Self-disgust: experiences of patients post-bariatric surgery

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Word count: 28,636

Research submitted in partial fulfilment of the requirements for the degree of Doctor in Clinical Psychology (DClinPsy), to the University of East London, School of Psychology.

ACKNOWLEDGEMENTS

ABSTRACT

Background: Research suggests that individuals who are obese are rated less favourably across all social groups (Wing & Jeffrey, 1999), with disgust being the strongest predictor of negative attitudes (Vartanian, 2010). Whilst some studies have explored the role of disgust in obesity, there is a distinct gap in the evidence base in relation to self-disgust and visual perspective taking, and how individual's respond once they have transitioned out of weight-stigmatising environments. The proposed study aims to address this gap by using visual imagery to explore how individuals that have had bariatric surgery may 'see' themselves in relation to self-disgust.

Method: The researcher interviewed eight patients (six women and two men) in an NHS Trust that had bariatric surgery and lost approximately 50% of their excess body weight.

Results: Interviews were transcribed and analysed using thematic analysis. Four key themes and ten subthemes including negative childhood experiences, societal shaming and exclusion, being revolted by their body and connecting differently to self and others.

Conclusion: The study concluded that people who are obese experience significant prejudice and discrimination in settings including employment, public spaces and healthcare. Recommendations were made to help individuals and communities via incorporating ideas of compassion in wider systems such as public health campaigns and the media.

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TERMS OF REFERENCE

i) <u>Body Mass Index (BMI)</u>

A term that is used to denote the measure of body fatness in an individual, which is then used to understand how their weight is related to their height, and whether this is at a healthy level. Typically this is calculated as weight (kilograms) / height (meters2). Additionally, the following categories are used:

BMI of <18.5 = underweight
BMI of 18.5 – 25 = normal
BMI of 25 – 30 = overweight
BMI of 30 – 35 = moderately obese
BMI of 35 – 39 = severely obese
BMI of above 40 = very severely obese

ii) <u>Bariatric surgery</u>

Invasive surgery for people who are typically above 40 BMI but is also common for people with a BMI of 35 – 40 with additional health difficulties such as diabetes. The general premise of the surgery is to physically help reduce food intake and decrease food absorption in the stomach and intestines. In the UK three main types are offered; gastric banding, gastric bypass and sleeve gastrectomy. For long-term success of weight loss, lifestyle changes need to be made and maintained, such as healthy eating habits that incorporate specific 'rules' (e.g., small bites and no drinks with meals) and regular exercise. Furthermore, typical risks associated with surgery include internal bleeding and infections.

iii) <u>Excess weight loss as a percentage (% EWL)</u>

This term represents the amount of 'excess weight' as a percentage that is lost towards attaining a healthy BMI. This is calculated by:

(Starting weight – current weight)

_____   X 100

(Starting weight – normal weight)

CHAPTER 1: INTRODUCTION

1.1 Overview of the research

This chapter will give an overview of the physiological and psychological implications of bariatric surgery, with particular attention paid to the current UK context within which bariatric surgery occurs.

1.2 UK context: obesity and bariatric surgery

The rates of obesity (Body Mass Index [BMI] of 30kg/m2 or greater) in the UK have increased significantly over the last decade (Health Survey for England, 2008), with a rise of 58% to 65% of men and 49% to 58% of women identified as obese. Currently, one in four adults are obese, with over half the adult population overweight or obese (NICE, 2006), with projected figures of 11million by 2030 (Wang et al., 2011). This means that approximately nine in ten adults will be either overweight or obese by 2050 (Department of Health, 2009). The projected figures for children are equally worrying (Joint Health Surveys Unit, 2006). Notably, obesity has been referred to as a 'worldwide health concern' (Finucane et al., 2011), resulting in the World Health Organisation (2000) issuing warnings against an "obesity epidemic". Additionally, the medical costs attached to conditions related to obesity such as stroke and heart disease are estimated at between £1.9-2 billion per year in the UK by 2030 (Wang et al., 2011) or £45.5 billion per year to the UK national health budget (Government Office for Science, 2007).

Given the above context, bariatric surgery is a recommended treatment option for adults who are morbidly or severely obese for whom non-invasive methods have failed to produce significant weight loss (NICE, 2006). It is noted as being the most effective intervention for severe obesity (Torgerson & Sjostrom, 2005), with costs associated with surgery being recouped within 12 months (O'Neill, 2010). Furthermore, bariatric surgery is considered to be one of the only weight loss treatments able to demonstrate long-lasting effects in the reduction of weight and comorbidities (Schouten et al., 2010).

Currently, three specific types of bariatric surgery are currently performed in the UK – the gastric bypass, gastric band and gastric sleeve. These procedures are either 'restrictive' (reduce the amount of food intake), 'malabsorptive' (reduce the absorption of calories) or a combination of 'restrictive' and 'malabsorptive' (reduce food intake and absorption of calories) procedures (Dent et al., 2010). Whilst the amount of excess weight loss varies with each procedure, generally patients can lose between 40-80% after two years (Sarwer et al., 2005), with an average excess weight loss of 61.2% (Buchewald et al., 2004).

