approaches emphasise our lived experience of embodiment. They argue that, as we have the ability to reflect on our choices, we have the agency to make decisions about our own identity. In particular, Merleau-Ponty (1962; 2005) points to our relational existence as bodies and their directed actions on the world, highlighting our body as our primary means of experience. We both constantly find ourselves within the world whilst moving towards it and organising it in terms of modifying or maintaining our body in a certain way. Therefore, the body is relational in the sense that it is indivisible from its surroundings.

Inspired by this thinking, Leder (1990) describes the human body is a sensuous perception-action system which does not merely perceive and act in the world but defines its own environment by way of its own perception and action. Under normal conditions this system is largely invisible to itself: It is 'pre-reflexive'. We have sensations but we do not experience the sensations themselves. Rather by way of sensations we experience the world around us. Thus, the sensuous structure of the world is intentional. Embodied consciousness offers a world, but when we focus on our surroundings we put ourselves out of focus. Leder (1990) proposes this foregrounding/backgrounding action of the body makes us aware of the body through its dysfunction. Bodily "dys-appearance" describes when our increased body focus is directed toward a dysfunctional state as a result of pain or when the body is unable to perform in the individual's desired project (Leder, 1990, p. 86).

Increased body focus is particularly relevant to WLS. When pain occurs as a result of a WLS patient becoming full, the body immediately shows its presence and demands the individual's full attention. However, participants differed in their responses to their increased awareness of the body and their experiences of distress as a result of its interruptions. Some participants reported high levels of distress, others suggested that they were concerned over losing sensations from the body as these seemed to re-enforce feelings of control.

1.14.1.2 Discursive Approaches

In contrast to phenomenologists, discursive researchers argue that the way individuals relate to and modify their body reflects the pervasive influence of society. Our bodies are discursive in the way that they both reflect and express context-dependent ideologies, but at the same time, are constrained by the ideals, meanings and identities available within that culture. As demonstrated in Engström and Forsberg (2011), as people lost weight, they were able to shop at 'normal' shops, feel listened to at work and blend in with the crowd. The individual was able to experience editorial control over how they were perceived (e.g., choosing to stand out for a colour they chose rather than simply being 'big'). This suggests that large bodies are viewed through a lens of stereotype whereas more slender ones are seen as individuals.

Foucault's (1977) account of 'body power' describes how the architecture of power in modern society is no longer a visible threat but is the method by which society operates to separate the mass into individuals. This renders each individual distinct and accountable. It is our own sense of being watched that constrains our behaviour, we are the subject of our own internalised structures of social control (Foucault 1977). Feedback on the self and body are relayed to the agent in their interactions with others. Feedback on our bodies and our comparative success in maintaining them to a social standard is prolific within society: ten-thousand steps a day, two thousand calories, dress sizes, BMI cut-offs, aeroplane seats. We achieve the sense of our body with comparison with others: Our embodied self-derives from our social life and experience. As such, we experience our bodies and tend to respond to it as others do and judge our bodies before others do, often more harshly (Bartky, 2015).

A Foucauldian analysis of discourses within periodicals by Drew (2011) found that WLS was characterised as risky, needless, selfish extravagant and lazy, framing it as an unnecessary risk. As a consequence, WLS patients are seen to deviate from social conventions in two ways: their bodies are not considered ‘normal’ (weight), and they do not alter their bodies by what may be termed ‘appropriate’ means. Throsby (2009) suggests that, in Foucauldian terms, WLS serves a confessional role, offering inclusion through corrective action. Throsby (2009) also suggests that the obese body is pathologised irrespective of its health status, function or perceived illness. Rather, it is defined by BMI, as a legitimate object for treatment, as if a high BMI were a disease in its own right. The management of body weight is therefore, considered a moral responsibility for all, irrespective of the means (Herndon, 2005).

The politicisation and discrimination of the body is salient to Crenshaw’s (1990) concept of intersectionality. Intersectionality describes a framework for understanding how aspects of an individual’s social and political identities (gender, race, age, height, etc) may combine to create unique modes of discrimination. Obesity is often heralded as the ‘last acceptable form of prejudice’ (Evans et al., 2011). At the same time obesity is also more present in disadvantaged groups (e.g., those who are non-white or of lower social-economic status), thereby legitimising discrimination of these groups (Hunger et al., 2015). As Hofmann (2013) points out, WLS is often framed as an effective prevention of health problems and a way to improve the wellbeing of a vulnerable group, but it might also be understood as a symptom-oriented medicalisation of appearance, a politicisation of the body and/or a legitimisation of cultural prejudices related to obesity.

1.14.2. Focus of the Research

As we have seen, individuals undergoing WLS are socially embedded in relationships which shape them reflexively. Mead (1967) describes how our practices on the body (washing, dressing, brushing teeth) are developmentally adopted. In the same way that young children imitate authority figures, such as parents and teachers in play, as self-aware adults we make decisions by internalising the voices of ‘others’ who communicate ‘the rules’ we live by. We are socialised towards certain patterns of eating including when, how much to eat, what to eat and under which circumstances by our caretakers. In addition to environmental factors such as availability of food options (Birch et al., 2007; Boswell et al. 2018), processed foods which include high levels of salt, sugar, fat and additive ingredients are also (often deliberately) designed to encourage the individuals desire to overeat by triggering the reward system of the brain (Ifland et al., 2012; Kahan & Mehrzad, 2020). Over-eating and use as food as a reward (particularly where parents feel there are limited alternatives available to reward their children) can be influenced by these developmental processes (Savage et al., 2007; Yee et al., 2017).

The internal 'voices' of authority do not necessarily subordinate the individual: they are conversations which allow us to reflect on multiple courses of action and are moderated by other aspects of our intersectionality (Crossley, 2006). In a recent systematic review of experimental approaches to modifying children's eating behaviour, although nutritional information and provision of fresh fruit in school showed long-term improvements in eating behaviour, the effects appeared weaker than more 'hands on' approaches such as gardening and cookery programmes (DeCosta et al., 2017). It has been hypothesised that more experiential approaches such as gardening allow children to challenge problematic developmentally acquired internal 'voices' regarding eating patterns and choices in a more holistic, multifaceted, reflexive way than education alone (Parmer et al., 2009).

Supporting individuals in the development of self-reflexivity and subsequently shifting behaviours in a valued direction is central to psychological practice (Kashima et al., 2004; Slaney et al., 2019). The subject of this study is the significant factors and mechanisms by which WLS patients negotiate these poly-vocal internal dialogues (determined by other aspects of intersectionality) and how this has shaped both the outcome and their perspectives on the practice of WLS.

1.15. Research Questions

This study aimed to examine the extent to which our identity comes from our body and social response to it following WLS: Can we choose our identities by changing our bodies? The exploration of this topic was guided by the following questions:

1) How do post WLS individuals negotiate having been overweight and subsequently post-WLS in a society which stigmatises both groups?
2) To what extent do post-WLS individuals consider themselves ‘normalised’ and ‘in-control’ of their bodies or their identity as a result of their surgery?
3) How do post WLS individuals negotiate changes in their social circles in response to their changing bodies?

CHAPTER 2: METHOD

2.1. Overview

This section will outline the research methods and epistemological position employed for this thesis project. The rationale for a qualitative methodology, the recruitment of participants and ethical considerations will be discussed.

2.2. Epistemological considerations

The study adopts a critical realist ontological position. The philosophical approach of critical realism was developed to address the limitations of positivism (only recognising what can be scientifically verified or mathematically proven) and relativism (arguing that since human beings are reflexive, scientific methods are inappropriate for the study of society) (Bhaskar, 1975,1989). Critical realism advances that the structures, practices and matter that makes up our reality exists independently of whether those entities or their effects are observable, known or understood by humans (Bhaskar, 1975). It asserts that, while there is a ‘real’ world, it is not directly accessible. Individual experience is instead mediated by sociocultural context which includes political and historical context.

A central tenet of critical realism is that findings that appear to be truthful are determined and linked through discussion and debate on a rational basis (Bhaskar, 1998). Therefore, critical realism avoids the trap of relativism, which holds that all beliefs are of equal truth value, while emphasising that knowledge is socially created. It is a position that asserts science should focus on the underlying causal relationships that are, or potentially are, involved in generating phenomena (which may not be reducible to their principle parts). In relation to the body, the position is that, although each individual is ultimately comprised of an organic system, cultural context will materially inform our social experiences and health outcomes.

A critical realist position is particularly relevant to the study of the impact of WLS as it is not possible to conceptualise and account for experiences of WLS without acknowledging both the physical reality of the body (having excess skin, physically weighing less or more than others, etc.) and the social processes that frame and limit a person's identity (e.g., media images that portray thin people as active and desirable and overweight people as sedentary and undesirable; Puhl et al., 2010). It is acknowledged that the research produced in this thesis is a culmination of both the data gathered and "beyond the text" (Harper, 2012, p.89). Hence, this research is only one representation of an underlying reality. Although the reality described exists for participants, the theories and methods employed to investigate the experience of WLS are shaped by pre-existing socio-cultural assumptions and practices (Pilgrim & Bentall, 1999).

2.3. A Qualitative Approach

While some positivist researchers may assert that quantitative methods are more objective, they can potentially obfuscate the multiplicity of human experience by reducing it to discrete variables. Methods of modifying bodily appearance and attitudes towards the body are highly variable by culture and intersectional position. If research within this area of psychology is to be useful it will need to identify what works for whom. Qualitative methods appear well-suited to this task.

Studies of the experiences of people who have undergone WLS in the UK are lacking. Existing literature identified by the researcher suggests that, although research has been generated by other Western countries offering valuable insights, (predominantly the United States and Norway), the UK arguably has its own set of contextual values and cultural idiosyncrasies. A UK understanding of WLS experience is particularly important given the UK is estimated to have one of the highest levels of obesity in Europe (World Health Organisation, 2013)

2.4. Thematic Analysis

Thematic analysis (TA) is defined as a *method* (rather than a methodology) “for identifying, analysing and interpreting patterned meanings or themes” (Braun et al., 2015, p. 95). TA is not linked to, nor grounded in a particular theoretical framework, thereby offering flexibility. The flexibility of TA facilitates a detailed exploration of the meaning that a participant brings to their experiences and is consistent with a critical realist epistemology (Nowell et al., 2017). TA is also well-suited for identifying patterns within heterogeneous data, which it was anticipated would emerge from the interviews (Braun & Clarke, 2006).

This approach has also been employed by research articles on people with obesity’s experiences, expectations and beliefs about WLS (Cain et al., 2017; De Brun et al., 2014; Mold & Forbes, 2013; Ogden & Clementi, 2010; Tarrant et al., 2017). It has also been used to explore people’s feeling towards their own appearance and the impact this has on their social interactions, relationships and identities (Frith & Gleeson, 2004; Silver et al., 2010). TA’s demonstrated utility, particularly in the exploration of highly contentious, value-laden topics such as obesity, is due to its ability not only to work with the explicit content of the data gathered, but to also integrate more implied or inferred meaning around the issues raised (Joffe, 2012; Willig, 2013). Attendance to broader, context-driven social constructs within individual accounts was considered crucial given that only one paper was identified as examining long-term experiences of life following WLS in the UK.

Interpretive Phenomenological Analysis (IPA) and Discourse Analysis (DA) were also considered. They were however, decided against, for several reasons. The first was that IPA (or variations on phenomenological analysis) have already been utilised in previous research in this area (e.g. Ogden et al., 2011). Although both IPA and DA are well suited to the research aim and questions concerning embodied aspects of WLS and discourses of societal power and discrimination faced by people who undergo WLS respectively, neither offered the same theoretical flexibility of TA. TA has been criticised by some researchers for being ‘unsophisticated’ in comparison to other qualitative approaches. However, this perhaps reflects some researchers’ application of TA rather that the method itself. To counter this, reflexivity in the process of analysis, in line with Braun and Clarke’s (2006) 15-point checklist for good thematic analysis, has been employed to ensure the integrity of the data and its reporting.

For the purposes of this study, the interest was primarily in examining how people who had undergone WLS considered their own identity in the context of societal stigma around individuals of higher weight and WLS. The aim was to be authentic to the ideas generated rather than to suggest explanations. This meant allowing meanings to emerge from an experience rather than narrow down a `truth' (Spence, 1982).

2.5. Recruitment Site and Participant Identification

Recruitment was conducted from a hospital within London offering gastric sleeve and bypass operations to adults over the age of 18. Referrals were typically received by the service from GPs and could be made from across the UK. The decision to accept referrals was made by a multidisciplinary team of surgeons, dieticians, specialist nurse-practitioners and psychologists.

As part of the patient pathway, patients were routinely asked whether they would be happy to be contacted regarding future research. Those that had indicated they would be happy to be contacted were contacted over the phone by the researcher. Purposive sampling of people who met the inclusion criteria (detailed below) was employed. Potential participants who indicated over the phone that they would be happy to receive more information about the study were sent a copy of an information sheet outlining the details of the study and asked to respond if they were interested (Appendix D). Those who wished to be interviewed were asked for informed written consent (Appendix E).

The researcher was working within the department at the time of recruitment and discussed the project within a team meeting. The researcher made clinicians aware of the inclusion and exclusion criteria and welcomed any suggestions of potential participants.

The desired sample size of approximately ten was determined based on the number of participants within interview-based studies identified the scoping review which ranged from five to 22 participants. Guest et al. (2006) discusses guidelines for when ‘saturation’ (when all of the key variants of the phenomenon have been identified and combined into the emerging theory) has been acheived. In their study involving 80 interviews Guest et al. (2006) found a majority of themes were identified from the first six interviews. A further 20 themes were identified from between seven and 12 interviews, with subsequent interviews yielding very little beyond that. Another study by Ando et al. (2014) found that 12 interviews provided all themes and the majority codes, although the vast majority of codes were identified in the first six.

This suggests, although 12 interviews may be optimal, six will provide almost as many codes. More than ten participants may have been beneficial, however, given the time and resource constraints (largely as a result of the length of time required to obtain NHS ethics and hospital site approval) it was hoped that approximately ten would be sufficient to reach theoretical saturation and that carrying out further interviews would incur diminishing returns (Guest et al., 2006).

2.6. Inclusion and exclusion criteria

Has undergone bariatric surgery over two years ago
Research has suggested that a majority of participants who do not experience complications following surgery experience rapid weight loss within the first 12-18 months, often described as the ‘honeymoon’ period. However, the long-term durability of weight loss is uncertain and a substantial proportion of individuals begin to regain lost weight or struggle with the idea that they are no longer within the enjoyable ‘honeymoon’ period of transition, instead facing the rest of their lives at their current weight or higher (Ogden et al., 2006).

Able to understand the information sheet provided in English and can consent to participation

*T*he study information, consent forms and interviews were carried out in English. Participants were thus required to be able to retain and understand information presented to them in English. It is also a requirement for the analysis of qualitative data that participants are able to select language which accurately expresses their desired meaning.

As some significant period of time had passed since undergoing WLS it was important that potential participants' social and mental state was relatively settled so as not to cause additional distress. In discussion with the field supervisor prior to ethics application, the following groups were excluded:

- Patients at high risk (this included patients who were a high risk to themselves or others who were more appropriate for emergency services, had complex needs requiring key working and a Care Plan Approach or whose mental state was adversely affected by delusions or hallucinations).
- Patients with a primary diagnosis of dementia
- Patients who had experienced a significant life stressor in the past three months. This was discussed with the field supervisor of the project as a general rule of thumb, purely to avoid exacerbating existing stressors within the patient's life. However, during recruitment where it was identified by a clinician that a potential participant may still be recovering from a significant life stressor (e.g. death, divorce) beyond three months these participants were not actively approached.

2.7. Procedure

2.7.1. Refining the interview schedule

Data was collected between August and October 2019. Based on previous research, an interview schedule was developed covering five focus areas: 1) motivation and expectations of surgery; 2) experiences of physical appearance; 3) social relations; 4) changes in physical wellbeing 5) experiences of support.

The content of the interview was discussed informally with members of the WLS support group which was held monthly within the hospital site. The group is facilitated by a clinician within the team (nurse, dietician or psychologist) and any patient of the department who has had the surgery can voluntarily attend. The groups are patient-led and participants will typically raise issues or problems that they wish to discuss with other patients or to gain more information from the clinical staff. No one who was consulted in the group was subsequently interviewed as all attendees at that time were slightly below two years post-surgery. Patients remarked that this was an important area of research as there had been significant changes in their self-perception and relationship with others since their surgeries for which they had not been prepared.

2.7.2. Recruitment Process

Those that had indicated they would be happy to be contacted for the purposes of research were contacted over the phone. Clinicians within the service (dieticians and nurse-practitioners) also offered participation leaflets in routine clinical appointments if the patient expressed that they were interested in participating and gave verbal consent to be contacted by the researcher. The researcher then made a call to the potential participant to provide more detailed information, answer any questions and arrange an interview.

2.7.3. Interviews

Participants were invited to attend an interview within the University of East London or the hospital building or alternatively to conduct the interview over the phone. Issues of safety were considered: All interviews took place within working hours and a member of staff was made aware that the interview was being carried out. Signed consent was sought for participation and for the interviews to be recorded and stored. All participants were asked to sign and return a consent form before commencement of the interview. Demographic data on participant age, gender and ethnicity was collected. Nine individual face-to-face interviews were conducted lasting between 55 and 97 minutes. All interviews were audio recorded on a digital Dictaphone and then transcribed.

Participants were debriefed about their experience of the interview and reminded of their right to withdraw consent for the interview to be included in the project within the next month. Further sources of information and support were provided. All participants were offered and subsequently requested to be sent a summary of the thesis when it was completed.

2.8. Ethical Considerations

2.8.1. Ethical approval

This study received full ethical approval from the Health Research Authority Research Ethics Committee on the 12th June 2019 (Appendix G). The NHS Research and Development Department within the hospital from which participants would be recruited approved the study on 30th July 2019 (Appendix H).

2.8.2. Informed Consent

All participants were given a minimum of a week to consider their involvement in the research. It was emphasised to all participants that their involvement in the study would not affect their treatment within the department and that the content of the interview would not be shared.

Participants were provided with and information sheet (Appendix D) which comprised a full description of the study including information that might impact their decision to participate (such as the emotional impact of the interview). There was no deception involved. The information sheet also outlined the procedures for maintaining anonymity and confidentiality. Contact details of the researcher and field supervisor were provided for queries as well as information on independent organisations which could address any concerns or complaints.

Participants were asked to complete a consent form (Appendix E) prior to the interview. This included a statement of the participant understanding the information given to them, what they were being asked to do and for the interviews to be recorded. A statement of the participant’s right to withdraw from the research at any time without impact on their care was included.

2.8.3. Confidentiality and Anonymity

Confidentiality of participant data was be ensured at every stage of the research process. Participants were made aware that verbatim extracts from interviews may be used in the final report and subsequent publications. Confidentiality was explained prior to interview both verbally and in writing within the consent statement. Limits to confidentiality such as the legal obligation to disclose active risk to the participant, known others or the wider public to the relevant organisations (e.g. the police, social services) was discussed.

Anonymity was ensured by using participant codes and keeping identifiable information separate from data. Interviews were transcribed into word documents without any identifiable information to protect participants' identities. Files generated were password protected and encrypted and stored on a password protected, encrypted e-drive within the university.

2.8.4. Disclosure of Risk

Upon review of the literature and the researcher’s previous clinical work in this area, it was anticipated that individuals who had undergone WLS may find the interview distressing. Individuals who have struggled with their weight are likely to have experienced long-term discrimination, may have experienced the end of valued relationships, or have been unable to conceive or to play with their children as a result of their weight (Ogden et al., 2006).

The researcher discussed the possibility that they may find some of the questions aversive and the participant had the right not to answer questions if they felt uncomfortable. The researcher also stated they could offer signposting to local support groups, charities and further sources of psychotherapeutic support where necessary. Participants were also encouraged to speak to their clinician within the surgical team if they felt they would benefit from more space to talk outside of the interview. No participants responded that they would like further information on nor required further support.

2.8.5. Withdrawing Data

Participants were informed of their right to withdraw data within one month of interview both before and after the interview. It was re-iterated that there was no compulsion to take part in the study. It was communicated verbally and in writing that recordings would be deleted immediately following examination (September 2020). All other data (participant names, emails, consent forms and anonymised transcripts) would be stored for a maximum of three years following which all confidential data would be destroyed.

2.9. Participant Characteristics

Nine interviews were conducted in line with recommendations regarding data saturation (Guest et al., 2006). Data was collected between August and October 2019 with interviews lasting between 55-97 minutes. The interviewees comprised seven females and two males aging between 31 and 66 (mean 46.4). Participants were from a range of ethnic backgrounds. All participants had undergone either a gastric bypass or gastric sleeve operation between 24 and 204 months prior to interview (mean 60.4).

Table 2: Characteristics of participants

No.	Gender	Age	Ethnicity	Months Since Surgery	Maintained/ Regained
1	F	33	White Other (Polish)	24	Maintained
2	F	66	White Other (Irish)	71	Regained
3	F	43	White British	38	Maintained
4	F	48	White British	62	Maintained
5	F	55	White British	26	Maintained
6	M	63	White British	211	Regained
7	F	31	Black African (Kenyan)	36	Regained
8	M	38	British Other (Jewish)	24	Maintained
9	F	41	White British	52	Maintained

Many studies within the area of WLS (arbitrarily) define success as a percentage of excess weight lost. These static definitions may not reflect the subjective experience of the individual. However, whether weight was initially lost or whether that loss had been maintained was likely to have significant impact on the patient's identity. Weight loss was roughly summarised as being 'maintained' following surgery (often with a minor regain of around ten kilograms) or 'regained' if participants reported regain which was more significant.