In line with the above recommendations and the surge of trends in obesity, bariatric surgery procedures have also increased. From 238 operations being performed in the year 2000, 2543 surgeries in 2007 (Burns et al., 2010), to 32,073 in 2014 (The UK National Bariatric Surgery Registry, 2014). However, surgery is not effective for everyone and there have been a mixture of outcomes thus far. For example, some patients reported difficulties in maintaining weight loss long-term (Picot et al., 2009) with 20-50% not achieving their desired weight loss, and other patients being re-referred to services after surgery (Magro et al., 2008).

There are two main routes through which an individual may pursue bariatric surgery in the UK; either through the National Health Service (NHS) or privately funded through independent healthcare organisations. Individuals are eligible for bariatric surgery if they meet the criteria outlined by the National Institute for Clinical Excellence (NICE) and NHS Commissioning Board for Complex and Specialised Obesity Surgery. NICE guidance on obesity (2010) for the suitability of bariatric surgery procedures specifies a BMI of 35+ with physical co-morbidities such as diabetes and sleep apnoea.

1.2.1 Physiological implications of bariatric surgery

Bariatric surgery is, however, not without complications. The risks associated with conducting surgery is high with increased incidences of blood clots, heart

attacks and strokes during the surgery itself, as well as longer term risks such as the possibility of the breakdown of the pouch, poor nutrition and vomiting (Hsu et al., 1997; National Institute of Mental Health, 2010). These complications may lead to additional surgery, as well as difficulties related to the quality of an individual's life. Furthermore, weight regain is not uncommon; for example research suggests that 30% of gastric bypass patients regain their excess weight (Chen et al., 2009). Given these complications, it is understandable that bariatric surgery can be a challenging pathway for some, and by no means an easy decision to make.

1.2.2 Psychological implications of bariatric surgery

Ratcliffe et al. (2014) categorises psychological difficulties in the bariatric population as either pre-existing, specifically related to the behaviour changes involved in bariatric surgery or a post-operative development of new difficulties or the reactivation of pre-existing difficulties. Additionally, research suggests that individuals who are obese have complex psychological needs in comparison to those that are not obese, with psychological difficulties experienced before and after bariatric surgery (Mühlhans et al., 2009; Ratcliffe et al., 2012).

Individuals meeting the criteria for bariatric surgery present with a number of mental health issues, such as difficulties with anxiety disorders and diagnoses of personality disorder (Scott et al., 2008). However, to date, research has been unable to identify consistent psychological contraindications for the successful outcome of surgery (Wadden et al., 2007). What is clear nevertheless, is that whist the reduction in weight (as explained above) is generally associated with enhancements in physical, psychological and social concerns (Chang et al., 2010; Herpertz et al., 2003), a significant proportion of patients report negative outcomes (Sarwer et al., 2011) as illustrated in the examples below.

A survey conducted in the UK exploring the psychological benefits and challenges for post-operative patients found that individuals reported a

number of positive psychological consequences as a result of weight loss such as increased self-confidence and improved health (Ratcliffe et al., 2013). However, there were also some concerns in regards to excess skin and body image. Nonetheless the overwhelming response was positive, thus indicating that whilst there were still challenges post-surgery, the positive outweighed the negative. The participants of this study were on average 20 months post-surgery, thus, within the two year period of undergoing surgery.

The difficulties highlighted above raises the question as to whether positive changes seen in the initial period of weight loss (up to two years post-surgery) are temporary and therefore require further input (e.g., psychological and/or behavioural), to maintain weight loss. In fact some researchers have emphasised the importance of adopting and maintaining long term healthy lifestyle changes, in addition to having bariatric surgery, in order to attain successful post-surgical outcomes (Zijlstra et al., 2009), such as adhering to dietary instructions and attending post-surgery clinics (Schouten et al., 2010).

In conclusion, psychosocial outcomes for the bariatric population are varied and at times, contradictory. Some studies suggest surgery leads to improved quality of life (Heo et al., 2003), reduced depression (Burgmer et al., 2007) and reduced eating difficulties (Larsen et al., 2004), whilst others highlight the potential for surgery to reinforce psychological problems which may lead to a reduced quality of life (Van Hout et al., 2005).

1.2.3 Summary

The issues highlighted above suggest that there are physiological and psychological difficulties that arise post-surgery that may hinder an individual's overall progression. The complications related to unsuccessful procedures, excess skin and body image highlights a need to investigate this area further, especially given the predicted rise of bariatric surgery in the UK.