2.10. Analytic Approach

2.10.1. Transcription

Interviews were audio-recorded and transcribed by the researcher with an orthographic focus. Punctuation can alter the meaning of data (Poland, 2002) therefore, consideration was given in producing the transcript in order to stay true to the meaning of the verbal account. The notation system used can be found in Appendix I. All transcriptions were anonymised with any identifiable information removed. An exploratory, data-driven approach was taken to identifying themes. These were discussed and guided by the internal supervisor within the University of East London at all stages of the analysis.

2.10.2. Analysis

The analysis followed Braun and Clarke's (2006) six stages comprising: familiarisation with data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. Transcripts were read several times to develop familiarisation with the accounts. Codes – described as "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998, p.63) – were subsequently identified. The coding frame created included both inductive codes from the raw data and theory-led codes informed by the literature. As the objective of the study was for the results of the analysis to be 'data-driven' the data set was then coded systematically. The list of codes generated is presented in Appendix J. Some extracts received multiple codes. A coded extract is included in Appendix K.

Themes were built from codes through a fluid process of reflection and revision. A theme is defined by Braun and Clarke (2006) as something which ‘captures something important about the data in relation to the research question’ (p. 82). The relevant codes were collated with data extracts in spider diagrams and discussed with the project supervisor. These diagrams were then used to group codes and potential themes to form subordinate and superordinate themes (Braun & Clarke, 2006). An initial thematic map was created (Appendix L). These themes were then assessed for internal homogeneity and external heterogeneity within supervision for the thesis. They were reviewed to ensure they represented and were meaningful to the entire dataset (Patton, 1990).

CHAPTER 3: RESULTS

3.1. Overview

This chapter will present the results of the analysis. An overall thematic map with themes and sub themes will be presented before being discussed in more detail using examples from the data.

3.2. Thematic Map

In total three themes and seven subthemes were identified. A summary of these themes is presented in Table 3.

Table 3: Summary of themes and subthemes

Superordinate Themes	**Subordinate Themes**
A Life Worth Risking	Medical Certainty
	Entitlement
	Going it Alone
Battling the Body	Physical Warfare
	Powerful Allies
Search for Belonging	Finding Ways to Cope
	The Meta Perspective

3.3. Themes

3.3.1. Theme One: A Life Worth Risking

Within the medical context participants were met with arguments that framed their bodies as facing immediate risk, despite most participants not experiencing health problems. Confronted by the risks of the surgery, participants were brought to consider what their life meant and how much they were willing to give up their present life for the possibility of a new one. Despite the medical opinion that their weight would be life-threatening, participants described resistance from family members to having an ‘elective surgery’. Participants themselves battled with moralistic arguments around personal ‘entitlement’ to surgery which they weighed against social narratives of personal responsibility which deemed them not worthy of the intervention. This divisive decision, along with physical changes and the rarity of the procedure caused participants to feel alone in their undertaking.

3.3.1.1. Subtheme One: Medical Certainty

Participants described their interactions with medical professionals as significant in their decision to undergo surgery. The participants highlighted how prior to these discussions, although they had continually tried to lose weight, they viewed WLS as high risk and considered it unnecessary, given that most had no weight-related health problems. Medical professionals, however, framed the risk of living in their body as immediate:

> “’you know when you signed the consent for your gallbladder to be removed did you think about the risks?’ And I was like ‘no I just had to stop the attacks’ and he said ‘well this is a risk’” (Participant 2)

> “I remember the surgeon said to me ‘you know why have you not considered weight loss surgery?’ and I said ‘because it’s too dangerous’ and he said to me ‘do you not think you’re not risking your life everyday living like you are?’ and I never looked at it like that.” (Participant 4)

Participant 4 was told by a surgeon “the trouble with you is that your body doesn’t know its fat, you don’t have diabetes, you don’t have high blood pressure, you don’t have any weight related issues”. However, he warned “one day you will just hit a brick wall”. This implied that although her body showed no markers for illness, the participant would one day suddenly experience severe consequences without warning. In this way, the knowledge of medical professionals was positioned as more significant than both objective measures of blood pressure and the participants own subjective experience. Through this, participants were brought to view their bodies as posing an uncertain risk, rather than simply “day to day living, you just get through the day” (Participant 4).

Some participants also looked to relatives who had developed health problems and considered following in their footsteps almost inevitable:

> "I think my main driver was that my mum has been clinically obese for probably you know her whole adult life or the vast majority of it and she has diabetes now and a whole host of medical conditions and I think I was just concerned that I was gonna be heading in the same direction" (Participant 8)

Other participants who experienced health problems consistently received the message that these would be improved by reducing their weight:

> "I would go complaining about something and then they would send me to some specialist somewhere and then it would turn out it was something big I was scared of the surprises (.) and all of them would be like 'maybe if you lost a bit of weight' it felt like if I lost weight it wouldn't be too much pressure on my bones" (Participant 7)

Participants described how they were aware of the immediate risk of complications or death from surgery and struggled to weigh this against long-term risk of being higher weight. There appeared to be a point where these potential negatives had to be 'switched off' or 'detached from' in order to go through with the surgery.

> "…you know I was very, very, scared of the consequences of the surgery. I didn't do any reading around it…yeah cos if I need an emergency op because I'd had a road accident […] I wouldn't have time to look it up would I?" (Participant 2)

The internal dialogue around whether to have WLS, similar to several other participants, appears to consist of arguments against the dominant medical narratives about the risk obesity posed to long term health against the lived experience of a relatively fulfilling life and few health problems (for a majority of participants). Arguments against this medical narrative, participants appear to recognise at one stage or another, cannot be won on the basis of their experience of the absence of illness, but only succumbed to. This also reflects inherent biases in the epistemological value society places on data such as the RCTs informing surgery, over the lived experience of those who undergo it.

Several participants commented on their perception of the risk of surgery, believing it to be between 25-50% risk of mortality at the time. One participant explained that this risk was worth taking given the quality of life they experienced socially, emotionally and physically prior to surgery. Prior to surgery they could barely walk two paces, were contemplating using a wheelchair and feared greater dependence on their spouse. Another participant, a mother with a young child, reasoned that at her weight before surgery the child would not have an adequate parent- a role which she described as the most important to her self-worth. The breadth of reasons given for undertaking the risks of surgery further highlight that 'superficial' weight-loss is not necessarily the most important outcome for participants, rather, the ability to perform well in valued aspects of their intersectional identity and relational roles.

Post-surgery participants continued to worry about the long-term effects of the surgery and battled with the 'known-unknowns' of the surgery and whether they had made the right choice:

> "you never really know what the long term effects are going to be off surgery you know there might be […] other long term effects that they haven't realised yet you know so I feel like I may be helping myself on one had but I may I may be shortening my life for other reasons that we don't know yet you know?" (Participant 8)

3.3.1.2. Subtheme Two: Entitlement

Participants not only negotiated the medical risks of surgery, but also moralistic arguments around responsibility and entitlement to surgery which they had been informed was necessary. Whether participants therefore, 'deserved' NHS resources was intimately linked to their evaluations of their character lacking the 'fortitude' (Participant 8) to lose weight themselves, resulting in feelings of shame and guilt:

> “but the guilt side of it, you know it’s absolutely embedded isn’t it that everything you hear is always about wasting NHS money” (Participant 2)

> “I was a bit ashamed turn to a surgical solution, that everybody else I thought didn’t have a problem with I’ve since come to realise that people can have loads of different problems with food. But at the time I thought ‘it’s me’ I’ve since come to realise as well, I’m a very depressive personality and I sort of turned it in on myself saying ‘you shouldn’t’ve let yourself get to this stage’” (Participant 5)

> “Oh, yes, because deep down, deep down, deep down in my deep psyche I think I (.) I probably still think it’s all my fault.” (Participant 2)

Questions over entitlement to a publicly funded surgery also linked to participants’ awareness of public attitudes towards their bodies. Systematic exclusion often stemmed from childhood with several participants describing being excluded from children’s games and not being picked for sports teams because “unless you were a great athlete […] they weren’t interested and they would humiliate you and they would send you on cross country runs” (Participant 5). This continued into adulthood through the discrimination and dehumanising treatment they received on a regular basis. Participant 5 described how men in the pub would feel entitled to grab his stomach and referred to him only as ‘big fella’. Participant 4 similarly states;

> “You know I walked into a shop one day and I was told that […] I wouldn’t be able to buy anything in there so what was the point in coming in? People are cruel so I wanted to be normal” (Participant 4)

This participant highlights how their weight appeared to exclude them from their right to ‘normal’ aspects of public life. This participant in this instance was not entitled to browse a shop and make her own decision about whether or not to buy anything, but actively asked to leave. There is also the assumption of this shop keeper that the participant is there to buy something for themselves, rather than for someone else. It unclear whether this assumption would have been made in the respect of other population demographics (e.g. a male entering a female clothing store). WLS appeared to offer the potential to ‘normalise’ the participant and allow them greater experiential access to ‘normal’ life and identity.

The stigma within society towards individuals with obesity was also extended to those who underwent this surgery as “easy fix” (Participant 3). The participants highlight the interaction of public opinion of WLS (and to an extent, their own) as a selfish, lazy, needless act. Participant 3 discusses her decision not to tell parents at her children’s school about her surgery:

> “when I looked up gastric bands and things like that that it was like a cheating way out and people would’ve said ‘oh it’s an easy way, you’re just, you’re lazy’” (Participant 3)

The theme of entitlement to surgery was particularly salient for two mothers within the sample who described the importance of meeting their children’s needs came before everything else. They saw surgery as a ‘selfish’ (Participant 3) act incongruent with motherhood, but one that was perhaps necessary in the long term to give their children the best mother possible. Participant 3 raised how her caring for her children’s bodies took precedence over her own, at the price of her own wellbeing:

> “I think you spend so much time thinking about what the kids should be eating, what they shouldn’t be eating, when they should be eating, that you kind of forget about what you should be doing for yourself in that time” (Participant 3)

This meant that the prospect of undergoing WLS posed an interruption of the identity of mother who put their children first:

> “I think I had almost put it in the same category as going to have a boob job […], so I felt like because I’ve got 4 amazing kids I was almost being really selfish to decide to do it” (Participant 3)

The lack of entitlement to WLS is further developed by this participant by framing it as comparable to a “boob job” locating a potentially life-saving surgery in the same category as a cosmetic procedure (although not all breast enhancement/reduction surgery is cosmetic), with implied connotations of being unnecessary and wasteful. This was at odds with discussions with medical professionals who warned them of potentially fatal consequences if they did not have the surgery. This perception of WLS as ‘cosmetic’ despite the long-term risks was felt to be pervasive throughout society. Following surgery one participant described a nurse who had been teaching her how to inject herself with blood thinner:

> “I was struggling with it and she looked at me and said, ‘you were trying to make yourself look beautiful so why are you afraid of doing this now if you want to look beautiful?’” (Participant 7)

By positioning WLS as a cosmetic procedure, people with obesity who undergo this surgery are seen as confirming cultural prejudices which regard obese people as deficient or lazy. This participant described that this interaction convinced her not to share her surgery with others:

> “I was being attacked for it so if I take it out of here and this is like almost like a safeish place I will get the same treatment out there so I decided to keep it to myself” (Participant 7)

3.3.1.3. Subtheme Three: Going it Alone

‘Going it Alone’ described the way in which the decision to undergo WLS, subsequent alterations in physical appearance and ability to tolerate food caused rifts between the individual and their relational network. In undergoing WLS, over half of participants expressed some indication that they had gone against their families’ wishes to have the surgery and often kept the surgery secret from friends. This caused additional stress in terms of feeling that they had done something ‘selfish’ (Participant 3) rather than having a ‘lifesaving’ operation and contributed to a feeling of aloneness following surgery.

> “Literally my husband was against my surgery he was like ‘no, no, no’ and I told him ‘I make my decision, this is my life and you will be with me or there is the door you can go and never come back because this is my life and I do that to have healthy life.” (Participant 1)

> “my mum was obviously really worried the same sort of way my husband was but was very supportive. But again, it’s like ‘you’ve got to have major surgery, you’re electing to do that and you’re not being told you have to have this otherwise this is gonna happen you know um, that its, it’s difficult” (Participant 3)

Participants were faced with moving away from the relational roles they enacted previously as a result of the decision to have surgery and the subsequent physiological changes. Participants found themselves unable to join social events in the way they had previously:

> “... I’m Jewish and there is basically a Christmas dinner every Friday night and tonnes of festivals throughout the year which everything revolves around food the new year that I had last week and I went to my sister for a festive meal with my family and […] I hadn’t really over eaten but basically the types of stuff that I was eating I had the worst I suppose dumping syndrome […] that I have had in a very long time I just felt so ill and that basically destroyed the meal for me […] I mean in that example I just gave you in the past I would have been a big part of the conversation and I’d be very active at that meal eating and socialising and if I am feeling so ill like I did that’s me kind of gone.” (Participant 8)

The post-surgery period was challenging for all participants: three suffered complications and attended accident and emergency but found staff ill-equipped to deal with the procedures they had had. One participant had no one to call at Christmas despite being in extreme pain:

> “there was no one. Everyone was on holiday and that was one of my worst experiences when I was in so much pain like maybe not a month after, a few

> weeks after I was in so much pain and I phoned and I think the nurse is on holiday […] and that when I realised I was alone in this” (Participant 7)

A majority of participants had not met anyone who had undergone the surgery and were left to negotiate the symptoms alone:

> “any time I had anything that wasn’t liquid I just vomited and for the first 6 weeks I thought that was how it worked I was carrying round a bucket and vomiting all the time and its 2002 and I hadn’t ever met anyone who’s had a bariatric surgery” (Participant 5)

Many aspects of the process – the restrictive post-surgery diet, changes in tastes and at a later stage weight regain – were difficult for participants to communicate to the people closest to them:

> “everybody you have spoken to even my best friend who I have explained it to does not understand why I have not gone into a normal weight” (Participant 2)

Overall the WLS journey often appeared to be a lonely experience, with family members positioned as critical observers rather than active support. Participant 7 describes that her weight is a divisive matter between her and her family:

> “when I lost so much weight uh, it became almost an issue and when I put on all my weight again it’s become an issue again” (Participant 7)

With weight loss came an alteration in power dynamics, particularly for women within the sample, which caused further pressure or rifts in relationships. Participant 3 describes how her partner appeared more jealous than he had been prior to surgery:

> “I think um, my husband definitely, he, it’s a positive and a negative with him I think cos he is very pleased that I have lost the weight and that I’m healthier, but also I think it’s made him a bit insecure because he assumes that everybody thinks I look amazing and obviously everybody doesn’t, but like he would be a little bit insecure if I was out with my friends um, because he’d be

> like ‘oh you’d be […] being chatted up in the pub’ or whatever and I’d be like ‘no’ never did that before” (Participant 3)

Participant 1 describes the shift in power which contributed to the end of her marriage. Participant 1 reflects on her feelings that her husband possibly been trying to control her by keeping her trapped in a higher weight body:

> “he was like buying me sweets and things like that and he was like taking one and he, he just feed me and feed me and put me more and more. Maybe it was his own thing that he wanna keep me at home? For himself?” (Participant 1)

WLS served as emancipatory for several women in relationships, which with hindsight they reflected had been unhealthy or unhelpful. These women reflected that issues relating to their weight had often brought them to and maintained relationships which were emotionally unsupportive.

> “he used to come in and he would eat his dinner and then he would go upstairs and play his music and I would be sitting downstairs alone and I would get a packet of crisps out or a bar of chocolate but I didn’t realise that I didn’t want that food” (Participant 6)

This participant describes the end of a relationship where both partners had lost weight through WLS having both experienced obesity:

> “I had tried to break off the relationship a couple of years before and it just never stuck I think so is it because of the surgery I think it was an inevitable thing and I think finally because he got the confidence that he needed to actually break up with me” (Participant 9)

This highlights the interplay between societal stigma in the intimate relationships of higher weight individuals. This suggests that owing to poorer self-perception as a result of stigma, participants (particularly female participants) selected partners which matched their low estimation of their self-worth, which created a re-enforcing cycle. Another participant describes how her friendships diminished now she was no longer the ‘ugly’ friend:

> “I lost many friends because I lost weight. I lost many friends. […] I was very close with one of my friends from my gym and when the point come that I was slimmer, people want, more than her, want to speak with me more and more and ignoring her, she just started to turn her back on me, gossiping about me and things like that so I lost a friend cos I just changed the weight.”
> (Participant 1)

For some participants, the social power afforded by weight loss created a strain sufficient to end even relationships. The ending of relationships as a result of altered appearance was mentioned by almost every female in the sample, but not by either male, possibly suggesting differing levels of significance of weight-related appearance between the genders.

3.3.2. Theme Two: Battle of the Body

Battle of the Body describes participants’ struggles for control of their body prior to surgery. Participants described long histories of efforts, often from childhood, to lose weight at huge emotional, physical and financial cost. Post-surgery, participants detailed an altered relationship with the body, with a greater awareness of sensations forcing participants away from their old patterns of eating. Enhanced responsiveness of others towards them as a result of their smaller size allowed for a greater feeling of security in their bodies as participants no longer feared being discriminated against. The weight lost was seen almost as a signal to stop fighting the body and to attend to its perceived needs.

3.3.2.1. Subtheme One: Physical Warfare

The way participants felt about their body was mirrored by society and vice versa. For many participants pre-surgery, dieting was a process which took up much of their mental (and monetary) resources. Participants described how they had spent thousands of pounds on dieticians and personal trainers, taken slimming pills, weighed everything they ate for decades and pushed themselves through unsustainable ‘starvation’ diets. Participant 3 described how her body would ‘remember’ being ‘destroyed’ through decades of dieting. This participant had even developed gallstones as a result of following one diet, resulting in her gallbladder being removed.

> “you’re on a diet and then as soon as you start piling the pounds back on you’re not in control again and that makes you feel so awful” (Participant 3)

Participants held the idea that the weight was both something that should be under control as a part of their bodies, but at the same time a disease-like entity to be ‘fought’ with parallels made with alcoholism and the belief obesity should be seen as the “twenty-first century cancer” (Participant 2). The theme of attacking their body appeared to mirror participants’ social relationships:

> “when I was bigger I would attack, not physically, but I would attack you know you, do you, protect myself […] I would be like ’what you looking at?’” (Participant 4)

> “I was always cracking jokes, I knew every fat joke in the book so if somebody cracked one I cracked three back and then you know I was a vicious with me tongue, I would insult them about any aspect of their personality or appearance that I could” (Participant 5)

> “it just felt like an ongoing battle half the time just though I am not making myself any thinner but I also can’t control my eating” (Participant 8)

Participant 5 described how he curated a ‘larger than life’ character. This fitted with the brightly coloured clothing from specialist plus size mail-order catalogues that he was limited to (prior to the availability of the internet) as high street clothing shops rarely stocked his size. Other participants with more recent surgeries, described dressing in black before surgery, avoiding shopping socially with friends and described feeling uncomfortable in ‘normal’ shops. The body’s ‘retaliation’ was felt in emotional terms at weigh-in and was an experience participants dreaded:

> "And I have to say that there is nothing that is as stigmatising and as embarrassing and as soul destroying than weighing in. Doesn't matter whether it's in private or not it's irrelevant […] but weighing in and then knowing that you've put on, or that you've not lost or that fear and dread of going. It's like you're being punished." (Participant 2).

Participant 6 described her entrapment in her own body, being unable to do fewer and fewer activities as her anxiety grew:

> "…every time I went everywhere I had to think 'is the chair going to be big enough? Is it going to hold me? Is the chair gonna collapse?' and of course soon as you start thinking like that you're unhappy so […] you're compulsive eating" (Participant 6)

Repeated "failures" against their body to lose weight confirmed participants lack of "fortitude" and their inability to "lose the weight themselves" creating an endless "downward spiral" (Participant 9). Although a majority of the sample were able to describe more of an allegiance with their bodies post-surgery, several found it difficult to accept the dramatic changes their body underwent and continued to oppose it. Participant 6 describes her ongoing struggle with excess skin which caused excruciating pain, identifying that the body still needed to be 'fixed':

> "You're fixing the making us look socially acceptable from the outside with our clothes on but you're not fixing the problem, you're not fixing the body" (Participant 6)

A majority of participants remarked on the need to address the excess skin following surgery. Living with excess skin appeared to make the success of weight loss bittersweet as it often resulted in pain and discomfort and failed to 'normalise' their appearance. Feelings of sadness, exclusion and shame about their excess skin dissuaded people from wearing more attractive clothing or undertaking certain types of exercise which would involve using a public changing room. For several participants these feelings resulted in a return to comfort eating. By addressing only the biological mechanism of digestion, participants had believed that their bodies would finally be under ‘control’ following WLS and the procedure would offer relief from constant bodily vigilance. Through services not offering the patient space for consideration of the consequences of the surgery (i.e. through psychological assessment) several participants described being unprepared for the long-term reality of the post-WLS body. This resulted in regret and sadness as they recognised that the reality they had hoped for of a ‘normal’, ‘under control’ body would not materialise.

Some participants reflected in hindsight they had expected the surgery to do most of the ‘work’ rather than engage fully in the process, gaining weight as a result. Other participants described how their minds had still not ‘caught up’ with their bodies which created uncertainty.

> “I’m aware that people look at me now as being a thin person but when I look at myself in the mirror I don’t see that actually and quite often I look in the mirror and I still think that I look fat or I’m putting on weight” (Participant 8)

This participant described the need for ongoing vigilance of his body and was troubled by never being able to feel certain that the weight would stay off. He commented that ‘normal’ weight people could relax whereas his relationship to his body would remain a ‘constant battle’.

3.3.2.2. Subtheme Two: Powerful Allies

Participants had fought their body for so long that, following WLS and recognising they were winning the battle against their body, some were unnerved:

> “you get on the scales and you’re still losing weight and it’s a really weird thing for somebody that’s always putting weight on and then to be worried to be losing and people are like ‘you’re not losing any more are you? Seriously you can’t lose any more weight’ and you know in your mind – ‘I haven’t got any control over it at the moment cos it hasn’t stopped’. That’s a really scary time” (Participant 3)

However, weight loss was ultimately seen almost as a sign of the body offering its allegiance. A majority of participants began to listen to their body and appreciate it in a new way:

> “it’s funny because sometimes like (laughs) you can hear the digestion, you can actually hear it it’s really weird so it’s like, like you would have um, your belly growling but it kind of comes from here where, like where they’ve done all the stuff, um, and sometimes it might be that I’ve eaten too fast or I haven’t exactly left enough time between drinking something and then eating and I think I have but it definitely is a good reminder.” (Participant 3)

Over time participants expressed a growing sense of awareness of their body. The stomach was often described as having its own memory and communication. The ‘invasive’ nature of the surgery was referred to by three participants as bringing the body and its needs more into focus:

> “I pay attention more to what my body is telling me kind of, if it needs rest or if I need I can tell if I need more protein um, more water or something like that so I am definitely paying more attention to all of that stuff I think the surgery was quite its quite an invasive thing to do to your body and I make sure I take my vitamins every day and all the tablets I’m supposed to take and I get the B12 shot every 3 months and I am very, very conscious of all that stuff whereas you know I think before, since I didn’t feel all that great about myself, I a lot of times didn’t feel like I needed to really take care of myself all that well and I think that was kind of a cyclical thing” (Participant 9)

Another participant described treating her body “like a child” (Participant 7) which she had to iteratively respond to, so as to find out what it could tolerate. For three other females within the sample the communication of the body was more authoritarian: “don’t have this last drink, don’t do this and don’t do that” (Participant 3). However, all these voices were interpreted beneficially. All three participants discussed enjoying the ‘rules’ of dieting and having wished someone had been there to tell them what to do pre-surgery, the surgery seemingly providing this structure internally. The stomach – in contrast to an organ which needed ‘controlling’ or supressing in some way– was communicated with:

> “I feel it’s a voice in my stomach and I’m not hearing a whispering at the end of my garden saying ‘have a digestive’, it’s inside me telling me to eat” (Participant 2)

Participant 7 described the need to bring in the support of her siblings to negotiate being able to eat less, protect her body and not jeopardise the surgery:

> “…especially because I’m African, I’m Kenyan, people actually serve you they don’t ask you most places you go to they put the food on the plate for you so I find that my siblings are around me taking off the things that I can’t eat or when I ask for another plate they will say ‘oh she ate on our way here’ so that people don’t start gong ‘oh my gosh oh my gosh’” (Participant 7)

Participants were no longer critical of their bodies, but remarked at its incredible capacity for strength and survival despite what it (they) had been through:

> “you get this ‘look, look, look’ and they’re all in their bikini clad bodies you know and I’m like ‘you know this is my war wounds you don’t know what I’ve been through, this shows what I’ve been through” (Participant 4)

> “I know thinking to the other girls in the group that they also you know ‘we’re bloody worth it, we’ve come a long way’. And whereas I might not have said anything before now I’m gonna say it because you know what? It’s a long journey and it was a tough journey and I actually deserve better. So, I think sometimes I’m a bit more empowered since post-surgery because you know how difficult the road afterwards” (Participant 3)

For some participants, the body was no longer an object of shame or fear that would fail them, but almost a comrade that had been through difficulty and fought alongside them. Two participants discussed the ‘liver shrinkage’ diet which patients must undergo two weeks prior to surgery in order for the liver to shrink sufficiently for the surgeons to access the stomach. Typically, participants are asked to follow a strict 800 calorie per day diet comprising yoghurts, milk and low-calorie soup. Although the patients found this diet highly aversive, several of the participants described transformative moments within the process:

> “you know the pre-op diet which is – I still haven’t ate a yoghurt since- but, um it…it’s not easy because you can’t cheat you can’t. You have to really realise that it’s a complete lifestyle change” (Participant 3)

> “the 2 weeks before that really I dunno […] it’s like everything stopped and I had realised I had so much potential that I didn’t realise. It wasn’t something small that happened to me, it was a life changing thing, but it feels like I found out things I never realised: I had the self-control and the fact that I can commit to something and see it to the end. I learned something. I started seeing myself in a different way, I found out that I had so much strength that I didn’t know I had” (Participant 7)

Although such a low-calorie diet was unsustainable in the long term, it appeared that it represented a qualitatively different experience than the countless starvation diets both participants had undertaken in the past, which had inevitably ended in failure. The completion of this diet (marked perhaps by the ‘reward’ of surgery) caused them to set aside practices which were important facets of their previous identities (participant 3 felt the surgery was putting herself first over her children; participant 7 had to forego traditional food at Kenyan functions). Being able to ‘complete’ the diet in contrast to failed diets before appeared to be a fortifying experience and opened up new possibilities for their relationship to their bodies post-WLS. For some although their relationship and attitude towards their body was improved, their relationship to food continued as before, particularly where they had expected the surgery to do the ‘work’.

During the initial weight-loss period individuals were frequently supported in this new identity by the comments of people in their social network. Several participants described how they received multiple compliments on their clothing which, prior to significant weight loss, no one would have commented on.

> “I have this weird obsession with these dresses that I buy on eBay they are very cute and I keep buying loads and they are all fun patterns […] its ok its only £10 a go I mean I think that is something that has changed cos I used to wear black all the time as kind of an aside I used to wear just black clothing all the time and now I wear bright colourful fun and goofy prints” (Participant 9)

This participant describes how the lifting of the threat of higher weight allows her to express her identity and be seen for something other than their weight. This allows the participant to experience and aspect of personal expression and positivity towards their body in a way which may not have been possible prior to surgery. Participants 5 describes there being a pivotal point in which he could feel comfortable being seen to be buying food without anticipating criticism:

> “there is a point you are open to ritual humiliation and discrimination from the public and there is a point at which that changes I don’t know when there is, but there is also a point internally which you feel open to abuse and I guess how you feel inside influences how you come across you know. I can walk in a place now anywhere and buy anything with confidence” (Participant 5)

This quote illustrates some of the scale of the impact stigma had on the individual prior to weight loss. This may explain some of the difficulty psychologists face in treating or supporting individuals with their weight (particularly when focussing on aspects such as emotional eating) within a society where “ritual humiliation and discrimination” is highly prevalent. A substantial emotional stressor appears to be lifted for this participant when this discrimination is abated. Several participants described being able to speak publicly in front of others and being less concerned about reprisals for giving negative feedback to others:

> “…it was more the idea having to get up in front of a crowd and everyone would see how obese I was and why would they listen to this really fat person talking and not, um, and fear of people talking about me and my weight and stuff like that weirdly it’s hard to remember” (Participant 9)

Sense of unity and mutual understanding of their body meant that participants were able to step outside their comfort zone and try new things:

> "I was able to cope with my mental being and also my physical and everything and after if I was coming out learning different things about myself if I put my mind into something then I can do it like I discovered some passions and things that I didn't know" (Participant 7)

3.3.3. Theme Three: Searching for Belonging

> "Yeah, it's about that feeling of belonging somewhere, but who knows that? And no one could give you that answer. What is that feeling of belonging somewhere?" (Participant 4)

The end of the period of weight loss created pivotal moment for participants. Participants were compelled to reflect on what the rest of their lives and what that might look like. The dissonance between societal attitudes towards WLS and recognition of their own body's experience of suffering led to a sense of 'otherness' that needed to be coped with, or a need for self-actualisation through integration of the surgery into their identity. Being unable to fulfil the social roles they enacted prior to surgery, participants searched for a new sense of belonging as a result of a differentiated identity, no longer obscured by being obese. This uncertainty was anxiety-provoking and brought several participants to identify ways of 'coping'. Others who appeared to identify more with a community of similar perspectives were able to move away from issues of self-blame associated with their weight and adopt a 'meta-perspective'. Some participants who regained the weight described how retaining a meta-perspective of the broader landscape of bodies within society and the difficulties they had been through in undergoing WLS allowed them to challenge attitudes which overshadowed or devalued people of higher weights.

3.3.3.1. Subtheme One: Finding Ways to Cope

The rapid weight loss associated with the surgery brought meaning and validation for most patients. However, after weight stabilised, participants were forced to face painful emotions. For some these emotions stemmed from worries that they would regain the weight and be labelled a ‘failure’, others recognised that they had misplaced their blame their weight for emotions and had to face deeply painful underlying issues.

> “I think I’ve got a fear constantly of the weight coming back on steadily […] so I think the fact that I got very thin for my height and then now I’m still I think I’m still perfectly reasonable weight but I think that I put back on a stone or nearly a stone stressed me out quite a lot and made me worry it was kind of kind a precursor to an ongoing weight gain. That’s definitely been at the back of my mind this fear of putting the weight back on its I find it a big struggle on the day to day basis” (Participant 8)

These participants described greater difficulty when their weight began to remain stable, fearing that they might lose the new freedoms which weight loss had allowed them. Others began recognising that although the surgery had brought a number of benefits, it had not brought the self-contentment and feeling of connection they had hoped.

> “…you’re seeing the consultant and he’s saying ‘oh well done’ and you know ‘you’re doing a good job’ and ‘we’ve never had this much effort made’ and you know you’re on cloud nine you know when that stops you have nothing. You know what you’re doing it for? Nothing. I am a people pleaser. I’m like a child I like to be praised, you don’t get it, you don’t get it. It’s difficult.” (Participant 4)

This illustrates how the medical endorsement of losing weight positively re-enforces the initial stages of weight lost but offers nothing in support of the long-term maintenance of that low weight. The focus on perpetual loss of weight to support a positive identity leads this participant vulnerable to adverse emotions when loss stops. Participant 1 described herself as a ‘monster’ and felt ‘less powerful’ and ‘secure’ since losing weight following surgery:

> “people like me if you are focussing on something you go, go, go when your weight stops you start to worry. When it’s all the time saying same, same, same you get that feelings like ‘oh, it will never go down’ will I gain the

> weight? And its fear. And when its fear you can fight that fear, or you can be like ‘screw it I will be back on bad habits’.” (Participant 1)

Participant 6, who was highly distressed by excess skin which caused sores and backpain feared not being able to find anyone to help and went back to eating:

> “I just don’t know what will happen in 6 months’ time because the pain is ridiculous so I have swapped one pain for another and now I have gained weight in the last year and I think that is eating emotional” (Participant 6)

Some expressed missing the “vice” (Participant 8) of eating or replacing it in some way. However, these vices, such as drinking, spending large amounts of money on clothes and partying intersected with feeling more able to be present in social settings:

> “I probably get tipsy quicker but I would say I probably drink more regularly so and I know that from a couple of the girls that they’re like ‘you drink far much more now’ but then is that really as well that I’m a bit more social now that I perhaps go to more things, you know so it might be that as well I don’t know, that I’m like ‘yeah I’m up for that’ you know so, um, that might be a little factor as well.” (Participant 3)

Another participant described how throughout her life she felt her lack of friends had been due to her weight, but post-surgery, she had recognised how the early abandonment by her mother had made it difficult to trust others. Participant 6 remarked on how the stereotype of the ‘jolly fat person’ prevents people from recognising their own underlying issues and distress:

> “…nobody wants to be fat I don’t care what people say and they say ‘oh I was happier when I was fatter’ no what it was it masks things when you’re bigger” (Participant 6)

Three participants who struggled with the realisation that the weight lost had not brought the emotional resolution they had hoped, continued to focus on the possibility that feelings of self-hatred would relent if they could lose more weight:

> Researcher: “life would be different if you were 68 kilos?”
> Participant 1: “Yes I think it would be easier, I think that I will start to love myself, because I put the targets and so far I see that I fail because I didn’t actually achieve that target, so this is the thing with me, when I want something, I want that. When I don’t achieve that, it is a failure and this is a punishment for me. So, my dream when I find the money, when I (.) when a star will fall from the sky, I will always dream that I will be slim. Not money, not health, not happiness, it’s just the main thing I wanna be slim.” (Participant 1)

3.3.3.2. Subtheme Two: The Meta Perspective

Over time participants sought support through psychology services, family members and most commonly, WLS support groups. Participants noticed a dissonance with their minds and the way that their body was received:

> “I’m aware that people perceive me differently to how I perceive myself looking to the outside world and I can’t quite reconcile the two kind of like a mental barrier” (Participant 8)

Over time participants began correcting these perceptions of their body into a wider frame of understanding, realising that how they saw themselves was not always accurate:

> “People are cruel so I wanted to be normal to be accepted by people I felt I had to be normal and the thing I find most amusing now this is probably the wrong thing to say is that I strived all my life to be normal and now I see that the majority of the people are overweight you know I’ve strived to be normal and now it’s almost like I’m someone in the minority” (Participant 4)

Explanations for why a certain situation did not go to plan were less often reducible to ‘because I am fat’ or ‘it’s my fault’. Participants were able to interpret the world reflexively according to their own differentiated identity as opposed to a stereotype. Participant 3 describes how at a higher weight she would have considered not being able to fit into her size of clothing as her fault for not being able to control her weight. Post-surgery it appears that she is able to be more flexible in her interpretation of sizes:

> “say a 10 in one shop and a 10 in a another shop can be completely different, whereas before if I had put say I was a 22 and I picked up a 22 and I couldn’t get it on, I’d be like ‘oh my God it’s me, I’m absolutely huge and it doesn’t fit and that’s it, it’s my fault’. Whereas I would never have thought about the whole differences in size” (Participant 3)

WLS support groups were significant for half of the sample in understanding their body and overcoming the anxiety of the changes associated with the surgery:

> “there’s this group of people that know when I am struggling with food or especially after the surgery actually it is more helpful struggling with hair loss and trying to figure out why that is happening […] and everybody has gone through that or is about to go through it or you know it’s a nice environment and […] it’s led by the dietician or the nurses or sometimes the surgeons come […] its good to ask questions about stuff like ‘this is happening now what does this mean and should I be worried about that’” (Participant 9)

> “…if you ever could get someone to speak to these people that has had it done I would grab it with both hands because there’s not anything that can give anyone more insight than someone that has had it done.” (Participant 4)

The benefit of meeting people who had completed this surgery was echoed by almost all participants. Experiential information on how people navigated the wide-ranging physiological and social consequences of the surgery was something that participants felt was missing from the patient pathway. Participant 7 who underwent surgery three years ago remarks on the experience of meeting others who had undergone WLS for the first time only a few weeks prior to the interview:

> “… when you are surrounded by other people, cos it’s only my siblings who know about it, so it felt like I was, I see the people and it felt like I’m not the only one going through the struggles or anything we are many in this and it felt like […] it felt like there was a community type of thing” (Participant 7)

Owing to the stigma associated with the surgery as a ‘quick fix’ many participants kept their surgery secret from their wider social network, limiting the number of people they could draw on for support. Meeting others in person generated a sense of community and belonging which those who attended regular support groups felt was essential to maintaining their adherence to the post-surgery lifestyle. A number of participants commented that their experience of online support forums was that they overly focussed on the positive aspects of the surgery (i.e. weight loss) and were unable to support them in confronting the more challenging, long-term aspects, particularly as weight loss slowed or stopped entirely.

Several participants described the need to increase the visibility of advocacy work for people with obesity. Meta-perspectives around discrimination of body size also involved wider intersectional dialogues of gender, age and cultural beliefs. Women, in particular, commented on the importance of protecting girls from diets and body shaming. Participant 9 discussed how she had felt compelled to take a male colleague with daughters aside (who was unaware she had had the surgery) to address a comment he had made about his ‘hatred of fat people’:

> “and I said ‘you know you said this one time and I used to be quite heavy and it was really hurtful. You really shouldn’t be saying that in front of people it’s just not a kind thing to say’ and it was an interesting conversation with him but its yeah anyway its he was surprised and apologetic but you know hopefully he’s not gonna do that anymore” (Participant 9)

At the same time both males and several women who attended WLS support referenced the low levels of male representation within their support groups.

> “you go to a support group or look at our Facebook groups it’s about 20% men and 80% women so they’re not there for some reason and it maybe that they’re always doing fine and dandy but I suspect they’re not I know that what I wanted was someone to get close and express some empathy for where I was at” (Participant 5)

Participants recognised their comparison with bodily ideals had not been helpful. They discussed the importance of being visible in spaces and performing activities which higher weight individuals were excluded from or believed they could not do, in order to influence cultural ideas around bigger bodies not belonging. Participant 5 described feeling more comfortable within an accessible gym because it “wasn’t the sort of Lycra and steroids sort of look, it was these people of all ages and abilities trying their best”. At one support group he had suggested that they go on a bike ride or go swimming however, this still posed persistent psychological barriers:

> “they don’t wanna get changed in front of everyone else at the gym and the gym is quite a difficult environment anyway I wonder if we can rent a session or rent pool one of the groups of Obesity UK are renting bikes and uh they brought that up last week and they all started laughing when they said that they said they couldn’t imagine riding a bike and I said ‘well maybe that’s something we’ve got to try’” (Participant 5)

Despite having regained the weight lost, several participants retained the drive to continue to be recognised for who they were. However, participants faced additional barriers to belonging according to their intersectional position. Participant 2, now in her 60s refers to the additional challenges of her identity being obscured by her age:

> “there is definitely a bit of and ageist thing going on here as well at the moment, which […] I have never been aware of and um, it doesn’t really happen to me because I won’t let it happen to me. I say ‘look at me I’m 66! Look at the way I dress, I said do I look like I’m 66 years old?’ I make sure they look at me, I make sure they really look at me and really see who I am

> but you see most people who have had this lifelong obesity, they’re not like that.” (Participant 2)

As an Irish person living in Britain, she discussed how she identified less with British culture and found more connectedness in African styles of dress from a young age. Although she described experiencing derision from strangers in the street, she did not refer to ideas of ‘attack’ but appeared to address stigma in an assertive manner and maintained her differentiated identity irrespective of weight.

> “you know what I think has defined me I think what’s defined me has been my education, my cultural upbringing, which been embedded in a, um in a faith, not that I’m a very good example of it but it has been and my um, travel and then later in life my education, education came later to me really and, there’s the things that have defined me so I re-defined myself quite often, but I would say mixing with people from other cultures has been the major thing that has defined me and has supported me in not worrying about being big.” (Participant 2)

Exposure to African culture had led two women in the sample re-evaluate how their size impacted their self-worth. Looking at their bodies through an African lens allowed for an appreciation which did not obscure and stifle their individuality but enhanced it.

> “Cos they’ve actually said to me – I’ve had partners from, you know, people from Africa and say ‘you’re not that big’” (Participant 2)

> “every time I have been back to Kenya everything I hear surprises me cos everyone in Kenya like the way I am everyone compliments me and all the people my age are like ‘oh my gosh I don’t know why you would even want to lose weight’” (Participant 7)

CHAPTER 4: DISCUSSION

4.1. Overview

This chapter summarises and discusses the findings of the analysis. Methodological issues and limitations are also highlighted. Finally, attention is given to this study's recommendations for future research as well as implications for public policy and clinical practice.

4.2. Research Questions

This study aimed to examine the experiences of altered identity as a consequence of WLS by exploring the following questions:

1. How do post WLS individuals negotiate having been overweight and subsequently post-WLS in a society which stigmatises both groups?
2. To what extent do post-WLS individuals consider themselves 'normalised' and 'in-control' of their bodies or identity as a result of their surgery?
3. How do post-WLS individuals negotiate changes in their social circles in response to their changing bodies?

4.3. Summary of Results

Participants negotiated the stigma of having been overweight and subsequently having the surgery through adopting a medicalised perspective which characterised their weight as an imminent risk to their long-term health. However, although participants made the decision to have surgery largely on the basis of interactions with medical professionals who characterised the risk of their higher weight as grave and imminent participants bore the stigma for 'electing' to have WLS. Participants found that healthcare clinicians, although playing a central role in the decision to have the surgery, offered little support for the long-term emotional and psychological adjustment to the surgery. Participants were divided in their approaches, either viewing surgery as a procedure they did not share with others or they actively sought support and self-understanding through WLS support groups.

Several participants made reference to being ‘made normal’ by the surgery as a result of weight loss. The alleviation of experiences of weight-based stigma allowed participants to develop relationships to their bodies and appreciate its ability to survive. Participants felt free to explore new activities and interests (shopping in high street shops, going to restaurants) in line with what they considered to be the rest of society. However, for some, being able to participate in these ‘normal’ activities drew into contrast powerful feelings of exclusion which persisted as a result of underlying issues they now realised were not related to weight.

As participants experienced their weight stabilising some described feeling more anxious, uncertain as to whether they could continue to maintain their new weight. However, a number of participants, particularly those who had attended WLS support groups, were able to integrate WLS into an a post-WLS identity. This identity in contrast to pre-WLS attempts to control the body, fostered accountability for their eating behaviour alongside increased responsiveness, allegiance towards and appreciation of their bodies. Rather than adopt a ‘normalised’ identity to align with how they were perceived, these participants integrated previous experiences of discrimination and struggle with weight loss to challenge negative attitudes towards people of higher weight within society.

Even before the participants body changed, there appeared to be a dynamic shift in the participants’ position within their social circles. The values inherent in deciding to have the surgery, which participants described in term of putting themselves, or their health first marked a significant shift in relational power. In several instances this resulted in strain within, or the end, of the relationship. Intersectional positions such as gender, cultural identity and parenthood also played a central role in the decision to have and the adjustment to, life following WLS. It appeared in retrospect, that power imbalances, failure to fulfil certain roles and, sometimes lack of emotional fulfilment within these relationships, had been something which had perpetuated problematic patterns of eating.