The psychological implications of surgery imply that changes in the body do not always correlate with changes in the perception of the self. How one views

themselves may therefore be independent of how one is objectively viewed by others. Whether this has repercussions for the outcome of surgery is not clear, particularly when linked to physiological complications. Self-disgust and perspective taking are therefore crucial areas that require further examination.

CHAPTER 2: LITERATURE REVIEW

2.1 Overview

This chapter will examine the evidence base in relation to the current study. It will present the search strategy adopted in order to identify four key areas of research: obesity and disgust, weight stigma, self-disgust and obesity and perspective taking. Particular attention will be paid to understanding how visual perspective taking influences the construction and maintenance of these experiences. It will conclude by highlighting the rationale, aims and research questions of the proposed study.

2.1.1 Inclusion and exclusion criteria

Articles, theses and conference papers were generally included if they met the search terms, with particular attention given to peer reviewed publications and those that focused on psychosocial/psychological issues post bariatric surgery, as opposed to medical outcomes. Whilst priority was given to research conducted within the UK, it was not possible to only include these as they were limited in number and therefore research from other Western countries were also included if they met the inclusion criteria. The search strategy was then repeated to ensure all up to date research was included in the literature review.

2.1.2 Search strategy and search terms

Initially, clinicians working within the field of bariatric surgery were consulted to maximise the number of meaningful search strings. Following these consultations an initial searching of the generic literature was carried out to identify existing literature on the research topic using the guidance set by Shaw (2010) to develop the search strategy. The 'CHIP Tool' comprises of an understanding of Context, How, Issues and Population. Please see table 1 for further clarification.

Table 1: Utilisation of the CHIP Tool (Shaw, 2010) in the search strategy

Study components	Description	Search Terms
Context	Bariatric surgery	"Bariatric surgery"; "weight loss surgery"
How	Qualitative	"Qualitative"
Issues	Patient experiences of self-disgust and visual perspective taking	"self-disgust"; "perspective taking"; "visual perspective"
Population	Adults aged 18+ post bariatric surgery	"Patients"; "adults"; "post bariatric surgery"

The initial search also included scanning of reference sections of all potential articles to ensure that the search strategy had taken account of all relevant articles. Following this, a more focused approach was taken to centre around 'disgust', 'self-disgust', 'obesity', 'bariatric surgery', 'weight stigma', 'perspective taking' and 'visual perspective'. A range of combinations were used to elicit a wide yet relevant list of resources. Please see Appendix A for further details.

2.1.3 Summary of database search

A total number of 1262 were identified using the above strategies. All articles were checked for relevance using the CHIP tool. In the end only those that were pertinent to self-disgust, visual perspective taking and/or bariatric surgery were included in the literature review.

2.2 Obesity and disgust

Individuals who are obese are rated less favourably across all social groups (Wing & Jeffrey, 1999), with disgust being the strongest predictor of negative attitudes (Vartanian, 2010). Moreover, studies have found disgust responses triggered in participants' brain regions when viewing images of individuals who are obese (Krendl et al., 2006), even where the individual is obese

themselves (Schwartz et al., 2006). These findings suggest that disgust is elicited by individuals regardless of their weight status and that there are stigmatising conditions that individuals who are obese may experience (i.e., weight stigma). In order to fully appreciate the nature and function of self-disgust, a comprehensive understanding of disgust and weight stigma is therefore required. These will be presented first before discussing the self-disgust.

There are several models that have been proposed to account for the multi-faceted emotion that is disgust; each model identifying disgust elicitors (Rozin et al., 1993; Tybur et al., 2009) and disgust functions (DeBruine et al., 2010). The main model put forward is the Rozin, Haidt and McCauley Model (1993) of disgust that identifies four types of disgust (core disgust, interpersonal disgust, animal nature disgust and moral disgust). The function of these domains is protective in nature, such as, to protect the body from infection or to protect the social order. This Model is helpful in understanding the types and functions of disgust, but it does not attempt to explain the process by which they operate. Given the breadth of the disgust literature, it is beyond the scope of this research to consider the various models. For the purposes of this study disgust will be defined as an "*emotion that is elicited when people encounter a physical or moral contaminant and that which motivates distancing from the object*" (Vartanian, 2010; pg. 1303).

Following an in depth literature review as detailed above, two major theoretical explanations were found to explain the development of disgust (a biological and a socio-moral perspective). These will now be discussed.

2.2.1 Biological perspective

Most researchers agree that an evolutionary perspective is required to understand the development and function of disgust. Naturally this viewpoint is originally attributed to Darwin (1872/1965). One of Darwin's earliest studies first noticed distaste responses in the facial expressions and the physiological and behavioural responses of adults and new born babies (Chapman &

Anderson, 2012). For example, he noticed that the distaste of food led to spitting out of the unpleasant food. This food rejection response was subsequently identified as core disgust, and attributed to preventing illness, disease and infection. Following these studies, Darwin (1965) defined disgust as a response to "*something revolting, primarily in relation to the sense of taste, as actually perceived or vividly imagined*" (pg.250). This suggests that disgust can be an objective or a subjective experience.