Participants discussed moving from a position of being perpetually ready to ‘attack’ others (as they had attacked and punished their body through dieting), or shying away from visibility (e.g. dressing in black, avoiding public speaking), to one of assertiveness and self-advocacy. Participants appeared to take a meta-perspective on their own journey through WLS through identification with other individuals who had undergone the surgery. Others recognised the hardship they had been through and saw their own potential as valued members of their community regardless of their weight. This allowed them to reject the limitations imposed on them by weight-based stigmas.

4.4. Discussion of Findings

Bodies are both socially rooted and produce social effects. In western languages we find many metaphors concerning the stomach: ‘gut feeling’, ‘gutted’, ‘more than they could stomach’, or referring to ‘butterflies in the stomach’. Although the body gained some attention in early systemic literature (e.g. Minuchin & Minuchin, 1974) and more recently is being recognised within trauma focussed approaches (e.g. Cushing & Braun, 2018; Van der Kolk, 1994, 2015) the body has largely been neglected in psychological research and practice, given its definition as ‘the talking cure’ (Shapiro, 1996). The very act of having surgery of this kind and its wide-ranging effects within the individual’s system is a statement about the crucial meaning of the body within an individual’s identity.

4.4.1. Embodied Change

One of the over-arching ideas within participants’ accounts was how, despite researching the surgery extensively, they often felt unprepared for the psychosocial changes the surgery would bring. Similar to participant’s in Lynch’s (2016) study participants also continued to feel a ‘paradox’ of appearing ‘normal’ on the outside but struggling with the internal experience of stigma. In the literature concerning organ transplantations, there has been increased recognition of the significance of phenomenological ideas to understanding how individuals adapt psychologically to visceral alterations. New technologies which have allowed successful cornea, hand or face transplants are more ethically complex, because they imply “accepting the constant presence of another person, and even a modified expression of the recipient's personality [...] a deep identity split occurs" (Carosella & Pradeu 2006, p.183). Although the visibility of a face graft does entail distinct problems, such splits are increasingly being recognised amongst recipients of other emotionally significant *internal* organs, such as hearts (Shildrick, 2015).

In a qualitative study of adolescent heart transplant recipients, researchers identified that participants separated from their illness and worked towards normality through steps toward regaining their independence (managing their own medical regimes, attending school). However, at the same time participants described themselves as troubled by the notion of receiving the 'gift of life' a phrase which was inextricably linked more with the narrow avoidance of their own death and death of a stranger (Waldron et al., 2017). The post-surgery patient knows that something fundamental has been altered, they cannot simply adopt the heart as their own (Shildrick, 2015). In order to fully adjust, they must find ways to accommodate the reality of a corporeal change and the cultural constructs embedded within the act of this type of surgery.

In line with Ogden et al. (2011) and Stolzenberger et al. (2011), participants emphasised their desire for 'control' over their bodies. What was established within this study was that participants both expected that they *should* be 'in control' of their weight, but also held internalised constructions of obesity as a 'disease' that, by implication, they only had limited control over. Under the mind-body division model that our current medical interventions operate within, procedures that disassemble, suture or transform the body are deemed to have limited impact on the transcendent self, whose interest in the corpus is assumed to be predominantly that of a property relationship. Therefore, once the body has been corrected and healed, the core self is anticipated to re-emerge unscathed. The 're-plumbing' (Participant 8) of the stomach is assumed to be accomplished without psychological significance, in large part because the operative mode of discourse in WLS departments reproduces the modernist mind-body split in which the meaning of embodiment is entirely occluded. As Leder (1992, p. 23) remarks of modern medical practice; "*At the core of modern medical practice is the Cartesian revelation: the living body can be treated as essentially no different from a machine*."

In the same way that the architecture of the 'new' post-WLS stomach will never perform in the same way as their previous stomach, the WLS patient's body will never lose its otherness. The post-WLS will not allow Participant 8 to engage in and adopt the same identity at Jewish celebrations in the same way. All WLS must adapt and find methods of integrating the 'new' stomach into their 'old' lives. In effect—and despite any expectations of recovering oneself—the embodied self is, then, inevitably transformed (Crossley, 2006; Shildrick, 2015). This research therefore, further underlines the validity of phenomenological approaches to understanding the wider implications for individual identity following corporeal adjustment.

4.4.2. Responsibility

Participants entered into the decision to have surgery with the guidance that their body would almost inevitably develop an obesity related disease. The causative link between obesity and disease was not contested by participants within this study. However, there is substantial evidence to support the argument that not all bodies with obesity are unhealthy (Elagizi et al., 2018; Ortega et al., 2018). Although undoubtedly being higher weight increases risk of 'weight-related pathology', diagnosis of the 'disease' of obesity as a result of discrete categories of BMI ignores individual differences and potential modifying factors in the relationship between weight and weight related disease. Several studies have found there is no significant difference in mortality rates amongst those who are physically fit, irrespective of waist circumference, BMI or fat percentage (Ortega et al., 2018). Nevertheless, participants often described anticipating an almost inevitable decline in health that had framed their decision to have the surgery as imperative.

Participants within this study often spoke of feeling that they had no option but to undergo surgery as they did not have the character strength to lose weight themselves. Some participants referenced the concept of obesity as a disease, which limits blame by suggesting that weight is biologically or genetically determined. However, these arguments of an almost certain deterioration in their future were at odds with cultural beliefs about WLS being a 'waste of NHS resources' and a 'cheats way out'. Medical discourses position weight maintenance simply as an imbalance in the energy being taken into the body versus that being expended. In doing so, they place the responsibility solely on the individual, despite there being considerable evidence that a multitude of factors influence diet, exercise and weight gain, including prenatal factors, early childhood practices around food, metabolic rate, access to green space, socio-economic status, genetics, pharmacological factors and food availability (Apovian, 2016).

Many of the arguments which centre around whether individuals are entitled to health services centres on the perception of the individuals 'personal responsibility' in causing their condition. Friesen (2018) delineates 'personal responsibility' as referring to both causal responsibility and moral responsibility. There are innumerable cases in which individuals deliberately take risks with their own health for which we may assume 'causal responsibility' for a future health problem (e.g. choosing to live in a city with high air pollution levels, playing extreme sport, or a job that involves high levels of stress). However, behaviours such as smoking, drinking, drug use and poor diet attract particular attention in healthcare. When the case of 'poor eating habits' is compared with 'disease caused by living in a polluted city', it seems very likely that moral bias, not merely responsibility, is guiding the focus of this discussion; Smoking, drinking, drug use, obesity are highly stigmatised behaviours, while living in a polluted city or playing and extreme sport is not. Therefore, that an individual had the knowledge to avert the outcome does not predict blame. It has been suggested that actions may be interpreted as more deliberate if the person making the judgment disapproves of this behaviour (Alicke et al., 2008).

Attributions of responsibility permeate into WLS, as exemplified by Participant 7's interaction with a nurse post-surgery. The nurse's comment that the participant should endure pain as she had undergone WLS to "make herself look beautiful" in the context of the "safe-ish space" of the hospital increased her resolve not to share her surgery with others, making it less likely that she would access crucial post-surgery support. Stigmatising communications from healthcare providers have been demonstrated to cause them to avoid seeking medical attention and is associated with an underutilisation of medical screening and preventive care (Phelan et al., 2015). Importantly internalised weight stigma has been found to be predictive of binge eating, lower quality of life and physical activity (Hubner et al., 2015; Latner et al., 2008; Pearl & Pul, 2015). Many WLS patients feel they are perceived as abnormal and avoid contact with health services (Brown-Bowers, 2017; Merrill & Grassley, 2008). If people with obesity are to seek and implement health advice, the stigma of weight being something they are solely ‘responsible’ for needs to be addressed.

While debates over how to motivate positive health behaviours remain, there is widespread agreement that building experiences of individual self-efficacy and challenging societal norms which victimise people of higher weights all play an important role. Yet, public health campaigns in the UK such as ‘Change4Life’ and ‘5ADay’ consistently emphasise individual responsibility to follow guidance over challenging social inequality and societal norms which favour discrimination and trap individuals within a pattern of learned helplessness (Friesen, 2018). Likewise, in the ‘*Five Year Forward View*’ the NHS describes its plans for creating preventive measures to tackle non-communicable diseases, asserting that ‘there is broad consensus on what [the] future needs to be. It is a future that empowers patients to take much more control over their own care and treatment’ (NHS, 2014a; 2014b).

As Caplan (1994) has cautioned, “as increasing emphasis is placed on the role that personal responsibility plays in health policy and resource allocation, great care will be required lest sin become one of the tests increasingly applied at the bedside to determine who will live and who will die” (p. 221). The language of these statements, particularly words such as ‘empowerment’, indicates an explicit role for personal responsibility in changing health-related behaviour. These policy statements only very occasionally acknowledge the consensus emerging across a range of social and behavioural science research that physical, social and economic environments are central to behaviour (Hollands et al., 2016).

However, what the present study suggests is that there may be scope for environments or therapeutic interventions which are empowering to the individual. These may support the individuals recognition of wider systemic issues that affect their weight (such as social inequality, discrimination) and other non-weight related emotional issues which individuals may misattribute to their weight (e.g. finding it difficult to form relationships, but this being related to earlier attachment disruption not discrimination). These may facilitate separating the individual from cycles of self-blame and emotional eating freeing them to take actions which benefit their health in a sustainable way.

4.4.3. Weight-Based Stigma as an Obstruction of Identity

Prior to WLS, participants described restrictions on their identity, including dressing not to draw attention to themselves, or avoiding public speaking and social events. The role of being seen and not heard was one that participants were complicit in. Participants would dress in black, avoid public places (such as restaurants or cinemas) or correcting others. Two women also remained with partners they were unhappy with because they lacked the confidence to end the relationship. This is in line with Engström and Forsberg’s (2011) theme of individuals building ‘restricted life’ prior to WLS. The discourses of identity politics are such that a thin individual in society is allowed more space to inhabit culturally favourable identity options (e.g. beauty, intelligence). Higher weigh individuals are more likely to define themselves as deficient in self-discipline and willpower, unattractive, having “lost the battle” (Guilfoyle, 2009 p. 197) with their own body. Similarly, in this study, participants described themselves in negative terms as ‘vicious’, ‘manipulative’, ‘lazy’ or ‘lacking fortitude’.

Aspects of shame prevented many participants from accessing activities which would have improved their lives and broadened their identity horizons. Several participants were discouraged from playing sports from a young age, others would not give presentations at work for fear of people focussing on their weight rather than what they were saying. Shame was also highly prevalent in participants concealment of having undergone WLS. Shame is both a self-related and self-evaluating emotion defined as ‘‘a perception that one has attributes that others will find unattractive and be a cause for rejection and attack’’ (Skårderud, 2007: p. 94). Shame also connects through the internalised perspective of others to a form of self-awareness in which one no longer owns one’s own body (Fuchs, 2002). Both these attributes of shame were present in participant accounts where their bodies were physically grabbed in public, told not to enter shops and avoided public spaces as a result.

Shame therefore, plays a regulating role in our relationships to others. We censor our speech and cover our skin, particularly around authority figures, in order not to be reprimanded or lose our status. This demonstrates the isolating effect of weight and WLS-based stigma in preventing the implementation of health-behaviours. While the experience of stigma has been found to increase the desire to lose weight, it decreases the individual's ability to do so, and common responses to such stigma include exercise avoidance and refusing to diet (Myers & Rosen, 1999; Puhl et al., 2010), as well as increased food intake (Schvey et al., 2011). The importance of addressing shame through structured psychological intervention and support groups pre- and post-surgery highlights an important mechanism in maximising the potential psychological and physiological benefits from surgery.

4.4.3.1. Valued Identity

The initial period following surgery brought weight loss which was more rapid and more sustained than would be possible by non-surgical means. As a society which actively promotes weight loss, this was a hugely validating experience. The increase in awareness of the perspectives of others, particularly the way that being of low weight is socially valued, awakened a desire for recognition and validation. Hegel (1979) states that this desire for validation creates conflict, particularly the desire to be recognised as superior to the other. As Mead (1967) writes, much of our body modification is motivated by the desire for distinction from others: '*there is a demand a constant demand to realise oneself in some sort of superiority over those around us*' (p. 205). However, as this study has highlighted the ability to 'realise oneself' or be seen as anything other than 'obese' was obstructed by being of higher weight. Participants often felt they could only be defined by having a higher weight in comparison to the weight of others, rather than their ability in other areas.

Obesity is a deviation from what is held in Western culture to be the normative body. People with obesity who internalise this self-stigma view themselves as having a devalued social identity linked to pervasive cultural ideas of being 'lazy' or 'stupid' (Kahan & Phul, 2017). Although people who undergo WLS deviate from 'normal' people in that they do not lose weight by conventional means, participants highlighted the difficulty within present day society of accessing 'normal' weight loss methods when your body is not considered ‘normal’. Slow, gradual weight loss by diet alone (which would not have been visible for many months) would not have offered the embodied privilege to avoid discrimination (which the rapid weight loss following WLS afforded) to allow participants to adopt alternative ways of caring for their bodies (e.g. going to the gym, ‘deserving’ to eat in public when they needed to). This created a context where the only option was an unconventional method of weight loss.

Individuals cannot escape a cultural context which limits their identity but must find a way to cope with its influence. Through consideration of WLS, patients negotiated with themselves and family members around their entitlement to surgery. In this, they were supported by the power embedded in medical discourses, which offered certainty about their apparently inevitable decline. Post-surgery participants were brought to answer the internalised structures of social control described by Foucault (1977) as positive feedback on the self and body were relayed to the participants in their interactions with colleagues, strangers and friends. As participant 5 described, there came a point that he was ‘no longer open to the ritual humiliation of the general public’ through the realisation that ‘obese’ was no longer his identity. Participants were able to realise and reclaim strengths and abilities which had been overlooked (e.g. participants that began public speaking, engaging in new hobbies, realising they were ‘worth it’).

This suggests that the sense of renewed control experienced by participants is not paradoxical, but represents surgery offering control over a narrative about their own identity as opposed to a stereotype. As weight was lost, participants were unable to disentangle their own identities from the stigma that they had experienced as a higher weight individual. Participants were taken aback by the body appearing to follow what the mind had desired for so long. However, the self which had been hidden was not entirely positive and several participants recognised the root of some of their emotional difficulties did not dissipate with the weight. In line with the findings of Ogden et al. (2011) and Lynch (2016) there emerged the necessity of ‘inner work’ alongside their appreciation for the outer body.

4.4.4. Intersectionality and The Meta Perspective

Three participants experienced romantic relationships ending shortly before or soon after WLS. Others described increased jealously from partners, as well as their own increases in confidence and assertiveness. This finding is consistent with the research of Bylund et al. (2017), Groven et al. (2015) and Lier et al. (2015), which detailed the marked systemic shifts in family interactions following WLS in order to achieve stability. In the present study, pressures on relationships appeared from the point of the *decision* to have surgery. Participants remarked on resistance from their partners and friends, with one participant reflecting that her husband may have been encouraging her to eat in order for her to remain at home with him and maintain a status quo in their relationship. The difficulties encountered by participants in adjustment to WLS highlight the significance of their weight in defining their role within their relationships and the power structures within wider society. Relational roles encoded by culture into discourses appeared to play a role in participants maintaining their body size prior to WLS.

Although outwardly participants could enjoy the benefits of being lower weight, such as being able to go to restaurants, they did not simply move into a ‘normal’ identity. Several described the need to advocate for people of a larger body type and increase visibility of higher weight individuals in order to subvert attitudes that prevented access to the community or to certain activities. Participants recognised how they had suffered as a result of the surgery and began challenging pervasive stigma. The mutual appreciation of each other’s suffering appeared to allow participants to see themselves as survivors of a society which discriminated against them rather than ‘cheats’. Fuchs (2002) writes that individuals cannot rid themselves of shame: It must to be done in a dialogue with others to facilitate distancing oneself from shame through a meta-perspective: “Taking a meta-perspective on situations that cause shame and guilt helps to cope with the self-devaluation […] adopting a meta-perspective depends on an open interpersonal space which allows for freedom of self-distance.” (p. 234).

In the present study, participants spoke of the helpfulness of meeting other individuals who had had the surgery. However, it was noted by participants within the study that male representation was low within these groups, as it was in this study and the previous research highlighted in the scoping review. An examination of data on WLS in England found that, although women were more likely to be eligible for WLS than men (58% compared to 42% of men), the proportion of women who received surgery was significantly higher (76% compared with 24% of men; Desogus et al., 2019). Males within society typically experience poorer health outcomes in terms of their weight, disability, chronic illness and mortality compared to women of similar social disadvantage (Evans et al., 2011). Contributing to this may be the fact that, within a neoliberal context, health is understood as an individual responsibility. Although both women and men are expected to control and care for their bodies, self-care is frequently regarded as a feminine undertaking (Hayes et al., 2017; Jones et al., 2019).

Male experiences of obesity and weight loss often locate the trope that “real men” do not diet. Dieting is principally regarded as a female occupation, with exercise-based methods of weight control seen as more masculine (Gough, 2007). There are also distinct differences between what male and female appetites ‘should’ look like, with small portions (like those required post-WLS) considered feminine and large, robust portions considered more masculine (Woolhouse et al., 2012). Attendance to issues of gender (for example offering male-only groups) in the pre and post-operative period may be beneficial in generating a sense of meta-perspective through shared experiences. This may highlight the difficulties for some men in not being able to fulfil the ‘large-portion’ aspects of masculine identity long term and how that can be managed in social contexts.

Although males faced their own barriers in accessing WLS and post-WLS support, medical and societal discourses around weight and WLS have largely focussed on the disproportionately negative impact on women (Halfmann 2012; Morgan 2009). Gendered analysis of individual experiences of obesity has suggested that larger body size does not necessarily negatively impact male identity in the same way (Newhook et al., 2015). Monaghan and Malson (2013) write that males framed fatness as “irrelevant or peripheral to masculine worth” (p. 311), in contrast to women, for which it was central. In this study men often drew on ideas of being strong and powerful as a result of their larger size. Feminist researchers have argued that body weight tends to hold different meanings for women and men (Bordo

2004). In a study by Newhook et al. (2014), women described intense feelings of shame concerning their appetite, some expressing the wish to get their jaw wired shut. Bordo (2004) described the female appetite as a metaphor for female desire and argued that the symbolic and practical control of female appetite is “continually constructed as a problem in patriarchal cultures ... and internalised in women’s shame over their own needs and appetites” (p. 206).

Ideas around whether female participants ‘deserved’ to have their needs met also emerged in this research. Stigmatising attitudes about the type of person who undergoes WLS as ‘selfish’ seemed at odds with female participants’ identities as a mother, which stressed the significance of self-sacrifice and putting their children first. Women also appeared to experience more resistance from their partners in undergoing WLS, in contrast to the men whose wives appeared to be in more passive agreement with their husbands WLS. In line with the resistance from the male partners of the women in this sample, the women described acquiring more social power and privilege as they lost weight, enjoying more freedoms (though often at the cost of the significant relationships they had had prior to WLS).

Cultural and religious background also appeared significant in how participants formed their identity following surgery. Participant 7 discusses the pain of no longer being able to eat Kenyan food. Participant 8 describes food as central to Jewish festivals with surgery limiting his ability to participate. Food, in contrast to the medical model, is more than just ‘fuel’ for the machine. Caplan (1997) discusses how social scientists have grappled with the huge variety of eating practices not purely concerning when, how and how much food is consumed, but also how this has changed over time and impacts relationships between age groups, food as a marker of identity and difference, and food and its relationship to health. Hence, participants face not just physical challenges in maintaining the dietary changes associated with WLS, but also have to undertake psychological, cultural and relational adjustments.

Two female participants achieved similar meta-perspective to those in the support group by viewing their larger bodies’ through the lens of African culture. They were able to garner a greater appreciation for their bodies, mirrored in others around them, and develop greater self-worth than they had prior to surgery. In a focus group study by Lynch et al. (2007), ‘African-American’ women discussed one reason they were ambivalent towards WLS was because of identifying with the larger body size of women in their family. Through eating together and exchanging clothes they found a sense of belonging and of being ‘in sync’ with other members of their family. Several participants had known family members undergo WLS and subsequently be unable to join in family activities in the same way. Although ideas around the greater value ascribed to larger bodies in some African cultures, discussed in this study and Lynch et al. (2007), cannot be generalised, it highlights the importance of considering the diversity of cultural values ascribed to body size as part of assessment and post-operative support.

The neoliberal chronic disease model of obesity is a hinderance in that it continues to individualise and medicalise larger body size, obscuring social contexts and limiting wider discussions around health and wellbeing. It connects large body size solely with physical dysfunction. Through this mechanism the medicalisation of obesity contributes to pervasive discrimination which intersects with sexism, ageism, racism, classism and also intensifies disordered attitudes towards the human body at personal and societal levels (Fikkan & Rothblum, 2012; Puhl & Suh, 2015). It is therefore, highly problematic to understand WLS purely within the strictures of the medical model. As this study demonstrates, sociocultural contexts are essential to understanding the decision to undergo surgery and the ability to maintain the outcomes of WLS since bodily meanings are constantly being produced by the interaction between the individual and their context.

4.5. Assessment of Research Quality

The breadth of different approaches to qualitative research creates difficulties in identifying appropriate means for assessing their validity (Yardley, 2000). The researcher drew on multiple sources to evaluate the quality of this research (Braun & Clarke, 2006; Willig, 2013). Yardley’s (2000) evaluative criteria were followed as these were also considered to be consistent with the epistemological position of critical realism.

4.5.1. Sensitivity to Context

Sensitivity to context was demonstrated through contextualising the study within existing relevant literature relating to WLS. Many studies within the area of WLS are quantitative, focusing on issues such as weight lost, engagement in physical exercise and complications. Working within physical health encourages medicalisation of the body, thereby reinforcing prevailing cultural discourses of the 'normal' body. The present study's attention to participants' relational, social, cultural and gendered roles – and how these intersected with their embodied experiences of WLS – is a strength of this research. Sensitivity to context was also employed through the analysis, with carefully chosen quotations, across all participants to represent a range of intersecting perspectives and experiences.

4.5.2. Commitment and Rigour

Commitment can be demonstrated through the researcher developing capabilities and immersion in the research subject matter (Yardley, 2000). It is proposed that new insights can be developed through the researcher generating empathic understanding of the participants' perspective. Extensive engagement with the topic was achieved principally through the researchers role as a trainee clinical psychologist within the bariatric surgery service for six months where the study was carried out. This involved conducting individual and group therapy with patients pre- and post- surgery and facilitating the support group. Engagement with the topic was further enhanced through reading additional literature. The researcher also published a related blog post on weight-based stigma on a critical psychology website, Psychologists for Social Change.

Rigour was demonstrated through the development of skills in conducting thematic analysis. Over a month was devoted to analysis and additional guidance through formal and peer supervision. This assisted my focus on the research questions and epistemological stance of the study. I also systematically sought out research which ran counter to my initial position on the topic in order to attenuate the influence of my own experience and beliefs (Creswell, 2012). This process improved my analysis by drawing out contradiction, for example, the paradox of the participant feeling a sense of personal control of their eating behaviours despite being physically restricted through a surgical operation. As a further measure of analytic validity, I will request participant feedback following examination (Yardley, 2008). Almost all participants accepted my offer of a summary of the research following the interview.

4.5.3. Coherence and Transparency

Through the process of designing, conducting, analysing and writing up, the research questions were repeatedly returned to ensure the coherence of the overall thesis (Yardley, 2008). Coherence was demonstrated through discussion of the quotes with the researcher's supervisor throughout the different stages of analysis. Presenting data extracts facilitated readers to assess the patterns identified within the analysis. An additional method of ensuring transparency is demonstrating researcher reflexivity in the research process. A reflective journal was kept to assist the analysis process as suggested by Braun and Clarke (2006). An extract can be found in Appendix M.

4.6. Implications

4.6.1. Practice

What is most apparent from the research is the importance of allowing pre-WLS individuals the opportunity to meet others who have experienced the long-term consequences. All participants expressed the feeling of togetherness that was produced by associating with others who were going through similar experiences. In the absence of such support, many of the participants expressed feeling ill-prepared. Some authors have suggested that responses to surgery are poorly defined as 'restriction and reduction in nutritional absorption' as there are multiple interacting factors which will vary according to individual differences (Sogg et al., 2018). This focus on biological mechanisms also obscures the role of psychological health and adjustment as a significant factor in the long-term maintenance of weight lost.

In line with other research (e.g. Bylund et al. 2017), physical and emotional changes following surgery led to increased strain in the system around the individual and in some cases ended friendships and intimate relationships. However, according to Ratcliffe et al. (2014) few WLS services offered routine pre-surgery psychological assessment and no services offer routine post-surgery follow-ups which may have offered the opportunity to highlight these issues to patients and support them with a management plan. These plans as well as any potential interventions should be considered in line with the individual’s intersectional position, which may incorporate different values about weight and/or greater significance to certain meals than the therapists own.

Ensuring that patients are able to meet other service users from a similar intersectional position who have gone through the process early in the pathway has been highlighted as crucial in helping WLS candidates understand and prepare for the physical and psychosocial consequences of surgery. Improved integration of psychological services and service user perspectives within MDTs in this way would offer a more comprehensive model of informed consent by allowing individuals to consider the potential psychosocial consequences (as well as physiological consequences) of surgery. This would attenuate the effects of the present mechanistic approach to WLS to ensure holistic formulation and problem solving approach towards a patient’s potential difficulties.

Based on the findings of this research, individual approaches such as Compassion Focussed Therapy (Gilbert, 2009) which address feelings of shame and support the development of the meta-perspective through recognition of social factors in maintaining weight should be offered. The psychologists who offer these may also be well-positioned to support teams systemically in challenging the stigmatising attitudes that are present amongst some healthcare providers, including (but not limited to) those who specialise in working with individuals who have obesity (Phelan et al., 2015; Schwartz et al., 2003).

4.6.2. Research

This research supported the further development of systemic approaches to weight loss to support higher weight individuals in negotiating the space they need to treat their bodies differently. This research found that successful adjustment to WLS was facilitated by the development of the meta-perspective which allowed participants to address internalised social stigma which had governed their behaviour. The way participants were able to adapt their identity to their new body varied according to the individual's intersectional position. Coproduced research into gender and culture-specific approaches may allow for further exploration and identification of, values and strategies which help patients integrate WLS into their identity. This may be accomplished by multidisciplinary research involving psychologists, occupational therapists, dieticians and nurses alongside service users themselves.

The body has largely been neglected in psychological therapy but has gained increasing interest in the field of trauma (Ogden et al., 2006; Van der Kolk, 1994; 2015). However, the continued silence of psychologists about the body may be framed as offering a position of 'neutrality' in the face of widespread discrimination. As increasingly recognised within the study of racial prejudice, not addressing issues of difference only perpetuates and legitimates the discrimination of all bodies thereby supporting the superiority of thin, white, heterosexual, male bodies (Anderson, 2010).

4.6.3. Public Policy

Social rhetoric in the description of obesity is often stigmatising, with phrases such as 'the war on obesity' and 'an obesity epidemic' (Saguy & Riley, 2005). As a result, people with obesity are considered a medical, financial and social liability in society (Brown-Bowers & Ward, 2017). At a public health level, the difficulties which participants in this study, and in the wider literature encountered, in achieving sustainable weight loss centred greatly around societal stigma. Brewis et al. (2018) maintain that the way in which shame and discrimination are mobilised to 'tackle' obesity will inevitably undermine public health efforts. Therefore, action is needed to reduce the vulnerability of those who are living with obesity through the address of moralistic arguments in public policy. Future obesity prevention initiatives and treatments must offer a society which facilitates freedom from discrimination to people living with obesity instead of reinforcing stigma, shame and lived distress.

It is well founded that weight-based stigma is pervasive within Western culture (Latner et al., 2013). However, the subject of weight-based stigma is largely absent both at the individual level of national discourse, as well as in health-promoting measures and political priority areas (Puhl & Suh, 2015). The language that is chosen by policy makers has been shown to impact public attitudes toward policy. In a study, by Thibodeau et al. (2015), people who agreed with a narrative that blamed individuals for their weight were more likely to support the use of penalties (such as increased tax on sugary products), while those who understood obesity in terms of environmental contributors (such as poverty) were more inclined to support polices designed to protect individuals with obesity.

A life-course approach which offers an empowering environment (as opposed to the expectation individuals can empower themselves in the face of considerable societal prejudice) is what is needed. This should involve making society accessible through challenging social stigma and promoting national access to a nutritional, sustainable, equitable food environment. This would mean addressing weight-based discrimination in childhood through primary care initiatives to support parenting of children with obesity, teacher training and educational programmes. Beyond addressing bullying these programmes should include offering opportunities to promote a range of healthy lifestyles through cookery classes and integration of body positivity ideas in physical education lessons beyond issues of weight or sports acumen.

As a society we should move away from the stereotyped imagery and language used to depict people living with obesity (e.g., images that depict overweight people in sedentary behaviours, eating junk food). Most significantly, the recognition of the link between income inequality and health must be recognised and addressed. In 2018 The Food Foundation published a report which claimed that households with children in the bottom two deciles, earning less than £15,860, would need to spend 42% of their disposable income (after housing) on food to meet the UK Government’s Eatwell Guidelines (Scott et al., 2018). Strategies such as taking a stronger role in the regulation of processed foods and additives which encourage and maintain overeating, ensuring food labels are simpler and people are encouraged to read them, improving the air and water quality and access to green spaces offer a multi-dimensional solution for a multi-dimensional problem. Public Health and healthcare professionals must universally recognise the damage simplistic obesity narratives can do, whilst supporting realistic and sustainable behaviour change in a way which addresses the multiple factors that influence weight.

4.7 Research Limitations

4.7.1. Sample

This analysis is based on a small sampled group of WLS patients from one hospital who were accessible through support groups and interested in participating. Efforts were made to recruit from a range of genders, age groups and ethnicities to target a diverse sample. However, towards the end of the timeframe for interviews several interviews were cancelled by participants which could not be rescheduled. While the resulting sample did garner some degree of diversity, these differences did not intersect sufficiently to form coherent patterns within the dataset. However, given the scarcity of comparable studies in the UK, it was important to capture the factors that were significant in adjustment following surgery.

Additionally as research by Ando et al. (2014) and Guest et al. (2006) has demonstrated, 12 interviews is considered optimal to identify all key variants of the phenomenon under study in order to combine into an emerging theory, although a vast majority of variants will have been identified within the first six. Particularly given the range of demographic backgrounds of people in the UK who undergo WLS a larger sample may have been beneficial to develop the perspectives of males and minority groups (race, nationality and sexuality) in particular.

4.7.2. Transcription

Hepburn (2005) has observed that transcription is a very limited means to capture the wealth of human (often embodied) reactions. I felt during the process of committing interviews to audio recordings and typed transcripts that something of the nature of the interactions was lost: tone of voice and gestures, expressions of sadness and uncomfortable moments. I attempted to counter this through a reflexive diary written immediately after the interviews which also informed the interpretation of transcripts.

4.7.3. Telephone Interviews

Six participants were interviewed over the telephone (the remaining three in the hospital). Interviewing over the telephone may have impacted the recordings in terms of giving fewer opportunities to build rapport. However, the researcher did not sense difficulties establishing rapport with participants, who were given a number of opportunities to withdraw from participation if they felt uncomfortable. Researchers such as Cachia and Milward (2011) highlight the potential advantages of telephone interviews, such as offering greater convenience. In the present study, participants often lived a great distance from the hospital and telephone interviews gave them flexibility in timing. Additionally, not being able to see the researcher may have enhanced disclosure about stigmatised topics. In the specialism of obesity, participants discussed the unhelpfulness and lack of understanding of healthcare professionals, particularly those of lower weight. It is possible that in-person interviews could have impeded participants’ ability to raise these issues through fear of judgement.

4.7.4. Generalisability

Dominant quantitative standards of generalisability are incompatible with the critical realist epistemology and qualitative methodology of this project. The analysis findings are “vertically generalisable” in that they build on previous research, wider social discourses around weight and WLS and institutional practices (Johnson, 1997). The project drew on participants with a broad range of demographics and identified unifying themes. This project has highlighted the necessity of a nuanced approach to assessment and support for those undergoing WLS.

4.8. Reflexive Statement

Reflexivity is paramount to maintaining integrity of the qualitative research. Reflexivity allows the researcher to critically reflect on the influence of their lived experience on the research (Spencer & Ritchie, 2012; Willig, 2008; Yardley, 2000). As a result of the immersion demanded of the researcher by qualitative methods the completed research is indivisible from the researcher therefore, it is essential to be transparent concerning the ways in which the researcher influences the research produced (Nightingale & Cromby 1999).

I consider my identity as a ‘normal’ weight white woman particularly significant in this research. Growing up in a racially divided city, I became aware of issues of white privilege from an early age. Areas of my community were burned down during the Oldham race riots of 2001. Rubbish or sometimes bricks were thrown at my non-white friends and I for associating in public. Such discrimination was temporary for me. However, my friends of colour have suffered continued discrimination based on their race, from being interrogated for hours in airports to being continually asked ‘Where are you *really* from?’

As a woman who has spent a majority of her adult life in central London, I was taken aback by a male friend’s throw-away comment that as an adult male he ‘rarely’ felt intimidated walking down the street. I became aware of the number of decisions I made in a day based on intimidation: wearing headphones in public, avoiding eye-contact, wearing particular clothes that made me feel ‘safe’, or not risking the short-cut home. Later at a one-woman play ‘Fatty Fat Fat’ by Katie Greenall, I saw a young performer describe painful experiences stretching from childhood: wishing that she could go to sleep not hoping to wake up thinner, to walk down the street without her body being politicised, or to not be confused with another member of a group because they were both ‘fat’. I reflected on how different bodies experience the world and how my identity, relationships and my choices had been shaped in ways I had not considered.

My assumptions on entering this research had been that WLS surgery was an extension of the politicisation and discrimination against higher weight bodies. However, on talking to the participants my position changed. It was clear that although the power inherent in discussions with doctors, the social stigma of being higher weight and its construction of being dangerous to life had influenced their decision and they had adapted reflexively to the outcome of surgery with strength and intuition. Although for a vast majority of participants the surgery was a positive experience, I do not feel individuals should have to endure major surgery to feel in control of their lives and be recognised for who they are.

White privilege exists as the direct result of historic and enduring racism within society designed to oppress people of colour. I believe that the legitimisation of weight-based stigma in society perpetuates the discrimination against all other forms of embodied difference including gait, accent, birthmarks and disabilities. As a ‘normal’ weight white individual I have experienced little social disadvantage. Therefore, I feel an ethical duty to use my position of privilege to highlight issues which perpetuate social inequality.

4.9. Importance of this research

This study added to limited research available on the long-term psychosocial consequences of WLS. The findings have important implications for clinical practice, in terms of preparing individuals for WLS and supporting them long-term. The finding that even the decision to have weight loss surgery placed pressure on participants relationships was significant. As weight loss ensued participants found themselves unable to maintain some relationships or participate in family meals, reducing social resources to draw on for support.

The surgery highlights the significance of both phenomenological and discursive ideas to understanding WLS experience. In particular meta-perspectives on the role of stigma in limiting the participants identity pre-surgery were significant in distancing participants from shame. Meta perspectives were most frequently generated by WLS support groups, but this study also highlighted the possibility of utilising alternative narratives such as African standards of beauty which were less stigmatising.

These results contribute to improving understandings among health professionals in the challenges facing WLS patients in order to enhance engagement and achieve a higher standard of care. It is the hope that this research will contribute towards a greater recognition of the damaging effect of stigma in preventing them from living their desired lives.

4.10. Conclusion

In undergoing WLS, individuals embark upon a dynamic and challenging path. They were brought to not only manage profound physiological changes, but also broader systemic adjustment to their public and private social spheres. This study emphasised the complex cognitive and behavioural aspects of embodied transition and sustained lifestyle change as patients adapt to the dynamic nature of this experience. Participants were necessarily forced to accommodate the surgery through radical changes to dietary habits, come to terms with their new body and the way others related to it. Participants who were able to do this had access to appropriate support networks, which facilitated an integration of the surgery into their pre-surgery identity. Although participants emphasised the many positive physical, social and emotional outcomes of WLS, given the context of stigma against heavier bodies in routines of eating and exercising WLS may be seen as perhaps maintaining an eminently improvable status quo.

REFRENCES

Alicke, M. D., Buckingham, J., Zell, E., & Davis, T. (2008). Culpable control and counterfactual reasoning in the psychology of blame. *Personality and Social Psychology Bulletin*, *34*(10), 1371-1381.

Alkharaiji, M., Anyanwagu, U., Donnelly, R., & Idris, I. (2019). Tier 3 specialist weight management service and pre-bariatric multicomponent weight management programmes for adults with obesity living in the UK: A systematic review. *Endocrinology, Diabetes & Metabolism*, *2*(1), e00042.

Allison, D. B., Downey, M., Atkinson, R. L., Billington, C. J., Bray, G. A., Eckel, R. H., Finkelstein, E. A., Jensen, M. D., & Tremblay, A. (2008). Obesity as a disease: a white paper on evidence and arguments commissioned by the Council of the Obesity Society. *Obesity (Silver Spring, Md.)*, *16*(6), 1161–1177. https://doi.org/10.1038/oby.2008.231

Anderson, K. J. (2010). *Benign bigotry: The psychology of subtle prejudice*. Cambridge University Press.

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: Development and refinement of a codebook. *Comprehensive Psychology*, *3*, 03-CP.

Apovian C. M. (2016). Obesity: definition, comorbidities, causes, and burden. *The American Journal of Managed Care*, *22*(7), 176–185.

Arksey, H., & O’Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology: Theory and Practice*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Avenell, A., Robertson, C., Skea, Z., Jacobsen, E., Boyers, D., Cooper, D., ... & Stewart, F. (2018). Bariatric surgery, lifestyle interventions and orlistat for severe obesity: the REBALANCE mixed-methods systematic review and economic evaluation. *Health Technology Assessment*, *22*(68).

Backman, O., Stockeld, D., Rasmussen, F., Näslund, E., & Marsk, R. (2016). Alcohol and substance abuse, depression and suicide attempts after Roux-en-Y gastric bypass surgery. *The British Journal of Surgery*, *103*(10), 1336–1342. https://doi.org/10.1002/bjs.10258

Bagnall, A. M., Radley, D., Jones, R., Gately, P., Nobles, J., Van Dijk, M., ... & Sahota, P. (2019). Whole systems approaches to obesity and other complex public health challenges: a systematic review. *BMC Public Health*, *19*(1), 8.

Bartky, S. L. (2015). *Femininity and domination: Studies in the phenomenology of oppression*. Routledge.

Baumeister, R. F. (1995). Self and identity: An introduction. In A. Tesser (Ed.), *Advanced Social Psychology* (pp. 51–97). New York: McGraw-Hill.

Beaulac, J., & Sandre, D. (2015). Impact of a CBT psychotherapy group on post-operative bariatric patients. *Springerplus*, *4*(1), 764.

Beck, N. N., Johannsen, M., Støving, R. K., Mehlsen, M., & Zachariae, R. (2012). Do postoperative psychotherapeutic interventions and support groups influence weight loss following bariatric surgery? A systematic review and meta-analysis of randomized and nonrandomized trials. *Obesity surgery*, *22*(11), 1790-1797.

Benson-Davies, S., Davies, M. L., & Kattelmann, K. (2013). Understanding eating and exercise behaviors in post Roux-en-Y gastric bypass patients: a quantitative and qualitative study. *Bariatric Surgical Practice and Patient Care*, *8*(2), 61–68. https://doi.org/10.1089/bari.2013.9989

Bhaskar, R. (1975*). A realist theory of science*. Brighton: Harvester.

Bhaskar, R. (1989). *The possibility of naturalism*. Brighton: Harvester.

Bhaskar, R. (1998). Societies. In M. Archer, R. Bhaskar, A. Collier, T. Lawson and A. Norrie (Eds.), *Critical realism: Essential readings*, pp. 206–57. London: Routledge

Bordo, S. (2004). *Unbearable weight: Feminism, Western culture, and the body*. Univ of California Press.

Borgès Da Silva, V., Borgès Da Silva, R., Prud'homme, A., Campan, P., Azorin, J. M., & Belzeaux, R. (2018). Association between binge eating disorder and psychiatric comorbidity profiles in patients with obesity seeking bariatric surgery. *Comprehensive Psychiatry*, *87*, 79–83. https://doi.org/10.1016/j.comppsych.2018.09.004

Boswell, J. (2018). What makes evidence‐based policy making such a useful myth? The case of NICE guidance on bariatric surgery in the United Kingdom. *Governance*, *31*(2), 199-214.

Boswell, N., Byrne, R., & Davies, P. S. (2018). Aetiology of eating behaviours: A possible mechanism to understand obesity development in early childhood. *Neuroscience & Biobehavioral Reviews*, *95*, 438-448.

Birch, L., Savage, J. S., & Ventura, A. (2007). Influences on the development of children's eating behaviours: from infancy to adolescence. *Canadian journal of dietetic practice and research: a publication of Dietitians of Canada= Revue canadienne de la pratique et de la recherche en dietetique: une publication des Dietetistes du Canada*, *68*(1), s1.

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development.* Sage Publications.

Brandenburg, D., & Kotlowski, R. (2005). Practice makes perfect? Patient response to a prebariatric surgery behavior modification program. *Obesity surgery*, *15*(1), 125-132.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Braun, V., Clarke, V., & Terry, G. (2014). Thematic Analysis. In P. Rohleder & A. Lyons (Eds.), *Qualitative research in clinical and health psychology* (2nd ed., pp. 95–114). Basingstoke: Palgrave Macmillan

Brewis, A., SturtzSreetharan, C., & Wutich, A. (2018). Obesity stigma as a globalizing health challenge. *Globalization and Health*, *14*(1), 20. https://doi.org/10.1186/s12992-018-0337-x

British Medical Association. (2017). Health at a price: Reducing the impact of poverty [online resource]. Retrieved from https://www.bma.org.uk/media/2084/health-at-a-price-2017.pdf

Brown-Bowers, A., Ward, A., & Cormier, N. (2017). Treating the binge or the (fat) body? Representations of fatness in a gold standard psychological treatment manual for binge eating disorder. *Health*, *21*(1), 21-37.

Bruze, G., Holmin, T. E., Peltonen, M., Ottosson, J., Sjöholm, K., Näslund, I., Neovius, M., Carlsson, L., & Svensson, P. A. (2018). Associations of Bariatric Surgery With Changes in Interpersonal Relationship Status: Results From 2 Swedish Cohort Studies. *JAMA surgery*, *153*(7), 654–661. doi.org/10.1001/jamasurg.2018.0215

Bylund, A., Benzein, E., & Sandgren, A. (2017). Stabilizing family life after gastric bypass surgery. *International journal of qualitative studies on health and well-being*, *12*(1), 1325674. doi.org/10.1080/17482631.2017.1325674

Cachia, M., & Millward, L. (2011). The telephone medium and semi-structured interviews: a complementary fit. *Qualitative Research in Organizations and Management: An International Journal, 6*(3), 265–277. doi.org/10.1108/17465641111188420

Cain, P., Donaghue, N., & Ditchburn, G. (2017). Concerns, culprits, counsel, and conflict: A thematic analysis of “obesity” and fat discourse in digital news media. *Fat Studies*, *6*(2), 170-188.