According to Darwin's perspective, distaste later evolved into 'disgust' and was conceptualised as a form of defence against threats to biological fitness. Thereafter, the protection against infection developed to include defence against other types of threats including psychological features such as increased risk of exposure in one's social life. Although the connections between physical disgust and moral disgust are unclear with no conclusive research, there has been some evidence to suggest that the excessive storage of body fat is a direct cue of pathogen, sexual and moral disgust (Lieberman et al., 2011), hence leading to stigmatising reactions.

Given that there is a higher incidence of prejudice and discrimination towards individuals who are obese (Vartanian, 2010), with clear links between disgust sensitivity and weight (Markham & Davey, 2010), it is apparent that a biological perspective can help better understand this association. Moreover, research suggests that the connection between disgust sensitivity and weight bias may have developed from psychological mechanisms for disease avoidance (Lieberman et al., 2010). Some theories propose that disgust leads to social distancing of people with physical characteristics that indicate poor evolutionary fitness (O'Brien et al., 2013; Vartanian, 2010). For instance, there is research to indicate that disgust can also arise when there are breaches in social-cultural morality. In this case, a person who is obese may be considered to have broken codes of morality such as greed (Lieberman et al., 2011). However, applying the same principles of biological disgust to psychological disgust can be problematic as these processes are not necessarily the same and much remains uncertain as yet.

2.2.2 Socio-moral/Socio-cultural perspective

As human beings live within groups, it is advantageous for them to have rules that favour their interests and objectives. These rules vary across culture and time, and new rules are often introduced to accommodate the changing context. In this regard, disgust functions by preventing an individual from committing acts that are against social norms. It therefore serves that the greater the level of disgust experienced, the more the likelihood of the individual avoiding that action (Tybur et al., 2013). Hence, disgust may also be explained by socio-cultural factors as there is clearly a link between disgust and moral judgement as discussed above. It is important to note that this study will predominantly focus on the Western conceptualisations of obesity.

Research suggests that disgust is linked to the dislike of people who are obese and that this is related to morality i.e., people who are obese are viewed as immoral (Markham & Davey, 2010).The disgust-obesity link is further explained by socio-cultural factors whereby the physical appearance of a person who is obese evokes disgust because it contravenes personal and societal attitudes towards physical appearance, slimness, beauty and fitness (O'Brien et al., 2009). Thus, disgust reactions enforce social norms, and serve as a form of social control by protecting the social order, strategically endorsing rules and coordinating the condemnation of body types that deviate from the socio-cultural thin ideal in Western societies (Lieberman et al., 2011). These societal discourses serve to reject individuals who violate social norms and moral values resulting in weight prejudice.

Whilst disgust has been linked to people who are obese as opposed to those that are thin (Vartanian, 2010), interestingly, men demonstrate more negative attitudes, whereas women are more fearful of becoming obese themselves (Lieberman et al., 2011). This suggests that there are different cultural expectations for men and women in relation to their weight. Nevertheless, as age and BMI increases, anti-fat prejudice decreases in both men and women (O'Brien et al., 2013).

Studies suggest that there are commonalities between the disgust related emotional responses of women with a diagnosis of an eating disorder and women post-bariatric surgery. Both present with increased disgust towards food and the human body (Harvey et al., 2002). Coincidentally, as part of the post-bariatric dietary intake, individuals are encouraged to practice restraint. Increasing core disgust sensitivity transforms food into forbidden substances thus reducing one's desire to eat high calorie food. This is in contradiction to pre-bariatric surgery, where individuals who are obese experience decreased contamination-based disgust (Houben & Havermans, 2012), and have a higher threshold for rejecting food products leading them to overeat. These findings indicate that participants of the current study are likely to express higher levels of disgust as they are post-bariatric surgery.

Whilst the studies discussed here suggest that disgust is linked to violations of social norms and moral values, particularly in relation to weight, it is unclear why or how this may occur. As research within this field is currently limited, especially within the UK, this is an area that needs to be explored further and perhaps considered more broadly in relation to intersectionality.

2.2.3 Disgust as an emotion

Disgust has often been linked to emotions such as anger and anxiety in relation to shame, and more notably body shame (Gilbert & Miles, 2002). Whilst an attempt will be made to understand disgust as a concept in its own right, these emotions are interlinked and therefore difficult to separate as individual constructs.

Research suggests that emotion regulation is directly connected to food (Berset et al., 2011). The foods that children are exposed to have specific associations, from being linked to social activities to emotional consequences. Food is used in both celebrations and as a way to regulate difficult emotions such as shame and loneliness (Goss & Allen, 2009; Goss & Gilbert, 2002). This therefore may lead to an array of conflictual messages about the types of

food people eat and when. Also, it makes sense that foods associated with joyful occasions may be eaten at times of difficulty and distress.

People who have repeatedly failed at losing weight or maintaining healthy eating habits may view themselves as failures and will therefore be more critical of themselves (Adams & Leary, 2007). In fact, one study suggested that people with weight problems find it more difficult to understand or process their emotions (Lehman & Rodin, 1989). However, it is unclear how these processes are linked or whether there are other factors that need to also be considered. In relation to the current study, as individuals seeking bariatric surgery have often tried and failed several methods of losing weight and thus sought surgery as a last resort, understanding shame and disgust is pertinent. By this stage, it is possible that the cycle of failure and self-criticism has become entrenched.

Shame and self-criticism is associated with conditions such as obesity (Stotland & Larocque, 2004), and it is understood that when individuals experience their bodies to be unattractive, they are at a higher risk of psychological distress (Thompson & Kent, 2001). Thus, some individuals who are obese may experience more shame and self-criticism as a result of having a negative self-image. Interestingly, Gilbert (2002) differentiates between experiences of shame; he explains that shame can be focused on numerous characteristics of the self, such as emotions, behaviours or perceived personality traits. He further states that body shame refers to negative experiences of the appearance and function of the self, that certain traits may be highly associated with aspects of the appearance. In relation to shame, it is the meaning attached to the event in which it occurred, as opposed to the type of event (Tangney, 1995). Moreover, internal and external components of shame have been discussed in the literature; internally negative self-evaluations construct the self as 'bad' and 'inadequate' (Fischer & Tangney, 1995) whilst externally shame arises in social contexts in relation to others viewing the self as 'inferior' and 'flawed' (Gilbert & Miles, 2002). A combination of internal and external shame can make it especially difficult for individuals who are obese to break free from this cycle.

Following on from Darwin's definition of disgust (pg.9), it has been hypothesised that disgust is a distinct emotion, different to shame (as defined above); one which may cause specific facial expressions, behaviours such as avoidance of what is considered to be disgusting and has associated experiences such as nausea (Gilbert & Miles, 2002; Overton, Powell & Simpson, 2015). From disease avoidance, disgust has evolved to incorporate social and communicative roles, one that allows strong moral judgements to be made against those that violate social and moral values. Attributing disgust responses to specific moral standards increases the severity of the negative response and thus makes it easier to internalise and harder to change.

In relation to obesity, research suggests that obesity elicits disgust and self-disgust (see section 2.2.2, second paragraph; pg. 10), with a number of hypotheses put forward. For example, the physical appearance of an obese person is currently perceived as unattractive in the UK, and this often extends to associations of greed, laziness and incompetence as discussed previously. This is in spite a large proportion of the population being overweight or obese, which possibly suggests that whilst being overweight is now more common, obesity remains a stigmatised condition.

Bariatric surgery focuses on behaviour change, but of equal importance are what motivates and drives that change (Gilbert et al., 2014). Thus, emotional drivers for seeking bariatric surgery and ultimately losing weight need to be assessed and incorporated into treatment plans.

2.3 Weight stigma: a negative emotional experience

Weight stigma plays a significant role in the experience of a person who is obese with documented evidence of prejudice and discrimination (Link & Phelan, 2001; Puhl et al., 2008). With the increasing rates of obesity, it appears that weight stigma is also increasing (Latner & Stankard, 2003). This trend is worrying as it has huge implications for the well-being of individuals.

Therefore an understanding of weight stigma is essential in order to appreciate the multi-faceted experiences of individuals.

2.3.1 The COBWEBS model (Tomiyama, 2014)

A range of models have been proposed to better understand the consequences of weight stigma, including the cyclic obesity/weight-based stigma (COBWEBS) model (Tomiyama, 2014). Its aims were to develop an integrated, biopsychosocial approach by drawing on literature in social psychology, health psychology and neuroendocrinology. It posits that weight stigma is a psychological stressor and is represented in the model as a "vicious cycle" as opposed to a static construct. Tomiyama (2014) proposes that similar to other negative emotional experiences such as depression, weight stigma can also cause behavioural, emotional and physiological responses, such as cortisol secretion. This then either leads to weight gain via cortisol secretion or the coping mechanisms that endorse eating behaviour. Interestingly, whilst weight stigma may be higher for individuals who are overweight/obese, to enter the cycle one does not need to be physically overweight or obese. In fact, any individual that feels stigmatised because of their weight can enter the cycle, therefore, self-evaluations are the key. Leaving the cycle, however, is much more difficult. There are three exit strategies that are described; individuals would either lose weight and maintain the weight loss, change their self-perception of weight or reach their physiological upper limit of their body weight. These strategies are individualistic and rely on the individual's perception and ability to make changes; they do not acknowledge the changes that could be made at interpersonal or institutional levels to challenge weight stigma.