Caplan A. L. (1994). Ethics of casting the first stone: personal responsibility, rationing, and transplants. *Alcoholism, Clinical and Experimental Research*, *18*(2), 219–221. doi.org/10.1111/j.1530-0277.1994.tb00002.x

Caplan, P. (1997). Approaches to the study of food, health and identity. *Food, health and identity*, 1-31.

Carosella, E. D., & Pradeu, T. (2006). Transplantation and identity: a dangerous split?. *Lancet*, *368*(9531), 183-183. doi: 10.1016/S0140-6736(06)68938-1.

Castelnuovo, G., Pietrabissa, G., Manzoni, G. M., Cattivelli, R., Rossi, A., Novelli, M., ... & Molinari, E. (2017). Cognitive behavioral therapy to aid weight loss in obese patients: current perspectives. *Psychology research and behavior management*.

Cerulo, K. A. (1997). Identity Construction: New Issues, New Directions. *Annual Review of Sociology*, *23*(1), 385–409.

Chang, S. H., Stoll, C. R., Song, J., Varela, J. E., Eagon, C. J., & Colditz, G. A. (2014). The effectiveness and risks of bariatric surgery: an updated systematic review and meta-analysis, 2003-2012. *JAMA Surgery*, *149*(3), 275–287. https://doi.org/10.1001/jamasurg.2013.3654

Cooper, T. C., Simmons, E. B., Webb, K., Burns, J. L., & Kushner, R. F. (2015). Trends in Weight Regain Following Roux-en-Y Gastric Bypass (RYGB) Bariatric Surgery. *Obesity surgery, 25*(8), 1474–1481. https://doi.org/10.1007/s11695-014-1560-z

Coulman, K. D., MacKichan, F., Blazeby, J. M., & Owen-Smith, A. (2017). Patient experiences of outcomes of bariatric surgery: a systematic review and qualitative synthesis. Obesity reviews, 18(5), 547-559.

Courcoulas, A. P., Gallagher, J. W., Neiberg, R. H., Eagleton, E. B., DeLany, J. P., Lang, W., ... & Jakicic, J. M. (2020). Bariatric Surgery vs. Lifestyle Intervention for Diabetes Treatment: Five Year Outcomes From a Randomized Trial. *The Journal of Clinical Endocrinology & Metabolism*. https://doi.org/10.1210/clinem/dgaa006

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stan. L. Rev.*, *43*, 1241.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches.* London: Sage.

Crossley, N. (2006). *Reflexive embodiment in contemporary society: The body in late modern society*. McGraw-Hill Education (UK).

Cushing, R. E., & Braun, K. L. (2018). Mind–body therapy for military veterans with post-traumatic stress disorder: a systematic review. *The Journal of Alternative and Complementary Medicine*, *24*(2), 106-114.

De Brún, A., McCarthy, M., McKenzie, K., & McGloin, A. (2014). Weight stigma and narrative resistance evident in online discussions of obesity. *Appetite*, *72*, 73-81.

DeCosta, P., Møller, P., Frøst, M. B., & Olsen, A. (2017). Changing children's eating behaviour-A review of experimental research. *Appetite*, *113*, 327-357.

de Montigny, F., Cloutier, L., Meunier, S., Cyr, C., Coulombe, S., Tremblay, G., ... & Dion, H. (2017). Association between weight status and men’s positive mental health: the influence of marital status. *Obesity Research & Clinical Practice*, 11(4), 389-397.

Descartes, R., & Kenny, A. (1984). *The philosophical writings of Descartes: Volume 3, The correspondence* (Vol. 3). Cambridge University Press.

Dewhurst, A., Peters, S., Devereux-Fitzgerald, A., & Hart, J. (2017). Physicians' views and experiences of discussing weight management within routine clinical consultations: A thematic synthesis. *Patient education and counseling*, *100*(5), 897-908.

Desogus, D., Menon, V., Singhal, R., & Oyebode, O. (2019). An examination of who is eligible and who is receiving bariatric surgery in England: secondary analysis of the health survey for England dataset. *Obesity surgery*, *29*(10), 3246-3251.

Dolan, A. (2014). 'Men give in to chips and beer too easily': How working-class men make sense of gender differences in health. *Health:*, *18*(2), 146-162.

Douglass, T., & Calnan, M. (2016). Trust matters for doctors? Towards an agenda for research. *Social Theory & Health*, *14*(4), 393-413.

Drew, P. (2011). "But then I learned…": weight loss surgery patients negotiate surgery discourses. *Social science & medicine (1982)*, *73*(8), 1230–1237. https://doi.org/10.1016/j.socscimed.2011.07.023

Durkheim, E., & Swain, J. W. (2008). *The elementary forms of the religious life*. Courier Corporation.

Elagizi, A., Kachur, S., Lavie, C. J., Carbone, S., Pandey, A., Ortega, F. B., & Milani, R. V. (2018). An overview and update on obesity and the obesity paradox in cardiovascular diseases. *Progress in cardiovascular diseases*, *61*(2), 142-150.

Engström, M., & Forsberg, A. (2011). Wishing for deburdening through a sustainable control after bariatric surgery. *International Journal of Qualitative Studies on Health and Well-being, 6*(1), 5901.

Erikson, E. (1968). *Identity, youth and crisis*. New York: Norton.

Evans, B., Colls, R., & Hoerschelmann, K. (2011). ‘Change4Life for your kids’: embodied collectives and public health pedagogy. *Sport, Education and Society*, *16*(3), 323-341.

Evans, J., Frank, B., Oliffe, J. L., & Gregory, D. (2011). Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *Journal of Men's Health*, *8*(1), 7-15.

Fikkan, J. L., & Rothblum, E. D. (2012). Is fat a feminist issue? Exploring the gendered nature of weight bias. *Sex Roles*, 66(9-10), 575-592.

Fleischman, S. (1999). I am...,I have...,I suffer from...: A linguist reflects on the language of disease and illness. *Journal of Medical Humanities*, *20*, 3-32.

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). London: Penguin Books Ltd.

Friesen P. (2018). Personal responsibility within health policy: unethical and ineffective. *Journal of Medical Ethics*, *44*(1), 53–58. doi.org/10.1136/medethics-2016-103478

Frith, H., & Gleeson, K. (2004). Clothing and Embodiment: Men Managing Body Image and Appearance. *Psychology of Men & Masculinity, 5*(1), 40–48.

Fuchs, T. (2002). The phenomenology of shame, guilt and the body in body dysmorphic disorder and depression. *Journal of Phenomenological Psychology. 33*(2):223–43. doi:10.1163/15691620260622903

Geraci, A. A., Brunt, A., & Marihart, C. (2014). The Work behind Weight-Loss Surgery: A Qualitative Analysis of Food Intake after the First Two Years Post-Op. *ISRN Obesity*, *2014*, 427062. https://doi.org/10.1155/2014/427062

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199-208.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Stanford university press.

Glenn, N., McGannon, K., & Spence, J. C. (2012). Exploring media representations of weight-loss surgery. *Qualitative Health Research, 23*(5), 631-644.

Gofman, A. (2019). Tradition, Morality and Solidarity in Durkheim's Theory. *Sosyoloji Dergisi/Journal of Sociology*, *39*(1).

Gough, B. (2007). 'Real men don't diet': An analysis of contemporary newspaper representations of men, food and health. *Social Science & Medicine*, 64, 326-337.

Griauzde, D. H., Ibrahim, A. M., Fisher, N., Stricklen, A., Ross, R., & Ghaferi, A. A. (2018). *Understanding the psychosocial impact of weight loss following bariatric surgery: a qualitative study. BMC Obesity, 5(1).* doi:10.1186/s40608-018-0215-3

Groven, K. S., Galdas, P., & Solbrække, K. N. (2015). Becoming a normal guy: Men making sense of long-term bodily changes following bariatric surgery. *International Journal of Qualitative Studies on Health and Well-being*, *10*, 29923. doi:10.3402/qhw.v10.29923

Groven, K. S., Råheim, M., & Engelsrud, G. (2010). "My quality of life is worse compared to my earlier life": Living with chronic problems after weight loss surgery. *International journal of qualitative studies on health and well-being, 5*(4), 10.3402/qhw.v5i4.5553. https://doi.org/10.3402/qhw.v5i4.5553

Groven, K. S., Råheim, M., & Engelsrud, G. (2013). Dis-appearance and dys-appearance anew: living with excess skin and intestinal changes following weight loss surgery. *Medicine, health care, and philosophy*, *16*(3), 507–523. https://doi.org/10.1007/s11019-012-9397-5

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough? *Field Methods*, 18(1), 59–82. doi:10.1177/1525822x05279903

Guilfoyle, M. (2009). Therapeutic discourse and eating disorders in the context of power. In H. Malson & M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 196–206). London: Routledge.

Halfmann, D. (2012). Recognizing medicalization and demedicalization: discourses, practices, and identities. *Health*, 16(2), 186-207.

Harper, D. (2012). Choosing a qualitative research method. In *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* (pp. 83–97). Oxford: Wiley-Blackwell.

Hayes, B. C., Prior, P., & Campling, J. (2017). *Gender and health care in the UK: Exploring the stereotypes*. Macmillan International Higher Education.

Heidmann, J., & Grønkjær, M. (2015). Health-related quality of life six years after gastric bypass: a mixed methods study. *Bariatric Surgical Practice and Patient Care, 10*(2), 56–61. https://doi:10.1089/bari.2014.0052

Health Survey for England. (2019). *Overweight and obesity in adults and children* [online resource]. Retrieved from https://files.digital.nhs.uk/52/FD7E18/HSE18-Adult-Child-Obesity-rep.pdf

Hegel, G. W. F. (1979). *Hegel's Introduction to Àesthetics': Being the Introduction to the Berlin Aesthetics Lectures of the 1820s*. Oxford University Press, USA.

Henderson, J., Wilson, C., Roberts, L., Munt, R., & Crotty, M. (2014). Social barriers to Type 2 diabetes self-management: the role of capital. *Nursing inquiry*, *21*(4), 336-345.

Hepburn, A., & Wiggins, S. (2005). Developments in discursive psychology. *Discourse & Society*, 16(5), 595-601.

Herndon, A. M. (2005). Collateral damage from friendly fire?: Race, nation, class and the “war against obesity”. *Social Semiotics*, *15*(2), 127-141.

Hilbert, A., Braehler, E., Schmidt, R., Löwe, B., Häuser, W., & Zenger, M. (2015). Self-compassion as a resource in the self-stigma process of overweight and obese individuals. *Obesity facts*, 8(5), 293-301.

Hofmann, B. (2013). Bariatric surgery for obese children and adolescents: a review of the moral challenges. *BMC Medical Ethics*, *14*(1), 18.

Hofsø, D., Nordstrand, N., Johnson, L. K., Karlsen, T. I., Hager, H., Jenssen, T., ... & Hjelmesæth, J. (2010). Obesity-related cardiovascular risk factors after weight loss: a clinical trial comparing gastric bypass surgery and intensive lifestyle intervention. *European Journal of Endocrinology, 163*(5), 735.

Hollands, G. J., Marteau, T. M., & Fletcher, P. C. (2016). Non-conscious processes in changing health-related behaviour: a conceptual analysis and framework. *Health Psychology Review*, *10*(4), 381–394. https://doi.org/10.1080/17437199.2015.1138093

Hübner, C., Baldofski, S., Zenger, M., Tigges, W., Herbig, B., Jurowich, C., ... & Hilbert, A. (2015). Influences of general self-efficacy and weight bias internalization on physical activity in bariatric surgery candidates. *Surgery for Obesity and Related Diseases*, *11*(6), 1371-1376.

Hunger, J. M., Major, B., Blodorn, A., & Miller, C. T. (2015). Weighed down by stigma: How weight-based social identity threat contributes to weight gain and poor health. *Social and Personality Psychology Compass*, *9*(6), 255–268. https://doi.org/10.1111/spc3.12172

Ifland, J. R., Preuss, H. G., Marcus, M. T., Rourke, K. M., Taylor, W. C., Burau, K., ... & Manso, G. (2009). Refined food addiction: a classic substance use disorder. *Medical hypotheses*, *72*(5), 518-526.

Ikramuddin, S., Korner, J., Lee, W. J., Thomas, A. J., Connett, J. E., Bantle, J. P., ... & Chong, K. (2018). Lifestyle intervention and medical management with vs without Roux-en-Y gastric bypass and control of hemoglobin A1c, LDL cholesterol, and systolic blood pressure at 5 years in the diabetes surgery study. *JAMA, 319*(3), 266-278.

Institute of Economic Affairs. (2017). Obesity and the public purse [online resource]. https://iea.org.uk/wp-content/uploads/2017/01/Obesity-and-the-Public-Purse-PDF.pdf

Ivezaj, V., Benoit, S. C., Davis, J., Engel, S., Lloret-Linares, C., Mitchell, J. E., Pepino, M. Y., Rogers, A. M., Steffen, K., & Sogg, S. (2019). Changes in Alcohol Use after Metabolic and Bariatric Surgery: Predictors and Mechanisms. *Current Psychiatry Reports, 21*(9), 85. https://doi.org/10.1007/s11920-019-1070-8

Johnson, R. B. (1997). Examining the validity structure of qualitative research. *Education*, *118*(2), 282.

Jones, N., Greenberg, N., Phillips, A., Simms, A., & Wessely, S. (2019). Mental Health, Help-Seeking Behaviour and Social Support in the UK Armed Forces by Gender. *Psychiatry*, *82*(3), 256-271.

Jutel, A. G. (2014). Putting a name to it: Diagnosis in contemporary society. JHU Press.

Kahan, S., & Puhl, R. M. (2017). The damaging effects of weight bias internalization. *Obesity*, *25*(2), 280. doi: 10.1002/oby.21772

Kahan, L. G., & Mehrzad, R. (2020). Refined food addiction and its relation to obesity. In *Obesity* (pp. 165-181). Elsevier.

Kaijser, M., van Ramshorst, G., van Wagensveld, B., & Pierie, J. P. (2018). Current techniques of teaching and learning in bariatric surgical procedures: A systematic review. *Journal of Surgical Education*, *75*(3), 730–738. https://doi.org/10.1016/j.jsurg.2017.09.023

Kalarchian, M. A., Marcus, M. D., Levine, M. D., Courcoulas, A. P., Pilkonis, P. A., Ringham, R. M., Soulakova, J. N., Weissfeld, L. A., & Rofey, D. L. (2007). Psychiatric disorders among bariatric surgery candidates: relationship to obesity and functional health status. *The American Journal of Psychiatry*, *164*(2), 328–374. https://doi.org/10.1176/ajp.2007.164.2.328

Kalarchian, M. A., Marcus, M. D., Courcoulas, A. P., Cheng, Y., & Levine, M. D. (2016). Preoperative lifestyle intervention in bariatric surgery: a randomized clinical trial. *Surgery for Obesity and Related Diseases*, *12*(1), 180-187.

Kashima, Y., Kashima, E., Farsides, T., Kim, U., Strack, F., Werth, L., & Yuki, M. (2004). Culture and context-sensitive self: The amount and meaning of context-sensitivity of phenomenal self differ across cultures. *Self and Identity*, *3*(2), 125-141.

King, W. C., Chen, J. Y., Mitchell, J. E., Kalarchian, M. A., Steffen, K. J., Engel, S. G., Courcoulas, A. P., Pories, W. J., & Yanovski, S. Z. (2012). Prevalence of alcohol use disorders before and after bariatric surgery. *JAMA, 307*(23), 2516–2525. https://doi.org/10.1001/jama.2012.6147

Koball, A. M., Clark, M. M., Collazo-Clavell, M., Kellogg, T., Ames, G., Ebbert, J., & Grothe, K. B. (2016). The relationship among food addiction, negative mood, and eating-disordered behaviors in patients seeking to have bariatric surgery. *Surgery for obesity and related diseases : official journal of the American Society for Bariatric Surgery*, *12*(1), 165–170. https://doi.org/10.1016/j.soard.2015.04.009

Kroger, J. (2008). Identity development during adolescence. *In Handbook of Adolescence* (pp. 205–226). New Jersey: Blackwell.

Lammers, W. J., van Tilburg, A. J., Apers, J. A., & Wiebolt, J. (2018). Liver failure caused by prolonged state of malnutrition following bariatric surgery. *World journal of hepatology*, *10*(3), 396.

Latner, J. D., Durso, L. E., & Mond, J. M. (2013). Health and health-related quality of life among treatment-seeking overweight and obese adults: associations with internalized weight bias. *Journal of Eating Disorders*, *1*(1), 3.

Latner, J. D., O'Brien, K. S., Durso, L. E., Brinkman, L. A., & MacDonald, T. (2008). Weighing obesity stigma: the relative strength of different forms of bias. *International Journal of Obesity*, *32*(7), 1145-1152.

Leder, D. (1990). *The absent body*. Chicago and London: The University of Chicago Press.

Leder, D. (1992). A tale of two bodies: The Cartesian corpse and the lived body. In *The body in medical thought and practice* (pp. 17-35). Springer, Dordrecht.

Lee, J. H., Nguyen, Q. N., & Le, Q. A. (2016). Comparative effectiveness of 3 bariatric surgery procedures: Roux-en-Y gastric bypass, laparoscopic adjustable gastric band, and sleeve gastrectomy. *Surgery for Obesity and Related Diseases: Official Journal of the American Society for Bariatric Surgery*, *12*(5), 997–1002. https://doi.org/10.1016/j.soard.2016.01.020

LePage, C. T. (2010). The lived experience of individuals following Roux-en-Y gastric bypass surgery: a phenomenological study. *Bariatric Nursing and Surgical patient care*, *5*(1), 57-64.

Li, L., & Wu, L. T. (2016). Substance use after bariatric surgery: A review. *Journal of Psychiatric Research*, *76*, 16–29. https://doi.org/10.1016/j.jpsychires.2016.01.009

Lier, H. Ø., Aastrom, S., & Rørtveit, K. (2015). *Patients' daily life experiences five years after gastric bypass surgery - a qualitative study. Journal of Clinical Nursing,* *25*(3-4), 322–331. https://doi:10.1111/jocn.13049

Livhits, M., Mercado, C., Yermilov, I., Parikh, J. A., Dutson, E., Mehran, A., ... & Gibbons, M. M. (2012). Preoperative predictors of weight loss following bariatric surgery: systematic review. *Obesity surgery*, *22*(1), 70-89.

Luoma, J. B., & Platt, M. G. (2015). Shame, self-criticism, self-stigma, and compassion in Acceptance and Commitment Therapy. *Current opinion in Psychology*, *2*, 97-101.

Luy, M., & Minagawa, Y. (2014). Gender gaps-Life expectancy and proportion of life in poor health. *Health Reports*, *25*(12), 12.

Lydecker, J. A., Galbraith, K., Ivezaj, V., White, M. A., Barnes, R. D., Roberto, C. A., & Grilo, C. M. (2016). Words will never hurt me? Preferred terms for describing obesity and binge eating. *International Journal of Clinical Practice*, *70*(8), 682–690. https://doi.org/10.1111/ijcp.12835

Lydecker, J. A., Ivezaj, V., & Grilo, C. M. (2019). Secretive eating and binge eating following bariatric surgery. *The International Journal of Eating Disorders, 52*(8), 935–940. https://doi.org/10.1002/eat.23089

Lynch A. (2016). "When the honeymoon is over, the real work begins:" Gastric bypass patients' weight loss trajectories and dietary change experiences. *Social Science & Medicine (1982)*, *151*, 241–249. https://doi.org/10.1016/j.socscimed.2015.12.024

Lynch, C. S., Chang, J. C., Ford, A. F., & Ibrahim, S. A. (2007). Obese African-American women's perspectives on weight loss and bariatric surgery. *Journal of general internal medicine*, *22*(7), 908-914.

Madura, J. A., & Dibaise, J. K. (2012). Quick fix or long-term cure? Pros and cons of bariatric surgery. *F1000 Medicine Reports*, 4, 19. https://doi.org/10.3410/M4-19

McNay, L. (2013). *Foucault and feminism: Power, gender and the self*. John Wiley & Sons.

Mead, G. H. (1967). *Mind, self and society*. *1934*. Chicago: University of Chicago Press.

Mechanick, J. I., Youdim, A., Jones, D. B., Garvey, W. T., Hurley, D. L., McMahon, M. M., Heinberg, L. J., Kushner, R., Adams, T. D., Shikora, S., Dixon, J. B., Brethauer, S., American Association of Clinical Endocrinologists, Obesity Society, & American Society for Metabolic & Bariatric Surgery (2013). Clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient--2013 update: cosponsored by American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery. *Obesity (Silver Spring, Md.)*, *21 Suppl 1*(0 1), S1–S27. https://doi.org/10.1002/oby.20461

Merleau-Ponty, M. (1962). *Phenomenology of Perception*. London and New York. *Routledge*, *5*, 15180.

Merleau-Ponty, M. (2005). *The Cambridge Companion to Merleau-Ponty*. Cambridge University Press.

Merrill, E., & Grassley, J. (2008). Women's stories of their experiences as overweight patients. *Journal of Advanced Nursing*, *64*(2), 139-146.

Mingrone, G., Panunzi, S., De Gaetano, A., Guidone, C., Iaconelli, A., Nanni, G., Castagneto, M., Bornstein, S., & Rubino, F. (2015). Bariatric-metabolic surgery versus conventional medical treatment in obese patients with type 2 diabetes: 5 year follow-up of an open-label, single-centre, randomised controlled trial. *Lancet (London, England)*, *386*(9997), 964–973. https://doi.org/10.1016/S0140-6736(15)00075-6

Minuchin, S., & Minuchin, P. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Mold, F., & Forbes, A. (2013). Patients' and professionals' experiences and perspectives of obesity in health-care settings: a synthesis of current research. *Health Expectations*, *16*(2), 119-142.

Monaghan, L. F., & Malson, H. (2013). ‘It’s worse for women and girls’: Negotiating embodied masculinities through weight-related talk. *Critical public health*, *23*(3), 304-319.

Morgan, K. P. (2009). Women and the knife: Cosmetic surgery and the colonization of women’s bodies,’. *Cosmetic surgery: A feminist primer*, 49-77.

Mulla, C. M., Middelbeek, R., & Patti, M. E. (2018). Mechanisms of weight loss and improved metabolism following bariatric surgery. *Annals of the New York Academy of Sciences*, *1411*(1), 53–64. https://doi.org/10.1111/nyas.13409

Müller, A., Hase, C., Pommnitz, M., & de Zwaan, M. (2019). Depression and Suicide After Bariatric Surgery. *Current Psychiatry Reports*, *21*(9), 84. https://doi.org/10.1007/s11920-019-1069-1

Mushquash, A. R., & McMahan, M. (2015). Dialectical behavior therapy skills training reduces binge eating among patients seeking weight-management services: Preliminary evidence. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, *20*(3), 415-418.

Myers, A., & Rosen, J. C. (1999). Obesity stigmatization and coping: relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity, 23*(3), 221-230.

NHS. (2014a).’Five year forward view’ [online resource]. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS. (2014b). Future of health conference to debate empowering people to take control of their care [website] Retrieved from https://www.england.nhs.uk/2014/11/future-of-health-empowering-people/

NHS. (2020). *Overview Weight Loss Surgery* [website]. Retreived from https://www.nhs.uk/conditions/weight-loss-surgery/

NICE. (2014). Obesity: assessment, intervention and management [online resource]. https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations

Natvik, E., Gjengedal, E., Moltu, C., & Råheim, M. (2014). Re-embodying eating: Patients' experiences 5 years after bariatric surgery. *Qualitative Health Research*, *24*(12), 1700–1710. https://doi.org/10.1177/1049732314548687

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. McGraw-Hill Education (UK).

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), https://.doi.1609406917733847.

Nuffield Trust. (2020). *Obesity* [online resource]. Retrieved from https://www.nuffieldtrust.org.uk/resource/obesity

O'Brien, P. E., Hindle, A., Brennan, L., Skinner, S., Burton, P., Smith, A., ... & Brown, W. (2019). Long-term outcomes after bariatric surgery: a systematic review and meta-analysis of weight loss at 10 or more years for all bariatric procedures and a single-centre review of 20-year outcomes after adjustable gastric banding. *Obesity surgery*, *29*(1), 3-14.

Ogden, J., Avenell, S., Ellis, G. (2011). Negotiating control: Patients' experiences of Unsuccessful Weight Loss Surgery. *Psychology and Health.* 26; 949-964.

Ogden, J., & Clementi, C. (2010). The experience of being obese and the many consequences of stigma. *Journal of obesity*, *10*. https://doi.org/10.1155/2010/429098

Ogden, J., Clementi, C., & Aylwin, S. (2006). The impact of obesity surgery and the paradox of control: a qualitative study. *Psychology and Health 21*(2), 273e293. http://dx.doi.org/10.1080/14768320500129064.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy (norton series on interpersonal neurobiology)*. WW Norton & Company.

Ogden, J., Ratcliffe, D., & Snowdon-Carr, V. (2019). British Obesity Metabolic Surgery Society endorsed guidelines for psychological support pre- and post-bariatric surgery. *Clinical Obesity*, *9*(6), e12339. https://doi.org/10.1111/cob.12339

Ortega, F. B., Ruiz, J. R., Labayen, I., Lavie, C. J., & Blair, S. N. (2018). The Fat but Fit paradox: what we know and don't know about it. *British Journal of Sports Medicine* 52**,** 151-153.

Overs, S.E., Freeman, R.A., Zarshenas, N., Walton, K.L., & Jorgensen, J.O. (2012). Food tolerance and gastrointestinal quality of life following three bariatric procedures: adjustable gastric banding, Roux-en-Y gastric bypass, and sleeve gastrectomy. *Obesity Surgery 22*(4), 536e543.

Parmer, S. M., Salisbury-Glennon, J., Shannon, D., & Struempler, B. (2009). School gardens: an experiential learning approach for a nutrition education program to increase fruit and vegetable knowledge, preference, and consumption among second-grade students. *Journal of nutrition education and behavior*, *41*(3), 212-217.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Sage Publications.

Pearl, R. L., & Puhl, R. M. (2016). The distinct effects of internalizing weight bias: an experimental study. *Body Image*, *17*, 38-42.

Peters, M. D. J., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. *International Journal* *of Evidence-Based Healthcare*, *13*(3), 141–146. https://doi.org/10.1097/XEB.0000000000000050

Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews, 16*(4), 319-326.

Pilgrim, R., & Bentall, D. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health, 8*(3), 261–274. https://doi.org/10.1080/09638239917427

Poland, B. D. (2002). Transcription quality. In J. F. Gubrium & Holstein. J.A (Eds.), *Handbook of interview research: Context and Method.* (pp. 629– 649). Sage.

Public Health England. (2019). *Adult obesity applying all our health* [online resource]. Retrieved from https://www.gov.uk/government/publications/adult-obesity-applying-all-our-health/adult-obesity-applying-all-our-health

Puhl, R. M., Heuer, C. A., & Brownell, K. D. (2010). Stigma and social consequences of obesity. *Clinical Obesity in Adults and Children*, *25*, 40.

Puhl, R. M., & Liu, S. (2015). A national survey of public views about the classification of obesity as a disease. *Obesity*, *23*(6), 1288-1295.

Puhl, R., & Suh, Y. (2015). Health consequences of weight stigma: implications for obesity prevention and treatment. *Current Obesity Reports*, *4*(2), 182-190.

Royal College of Surgeons (2014). Commissioning guide: weight assessment and management. London: Royal College of Surgeons. Retrieved from: http://www.bomss.org.uk/wp-content/uploads/2014/04/Commissioning-guide-weight-assessment-and-management-clinics-published.pdf

Saguy, A. C., & Riley, K. W. (2005). Weighing both sides: Morality, mortality, and framing contests over obesity. *Journal of Health Politics, Policy and Law*, *30*(5), 869-923.

Savage, J. S., Fisher, J. O., & Birch, L. L. (2007). Parental influence on eating behavior: conception to adolescence. *The Journal of law, medicine & ethics*, *35*(1), 22-34.

Schvey, N. & Puhl, R., & Brownell, K. (2011). The Impact of Weight Stigma on Caloric Consumption. *Obesity,* 19 1957-62. https://doi: 10.1038/oby.2011.204.

Schwartz, M. B., Chambliss, H. O. N., Brownell, K. D., Blair, S. N., & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research*, 11(9), 1033-1039.

Scott, C., Sutherland, J., & Taylor, A. (2018). Affordability of the UK's Eatwell Guide. *The Food Foundation*.

Shapiro, S. A. (1996). The embodied analyst in the Victorian consulting room. *Gender & Psychoanalysis, 1*, 297-322.

Shildrick, M. (2015). Staying alive: Affect, identity and anxiety in organ transplantation. *Body & Society*, *21*(3), 20-41.

Silver, J., Reavey, P., & Anne Fineberg, N. (2010). How do people with body dysmorphic disorder view themselves? A thematic analysis. *International journal of psychiatry in clinical practice*, *14*(3), 190-197.

Slaney, K., Tafreshi, D., & Wu, C. A. (2019). Philosophical Reflexivity in Psychological Science: Do We Have It? Does It Matter?. In *Psychological Studies of Science and Technology* (pp. 237-256). Palgrave Macmillan, Cham.

Sockalingam, S., Leung, S. E., Wnuk, S., Cassin, S. E., Yanofsky, R., & Hawa, R. (2020). Psychiatric Management of Bariatric Surgery Patients: A Review of

Psychopharmacological and Psychological Treatments and their Impact on Post-Operative Mental Health and Weight Outcomes. *Psychosomatics*.

Sogg, S., & Gorman, M. J. (2008). Interpersonal changes and challenges after weight-loss surgery. *Primary Psychiatry*, *15*(8), 61-66.

Sogg, S., Lauretti, J., & West-Smith, L. (2016). Recommendations for the presurgical psychosocial evaluation of bariatric surgery patients. *Surgery for Obesity and Related Diseases*, *12*(4), 731-749.

Sogg, S., Grupski, A., & Dixon, J. B. (2018). *Bad words: why language counts in our work with bariatric patients. Surgery for Obesity and Related Diseases, 14(5), 682–692.* https://doi:10.1016/j.soard.2018.01.013.

Sokol, R. L., Ennett, S. T., Shanahan, M. E., Gottfredson, N. C., Poti, J. M., Halpern, C. T., & Fisher, E. B. (2019). Maltreatment experience in childhood and average excess body mass from adolescence to young adulthood. *Child Abuse & Neglect*, *96*, 104070. https://doi 10.1016/j.chiabu.2019.104070

Spence, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis.* New York: Norton.

Spencer, L., & Ritchie, J. (2012). In pursuit of quality. *Qualitative research methods in mental health and psychotherapy*, 227-242.

Stegenga, H., Haines, A., Jones, K., & Wilding, J. (2014). Identification, assessment, and management of overweight and obesity: summary of updated NICE guidance. *BMJ*, *349*, 6608.

Stergiou-Kita, M., Lafrance, M., Pritlove, C., & Power, N. (2017). Examining theoretical approaches to men and masculinity in the context of high-risk work: Applications, benefits and challenges. *Safety science*, *96*, 150-160.

Stolzenberger, K. M., Meaney, C. A., Marteka, P., Korpak, S., & Morello, K. (2013). Long-term quality of life following bariatric surgery: A descriptive study. *Bariatric Surgical Patient Care, 8*(1), 29-38. https://doi 10.1089/bari.2013.9996

Stoner, L., & Cornwall, J. (2014). Did the American Medical Association make the correct decision classifying obesity as a disease? *The Australasian medical journal*, *7*(11), 462.

Strain, G. W., Kolotkin, R. L., Dakin, G. F., Gagner, M., Inabnet, W. B., Christos, P., Saif, T., Crosby, R., & Pomp, A. (2014). The effects of weight loss after bariatric surgery on health-related quality of life and depression. *Nutrition & Diabetes*, *4*(9), e132. https://doi 10.1038/nutd.2014.29

Sutcliffe, K., Richardson, M., Rees, R., Burchett, H., Melendez-Torres, G. J., Stansfield, C., & Thomas, J. (2016). What are the critical features of successful Tier 2 weight management programmes? A systematic review to identify the programme characteristics, and combinations of characteristics, that are associated with successful weight loss. Department of Health Reviews Facility. Retrieved from: https://researchonline.lshtm.ac.uk/id/eprint/4656948/1/Weight%20management%202016%20Sutcliffe%20report%281%29.pdf

Ratcliffe, D., Ali, R., Ellison, N., Khatun, M., Poole, J., & Coffey, C. (2014). Bariatric psychology in the UK National Health Service: input across the patient pathway. *BMC obesity*, *1*(1), 1-7. https://doi.org/10.1186/s40608-014-0020-6

Tarrant, M., Khan, S. S., Farrow, C. V., Shah, P., Daly, M., & Kos, K. (2017). Patient experiences of a bariatric group programme for managing obesity: a qualitative interview study. *British journal of health psychology*, *22*(1), 77-93.

Thibodeau, P. H., Perko, V. L., & Flusberg, S. J. (2015). The relationship between narrative classification of obesity and support for public policy interventions. *Social Science & Medicine*, 141, 27-35.

Throsby, K. (2009). There’s something in my brain that doesn’t work properly. Weight loss surgery and the medicalisation of obesity. *In* H. Malson, & M. Burns (Eds.), *Critical feminist approaches to eating disorders* (pp. 185-195). London and New York: Routledge.

Tomiyama, A. J., Carr, D., Granberg, E. M., Major, B., Robinson, E., Sutin, A. R., & Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Medicine*, *16*(1), 123. https://doi 10.1186/s12916-018-1116-5

Triandis, H. C. (2018). *Individualism and collectivism*. Routledge.

Uittenbogaart, M., Luijten, A., van Dielen, F., & Leclercq, W. (2017). Long-Term Results of Laparoscopic Sleeve Gastrectomy for Morbid Obesity: 5 to 8-Year Results. *Obesity Surgery*, *27*(6), 1624. https://doi.org/10.1007/s11695-017-2655-0

Van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry,1*(5), 253-265.

Van der Kolk, B. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma.* London: Penguin Books.

Waldron, R., Malpus, Z., Shearing, V., Sanchez, M., & Murray, C. D. (2017). Illness, normality and identity: the experience of heart transplant as a young adult. *Disability and Rehabilitation*, *39*(19), 1976–1982. https://doi.org/10.1080/09638288.2016.1213896

Watson, C., Riazi, A., & Ratcliffe, D. (2020). Exploring the Experiences of Women Who Develop Restrictive Eating Behaviours After Bariatric Surgery. *Obesity Surgery*, 1-9.

Wedin, S., Madan, A., Correll, J., Crowley, N., Malcolm, R., Byrne, T. K., & Borckardt, J. J. (2014). Emotional eating, marital status and history of physical abuse predict 2-year weight loss in weight loss surgery patients. *Eating behaviors*, *15*(4), 619-624.

Welbourn, R., Small, P., Finlay, I., Sareela, A., Somers, S., Mahawar, K., ... & Kinsman, R. (2014). The United Kingdom national bariatric surgery registry. *Second registry report*, *2014*.

Welz, C. (2011). Shame and the hiding self. *Passions in context: International Journal for the History and Theory of Emotions*, *2*(1), 67-92.

White, M. A., Kalarchian, M. A., Masheb, R. M., Marcus, M. D., & Grilo, C. M. (2010). Loss of control over eating predicts outcomes in bariatric surgery: a prospective 24-month follow-up study. *The Journal of clinical psychiatry*, *71*(2), 175.

Willig, C. (2012). Qualitative interpretation and analysis in psychology. McGraw-Hill Education (UK).

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education (UK).

Wood, K. V., & Ogden, J. (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study. *Journal of Health Psychology, 21*(11), 2447–2456. https://doi.org/10.1177/1359105315578304
Woolhouse, M., Day, K., Rickett, B., & Milnes, K. (2012). ‘Cos girls aren’t supposed to eat like pigs are they?’Young women negotiating gendered discursive constructions of food and eating. *Journal of health psychology*, *17*(1), 46-56.

World Health Organisation. (2013). United Kingdom WHO country profile [online resource]. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0020/243335/United-Kingdom-WHO-Country-Profile.pdf?ua=1

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 235-251). London: Sage.

Yee, A. Z., Lwin, M. O., & Ho, S. S. (2017). The influence of parental practices on child promotive and preventive food consumption behaviors: a systematic review and meta-analysis. *International Journal of Behavioral Nutrition and Physical Activity*, *14*(1), 47.

APPENDICIES

APPENDIX A: Illustrations of Surgery

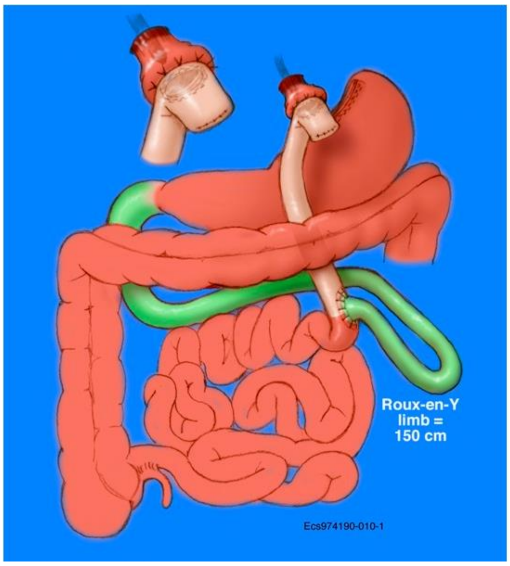


Figure 1: Laparoscopic Roux-en-Y gastric bypass

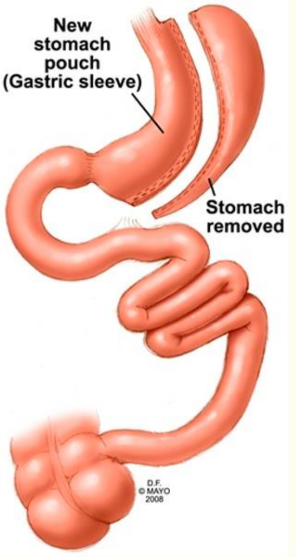


Figure 2: Laparoscopic vertical sleeve gastrectomy

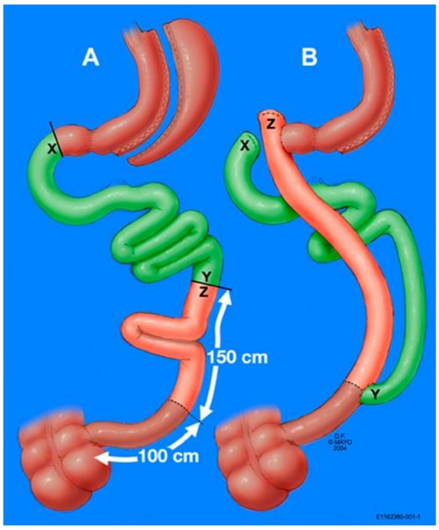


Figure 3: Laparoscopic biliopancreatic diversion with a duodenal switch

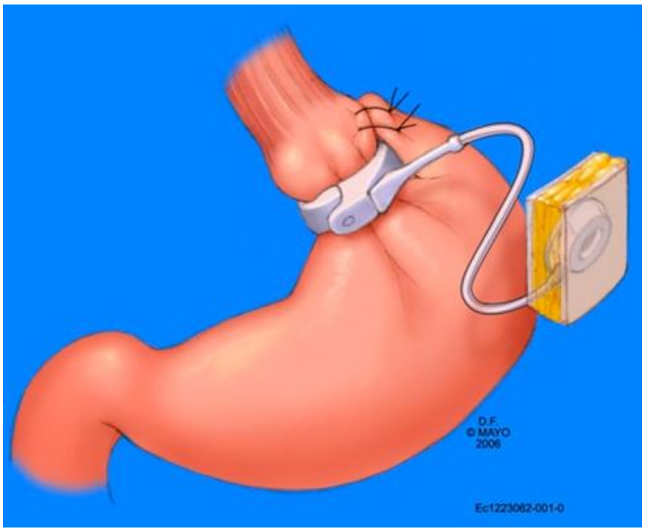


Figure 4: Laparoscopic adjustable gastric band

Figures reproduced from Mandura & Dibaise (2012).

APPENDIX B: Search Terms

	Search Terms
Context	Obesity, obese, overweight, overeating, weight loss, weight reduc* , gastroplasty, jejuno-ileal bypass, biliopancreatic or bilio-pancreatic, sleeve gastrectomy, gastric sleeve, stomach stapling, Roux-en-Y, duodenal switch,
Method	Group discussion(s) interview(s) ethnography, Ethnograph(s), Observation(al), Content Analysis, Grounded Theory, Grounded approach, Phenomenology, Discourse analysis, qualitative, focus group, case study, descriptive
Outcome	Psychosocial issues, Ident*, Self-perception, mental health, psychological health, psychology, relationship(s), family, work, wellbeing, self-perception, confidence, metal health, adjustment

APPENDIX C: Consort Diagram of Retrieved Articles

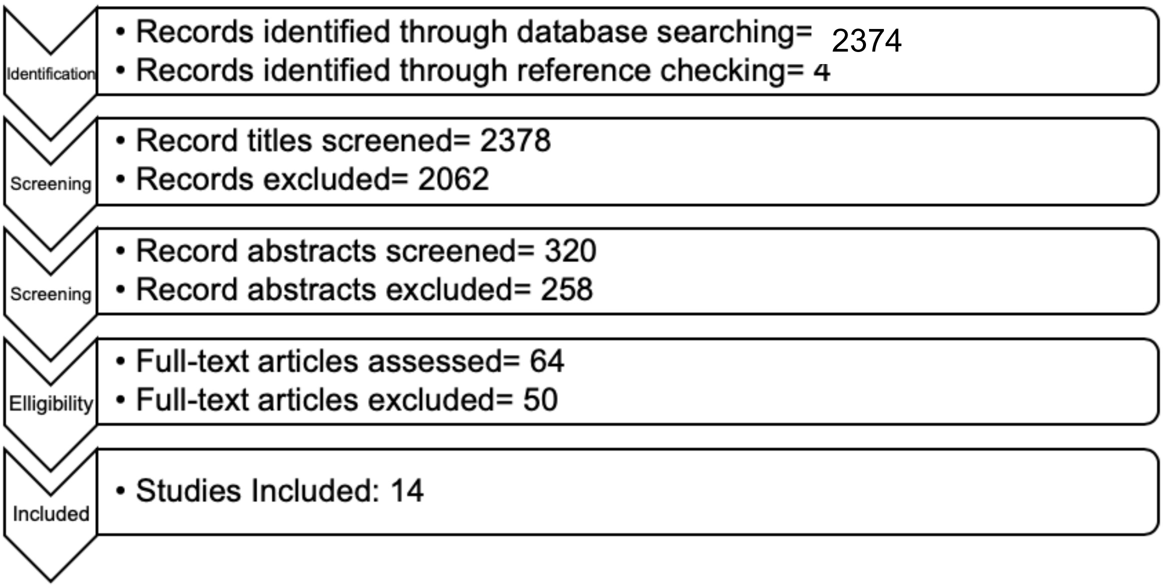


Figure 5: Consort diagram of papers retrieved

APPENDIX D: Participant Information

Information sheet for participants invited to contribute to the research study.
UNIVERSITY OF EAST LONDON
School of Psychology Stratford Campus
Water Lane London
E15 4LZ

Name: Alex Bogaardt Email address: u1725749@uel.ac.uk or Alexandra.bogaardt1@nhs.net

Information & Guidance About Participating in the Study: Identity Following Bariatric Surgery.