The COBWEBS model highlights how difficult it is to become stuck within the cycle, which ultimately leads to repetitive weight gain. Given this potential 'stuckness', there may be consequences for an individual accessing healthcare services, as well as their self-to-self relationship (i.e., internalised stigma). These will now be discussed further.

2.3.2 Weight stigma and its implications

Wotts and Carels (2010) model has been adapted to illustrate how weight stigma and self-disgust are connected. An attempt has been made to capture the multiple levels of contexts that may be involved and not just the individual level (Figure 1).

Weight stigma: institutional stigma (e.g., within policy).

Weight stigma: interpersonal stigma (e.g., healthcare settings or between family members).

Weight stigma: Internalised stigma (e.g., personal beliefs).

Self-disgust: A component of internalised stigma.
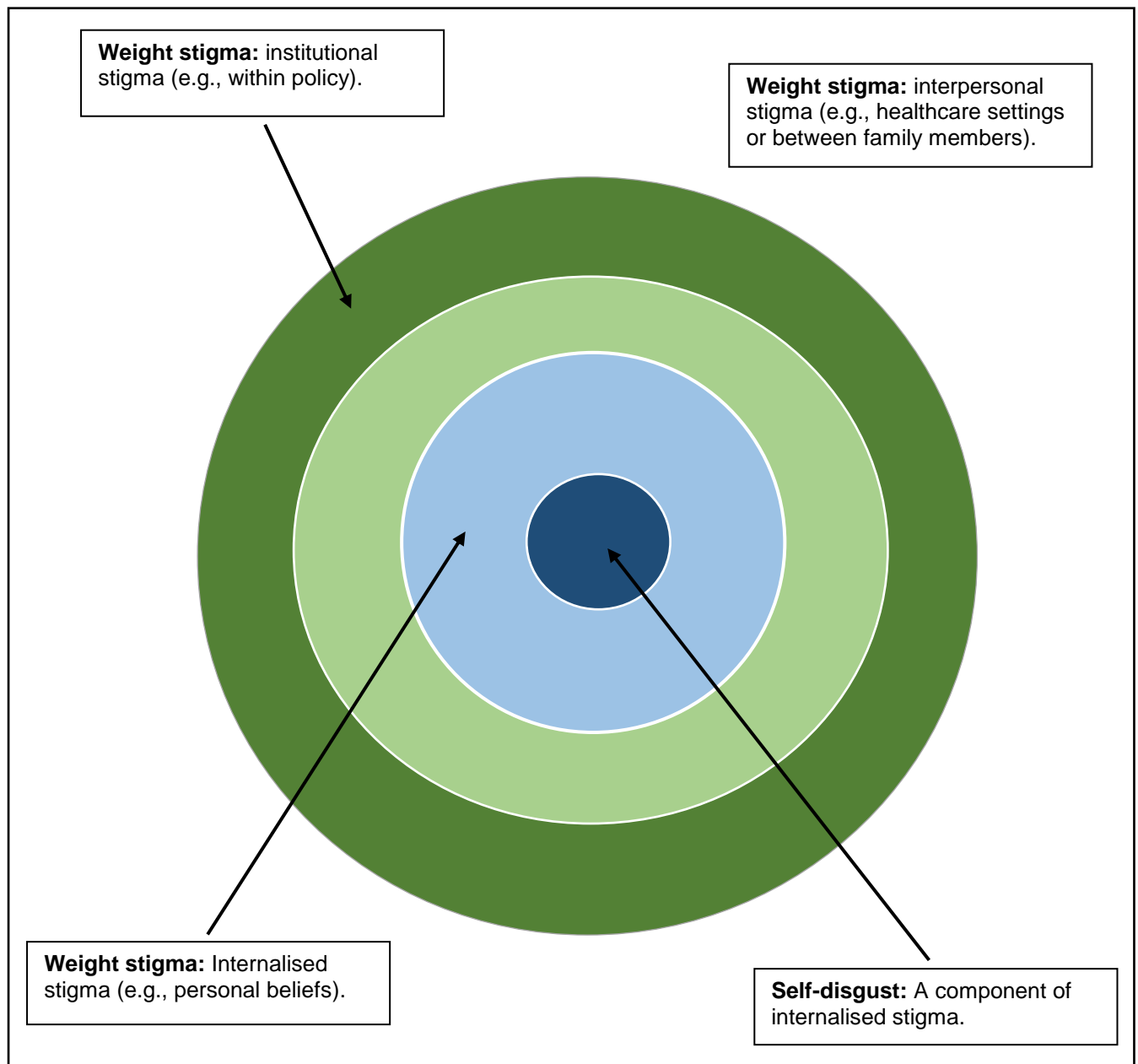
Figure 1: Self-disgust in relation to weight stigma (adapted from Wotts and Carels model, 2010).

As rates of obesity continue to rise, weight stigma has become a significant social problem (Brandsma, 2005; Davis-Coelho et al., 2000; Tomiyama et al., 2015). Some studies liken this growth to the same level as race based discrimination (O'Brien et al., 2013), with US figures indicating an increase of 66% in the decade leading up to 2008 (Puhl et al., 2008). More worryingly, these trends have also been noted amongst children (Latner & Stankard, 2003), with those as young as six years old labelling moral violations such as

those linked to fairness, as 'disgusting' (Danovitch & Bloom, 2009). Another study by Greenleaf et al., (2006) found an even younger group of children (three years old) ascribing traits such as 'stupid' and 'sad' to their peers who were obese. Additionally, research suggests that children who are overweight and obese are up to twice as likely to be bullied as 'normal' weight children (Brixval et al., 2012). Thus, it is worryingly clear that this process begins early on in an individual's life.

Anti-fat bias is described as a "*social devaluation of individuals that are perceived as overweight or obese leading to prejudice, negative stereotyping and discrimination*" (Puhl & Heuer, 2009; pg.941). Weight stigma on the other hand has been defined as '*negative weight-related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are overweight or* obese' (Puhl et al., 2008b; pg.347). Both these terms encompass the undesirable attitudes and beliefs that are attributed towards individuals due to their body size; in this study the terms 'weight stigma' and 'anti-fat bias' will be used interchangeably.

Researchers claim that weight stigma is more prevalent than racism, sexism and other forms of prejudice (Latner & Stunkard, 2003; Puhl & Heuer, 2009; Tomiyama, 2014). Documented evidence suggests that negative beliefs and attitudes are usually indicative of discriminatory behaviour towards people who are obese (Carr & Friedman, 2005). The most common types of weight stigma reported by Puhl and Brownell (2006) were encountering negative assumptions from others, receiving negative comments from children, encountering physical barriers and obstacles, and receiving inappropriate comments from doctors and family members. These were found in both men and women. Additionally, weight stigma has been found in a multiple domains including educational settings (e.g., being teased by peers and being viewed negatively by teachers; Weiler & Helms, 1993), employment settings (e.g., being treated badly by co-workers and being denied job opportunities or promotions; Roehling, 1999) and health care settings (e.g., receiving negative treatment by doctors, dieticians and mental health professionals; Schwartz et al., 2003). However, as these are subjective experiences, it is difficult to fully

distinguish between different types of bias and/or their intersectionality. For example, it may be easier and more acceptable for people to express their prejudice against obesity in comparison to say, race.

Weight stigma is associated with a range of psychological difficulties such as lower self-esteem and increased rates of depression (Friedman et al., 2008). Additionally, weight stigma has been linked to weight management efforts. For example, being teased has been related to increased eating disordered behaviours such as binge eating (Neumark-Sztainer et al., 2002). Experiencing weight stigma by individuals who are obese has led to a higher likelihood of overeating and avoidance of dieting (Puhl & Brownell, 2006), and frequent exposure to anti-fat bias has been connected to dissatisfaction of one's own body and the avoidance of exercise (Vartanian & Shaprow, 2008). There is however conflicting findings in respect to whether weight stigma experiences are correlated with BMI, with some studies suggesting that it does (Vartanian & Shaprow, 2008) and others showing that it does not (Friedman et al., 2008).

In light of the weight stigma that is prevalent in healthcare settings as suggested above, it is important to understand these experiences so that services can better cater to the needs of individuals who are or have experienced weight stigma.

2.3.3 Weight stigma in healthcare settings

Alongside the prevalence of anti-fat bias in social contexts, weight stigma has also been found in healthcare settings (Puhl & Heuer, 2009). A number of studies have identified that health care professionals often hold negative attitudes towards obesity, including specialists working in bariatric surgery (Brandsma, 2005), and psychologists are not immune from this. A study by Davis-Coelho et al. (2000) showed that psychologists' clinical judgements and treatment planning for clients who are overweight and obese were negatively affected by their weight. This suggests that a clinician's perception of a client may be altered by their beliefs about weight.

Two main outcomes have been linked to weight-bias in healthcare settings. Firstly, clinicians holding anti-fat attitudes have been associated with lower rates of preventative care and an increased number of emergency treatment visits by patients who are obese (Gudzune et al., 2003). Secondly, individuals that experience anti-fat bias are more likely to engage in unhealthy eating habits, thus worsening their obesity status (Major et al., 2014). Both outcomes are interpersonal and dependent on the interpretation and meaning attached to weight.

Tomiyama et al. (2015) carried out a study comparing weight bias in 2001 versus 2013. They looked at two types of anti-fat bias in obesity specialists – implicit (anti-fat attitudes outside of conscious awareness) and explicit (consciously accessible anti-fat attitudes) bias, and compared the changes over time. The results suggested that clinicians associated negative attributes with people who were obese in comparison to people who were thinner. For example, people who were obese were considered lazier. Whilst the decrease in the levels of implicit bias is positive, it still had significantly higher ratings of anti-fat bias across most domains. This is a worrying trend as it is indicative of an increase in the negative attitudes and bias of specialists, and perhaps suggestive of the wider societal discourses.