What is the project about?
I am conducting a study as part of my doctorate course in Clinical Psychology at the University of East London supervised by Jackie Doyle (Lead Clinical Psychologist, UCLH Centre for Weight Management, Metabolic and Endocrine Surgery). I am interested in people's experience of bariatric surgery. I am interested in what people's hopes were for surgery in terms of how their relationships might change, if these changes became reality and if so how they make sense of this. By participating in an interview, you will be helping to develop the research that is available around people who have undergone weight loss surgery, to help psychology (and other professionals) support people better in understanding weight-based stigma and how weight loss surgery impacts people's sense of self and relationship to others.

What would you be asked to do?
I will be carrying out an interview in the outpatient clinic of UCLH where I ask a few open-ended questions about your hopes about how your relationships would change following surgery (at work, with friends, family, partners), what has happened since

then and how things are now which I will audio-record. The interview will last between 60-90 minutes and you may take a break at any time.

Keeping your Information Safe

The University of East London is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of East London will keep identifiable information about you (your name and contact) until July 2020. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study after the data has been analysed (within 3 months after the interview), we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how I will use your information by contacting me at the email address above.

I will inform your clinician within the clinic that you are taking part however, details of the interview will only be shared with the supervising clinician Jackie Doyle (unless there is a significant immediate risk issue in which case I may need to liaise with external agencies). Your contact information will only be stored on secure drives within the NHS. Recorded interviews will be transferred onto a secure, encrypted e-drive within the university. Interviews will be transcribed within the following 3 months (by myself) with any identifiable information taken out. Recordings will be destroyed following the submission of the project in September 2020. Anonymised electronic copies transcriptions will be then be kept for 3 years before being destroyed. There may be verbatim quotes included in the final write up and potentially a published article, these will not contain any identifiable information.

I will hold your email and name on my NHS email account and will not pass this information to the University of East London. I will use this information as needed, to contact you about the research study findings if you would like this. Certain individuals from University of East London and regulatory organisations may look at the anonymised transcripts of interviews with any third party or identifiable information redacted to check the accuracy of the research study. The University of East London will only receive information without any identifying information. The people who read the study will not be able to identify you and will not be able to find out your name or contact details.

The Surrey Borders NHS Research Ethics Committee (REC) has reviewed and approved the study.

Are there any risks in taking part?
Some people find talking about their experiences difficult or distressing. I am unable to offer any formal therapeutic support, however, I can offer a list of local services, helplines and other sources of support that may be useful if necessary.

Withdrawing from the Study
You are not obliged to take part in this study and you are free to not answer any question or withdraw at any time from the study and the interview itself. If you choose to withdraw this will not affect your treatment or relationship with the service.

If you wish to participate in the study I will ask you to sign a consent form. If you have any further questions please feel free to contact me. If you have concerns about the way the study is conducted please contact the chair of the ethics of the university at the bottom of the page,
[Alex Bogaardt, School of Psychology, University of East London, Water Lane, London E15 4LZ.]
or
Chair of the School of Psychology Research Ethics Sub-committee: AE2.15, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: +44 2082234004 Email: m.j.spiller@uel.ac.uk)

Yours sincerely,

Alex Bogaardt

APPENDIX E: Participant Consent Form

Participant Consent Form
UNIVERSITY OF EAST LONDON
Participant Number:
Consent to participate in a research study:

IDENTITY TRANSFORMATION FOLLOWING BARIATRIC SURGERY

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I choose to withdraw, any data I have provided will be withdrawn from the study and not used in the final analyses.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………………….

Signature …………………………………………………… Date: ………………..…….

Alex Bogaardt (Chief Investigator)

Signature …………………………………………………… Date: ………………..…….

APPENDIX F: Semi-Structured Interview Schedule

Informed consent

Reminder of confidentiality and the right to withdraw/ not answer any questions.

Participants' expectations going into surgery

- What did you hope to happen following surgery?
- What did you want life to look like?
- How did you come to decide that surgery was for you? What information was important?

Post-Surgery

- Can you tell me how life has changed since surgery?

Social

- What did (partner/friends/family) think?
- Why did you think they thought/did that? How did you respond? Why?
- Has the way you think about your changed since you since you had the surgery? In what ways?

Intersectional

- Do you think it is different for women/men/people with X culture/?

Support

- Who do you discuss these issues with?
- How did you cope with… ?

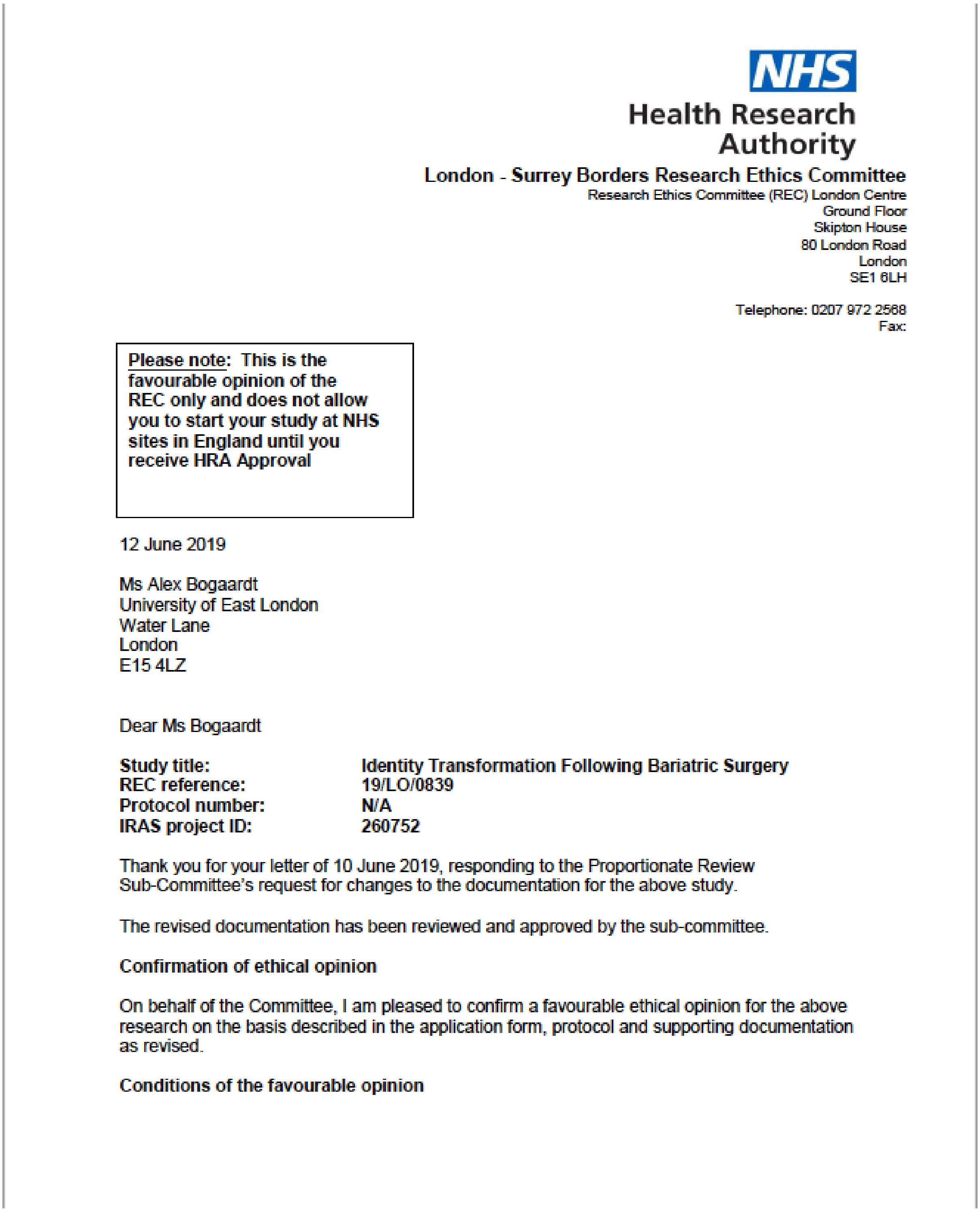
Final questions

- What do you think would be helpful to have done/heard/had access to if you could go back in time? What advice would you say to someone who was considering the surgery?
- Is there anything I have missed that I should have asked you?
- Is there anything you would like to say or add?

Other questions/prompts

- Can you tell me a bit more about…?
- Why do you think that is?
- Can you give me an example?
- Was it always like that? Or has it changed over time?
- How do understand…?
- How did you make sense of that?
- What do you mean by…?
- How you manage the impact of…
- When you said ‘x’ what did you mean?

APPENDIX G: Research Ethics Committee Letter



NHS
Health Research
Authority

London - Surrey Borders Research Ethics Committee
Research Ethics Committee (REC) London Centre
Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Telephone: 0207 972 2568
Fax:

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

12 June 2019

Ms Alex Bogaardt
University of East London
Water Lane
London
E15 4LZ

Dear Ms Bogaardt

Study title:	**Identity Transformation Following Bariatric Surgery**
REC reference:	**19/LO/0839**
Protocol number:	**N/A**
IRAS project ID:	**260752**

Thank you for your letter of 10 June 2019, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

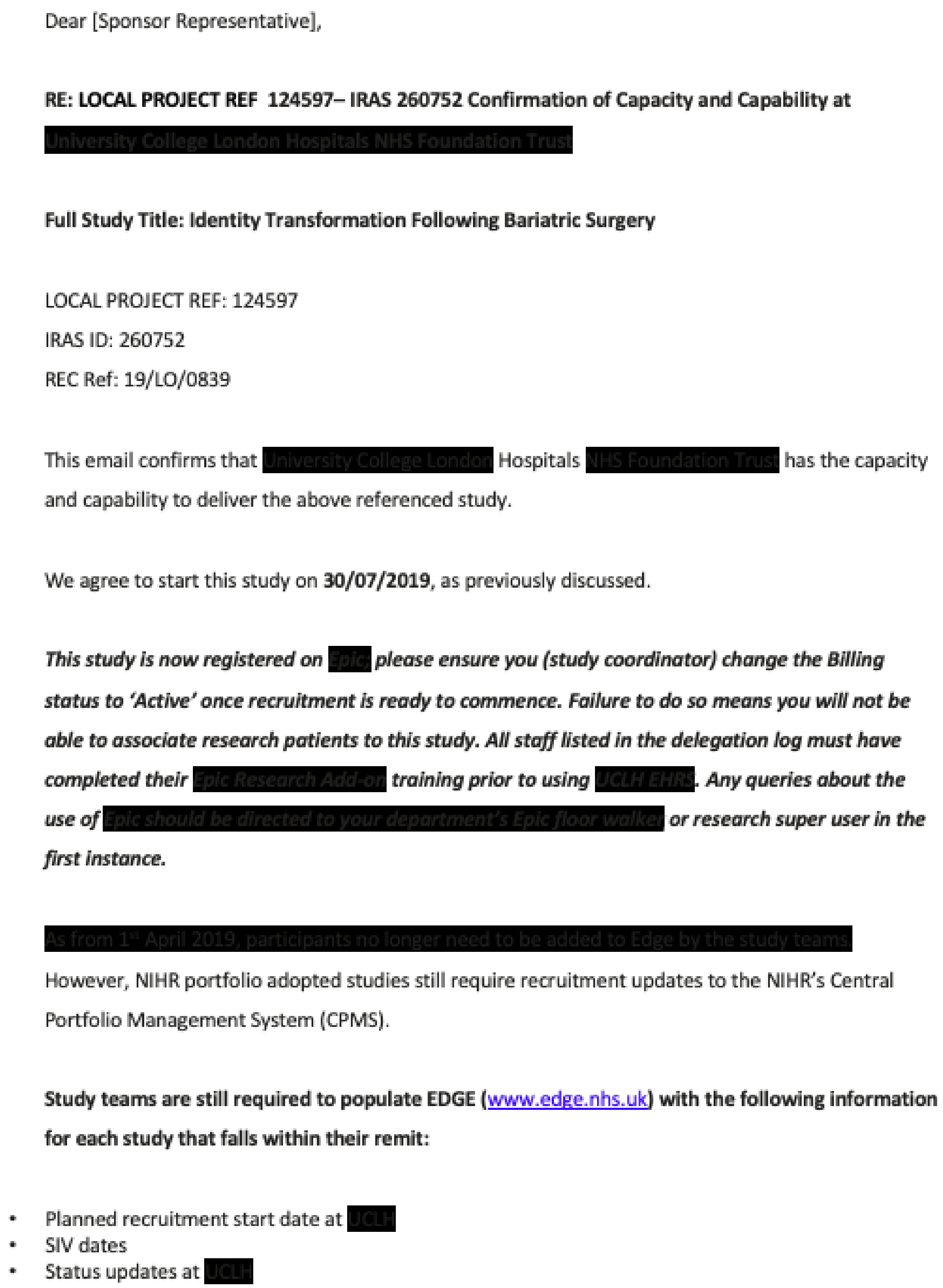
The revised documentation has been reviewed and approved by the sub-committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

APPENDIX H: Hospital Site Research and Development Approval



Dear [Sponsor Representative],

RE: LOCAL PROJECT REF 124597– IRAS 260752 Confirmation of Capacity and Capability at [redacted]

Full Study Title: Identity Transformation Following Bariatric Surgery

LOCAL PROJECT REF: 124597
IRAS ID: 260752
REC Ref: 19/LO/0839

This email confirms that [redacted] Hospitals [redacted] has the capacity and capability to deliver the above referenced study.

We agree to start this study on **30/07/2019**, as previously discussed.

This study is now registered on [redacted] please ensure you (study coordinator) change the Billing status to 'Active' once recruitment is ready to commence. Failure to do so means you will not be able to associate research patients to this study. All staff listed in the delegation log must have completed their [redacted] training prior to using [redacted]. Any queries about the use of [redacted] or research super user in the first instance.

[redacted]
However, NIHR portfolio adopted studies still require recruitment updates to the NIHR's Central Portfolio Management System (CPMS).

Study teams are still required to populate EDGE (www.edge.nhs.uk) with the following information for each study that falls within their remit:

- Planned recruitment start date at [redacted]
- SIV dates
- Status updates at [redacted]

APPENDIX I: Transcription Key

(.) Pause

[inaudible] inaudible section of recording

[laughter] laughter during the interview

[text] Clarificatory information

[…] Indicates removal of text not relevant to the point

APPENDIX J: List of Initial Codes

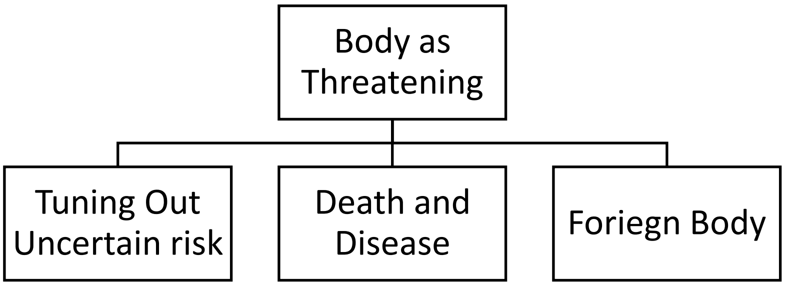
	Theme
1	Struggle
2	Control
3	Freedom
4	Exclusion
5	Isolation
6	Sadness
7	Loss
8	Avoidance
9	Body not fitting (seats, clothes)
10	Persecution
11	Attachment
12	Physical Pain
13	Cheating
14	Recognition
15	Individuality
16	Advocacy
17	Early Life
18	Relationship with food
19	Interactions with family
20	Support
21	Disease
22	Medical risk
23	Fear of physical decline
24	Moral judgment
25	Hoped-for body
27	Body as feared object
28	Expectations for surgery
30	Controllability
31	Self-policing
33	Other’s perspectives differing from own

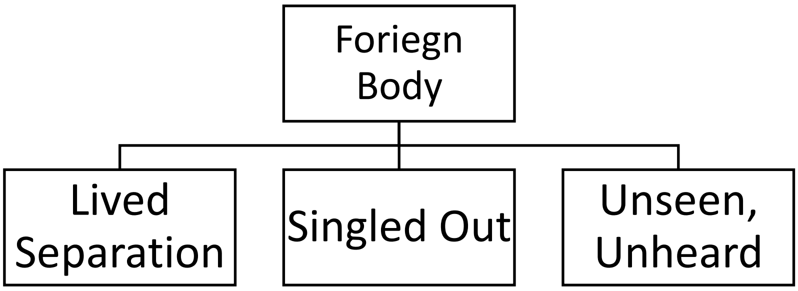
34 Pressure in relationships
35 Anxiety
36 Jealousy
37 Self-talk
38 Self-Care
39 Changing attitude to body
40 Survival
41 Compassion
42 Gender
43 Exercise
44 Thin privilege/value
45 Struggling to cope
46 African values around weight
47 Feeling uncomfortable/odd one out
48 Visibility
49 New Challenges
50 Self-stigma
51 Changing relationship to body
52 Not recognising self
53 Fighting/Warfare
54 Switching off
55 Enhanced understanding of self
56 Realising potential
57 Attitudes of healthcare providers
58 Self-sacrifice
59 Parenthood
60 Comparison with others

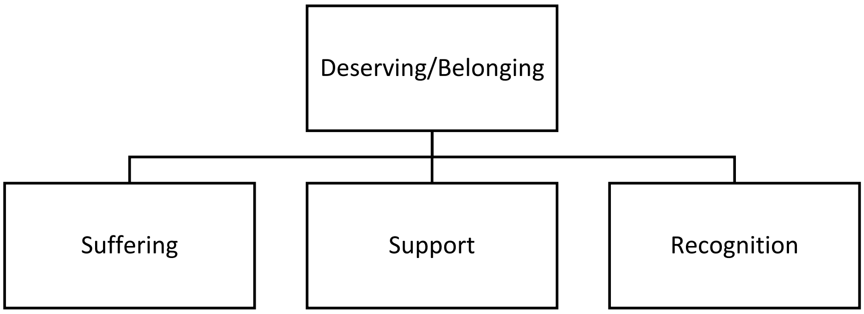
APPENDIX K: Example of Coded Data Extract

Quote	Reflections	Code
I only knew that I was very overweight as a child, I remember being, I always remember being different right? I never remember feeling the same. I always remember my mother struggling to get me clothes and cutting down adult-sized clothes and it wasn't the norm in the family because my mum was small, my dad was normal weight, my brothers were normal weight	Participant was different from birth, early life experiences, odd one out	Visibility, interactions with family, being 'other' Early life, comparison with others, not fitting
dream would have been to have got to a 14 and a half stone because at the age of 18 when I left home to go nursing my weight was 14 and a half stone, so for me it wasn't really about weight, I was young I was 18! You know? and for me that is, that was my normal. But what I, every time I have lost weight I got down to a round about 18 or just below 18.	Weight, body and the age at which she was her young (authentic?) self, embodied memory	Early life, freedom, hoped-for body
if anyone said to me 'would you do it again?' I… uh… I would probably say yes because I now understand that there is probably, there was really no choice for me	Out of options, character strength implicated here?	?self-stigma,
Oh, yes, because deep down, deep down, deep down in my deep psyche I think I… I probably still think its all my fault.	Resource limitation; meritocracy- who is deserving of what types of help. Deserve NHS resources if you were in a car crash, but not if there have been failures of the gov't to protect and support people	Self-stigma, moral judgment,
I honestly and truly believe that my obesity has not defined who I am. It might have defined who I am to other people but it has not defined me and I can put my hand on my heart and say that,	Dissonance between how the world sees her and how she sees herself	Recognition, individuality
I think my my fundamental, I had a very stable childhood, a very good family life you know I had a career, I always belonged to something, you know?	Early life experiences	Early life, attachment, interactions with family, acceptance

APPENDIX L: Initial Identification of Themes







APPENDIX M: Extracts from Reflective Diary

Excerpt of entry following interview

I am confronted by the resilience and positivity within this interview. It proposes challenges to my understanding of the surgery as a response to stigma. However, it often feels difficult to ask questions about the participants life beforehand. I sometimes felt silenced as if it would be 'too personal' to ask for more detail. This is unusual for me as I feel comfortable asking about difficult topics such as race or sexuality, but there is something about what Throsby 2009 describes as 'former fatness' that feels like I am pulling away a curtain on the Wizard of Oz. I feel almost a sense of guilt for not having struggled with my weight. I recognise the privilege of growing up in a household where I learned to cook, enjoy and savour foods

I wonder about the role of parenthood in particular and constructs of 'selflessness' which are expected of women in these roles. I'm unsure to whether fathers have the same expectation, but I think possibly not. It's a strange parallel that men are not held back by parenthood for having this surgery, but are held back from discussing aspects of their health to others as a result of hegemonic masculinity. The lack of male discussion around the surgery may make it easier to access perhaps? There are so many iterations in how people adjust to post-surgery. Early life also seems to be very significant. Some of the WHO research on stigma also seems to suggest that children experience bullying from their own families- this could be significant in how participants seek help and how able they are to adopt broader perspectives.

Entry following preliminary write up

I'm wondering about the roles of body acceptance, group membership and advocacy. I'm struck by a recent article on the singer Adele and her dramatic weight loss and the responses of 'fat activists' calling her weight loss a 'betrayal'. There seems to be an interpretation of Adele communicating that the 'fat body' is not acceptable. It seems that our bodies are constantly communicating. When we make one choice, we communicate the diminished value of the choice we left behind. Issues of shame and vulnerability are at play. Perhaps it is not enough to gain acceptance for yourself, but recognise the systemic trappings we all face.