Another interesting study (Brandsma, 2005) looked at physicians' and their patients' attitudes towards obesity. More specifically, it explored how accurately patients who were obese were able to perceive their physicians' attitudes. Their findings revealed that patients perceived their physicians' attitudes to be more negative than that reported by their physicians. It was hypothesised that this was because individuals were aware of their culturally devalued position in society and thus assumed that their physicians would also rate them accordingly. It may also have been that physicians were influenced by social desirability and therefore construed their answers in a positive light but were more correctly perceived by their patients. In both cases, these findings highlight potential difficulties in the physician-patient relationship.

Wotts and Carels (2010) explored the relationship between weight related stigmatising experiences, weight loss treatment outcomes and psychosocial factors associated with the weight loss treatment populations such as depression. They found that increased levels of weight stigma correlated with significant amounts of depression and binge eating. Additionally, the more the weight stigma, the poorer the weight loss treatment outcomes. Interestingly, Wotts and Carels (2010) distinguished between interpersonal stigma (e.g., inappropriate comments from their physician or family member) and institutional stigma (e.g., physical barriers such as the size of their chair). They reported that interpersonal stigma predicted poorer weight loss and less engagement with weight loss behaviours. This is in line with previous literature that cites family members and doctors as the most common perpetrators of weight stigma (Puhl & Brownell, 2006), with their comments being strongly linked to exercise avoidance (Vartanian & Shaprow, 2008). Hence, interpersonal and institutional stigma are key areas to target in addressing weight stigma.

2.3.4 Internalised weight stigma

As illustrated previously Wotts and Carels (2010) highlighted that stigma can be experienced at three different levels; at an institutional level (e.g., within public policy), an interpersonal level (e.g., between family members) and an internalised level (e.g., personal beliefs). This internalised weight stigma refers to the extent that an individual agrees with anti-fat stereotypes and attributes these to themselves (Durso et al., 2012). In line with literature on self-disgust, internalised weight stigma is also self-directed. The anti-fat bias, as illustrated above, is directed by the individual towards themselves due to the way in which they perceive themselves. The perception of oneself as overweight is important, as it is often subjective and has consequences for our beliefs, attitudes and behaviours, irrespective of the objective 'truth'. In essence, the external weight stigma experienced contributes and maintains the internalised weight stigma, and thus the extent of self-disgust experienced.

In one particular study of men and women who were overweight, a high level of internalised weight bias was associated with increased mood disturbance, body image concern, drive for thinness, binge eating and decreased self-esteem (Durso & Latner, 2008), thus hinting at the possibility of internalised weight stigma being connected to eating difficulties. However, it is unclear how these are related and whether internalised weight stigma lead to eating difficulties or the other way round. More surprisingly, research found that ideal body size standards are generally very thin and can be internalised by as young as three years old (Harringer et al., 2010). This illustrates how dominant discourses filter down to different levels, including children.

Interestingly, there has been some literature to indicate that weight stigma is not always linked to the physical weight of an individual, and that self-perception is more important than the objective reality (Griffin & Ross, 1992), with weight being particularly subjective. For example, one study highlighted that self-perceptions of weight were discordant with objective weight 29% of the time (Crawford & Campbell, 1999). This means that individuals can still experience weight stigma in spite of not being overweight or obese themselves.

One suggestion by Durso et al. (2012) posits that people who are obese with a diagnosis of binge eating disorder are more vulnerable to weight stigma. Their study explored the internalisation of weight bias among treatment seeking men and women who were obese with binge eating disorder. They found that a greater internalisation of weight bias was correlated with greater eating difficulties, greater weight phobia, greater depression and lower self-esteem. Surprisingly, internalisation of weight bias did not correlate significantly with BMI and therefore they concluded that whilst internalisation of weight bias captures negative cognitions, it is not based solely on the weight of the individual. However, this study was conducted quantitatively, and therefore did not capture the subjective experience of individuals.

In summary, internalised weight bias can be detrimental to weight loss treatment outcomes (Wotts & Carels, 2010). In relation to bariatric surgery, this could potentially mean that individuals experiencing internalised weight stigma may have greater difficulty in accessing help, making lifestyle changes such as self-monitoring and engaging in exercise.

2.4 Self-disgust

Whilst much has been written about disgust, self-disgust and its connection to psychological distress remains overlooked (Gilbert & Miles, 2002). Researchers claim that self-disgust has been wrongly ignored within the literature on psychological distress due to an over emphasis on food related disgust (Powell et al., 2014; Power & Dalgleish, 1997). Self-disgust is a term that is difficult to define with researchers using different words to identify similar or the same emotion. For example, words such as 'guilt' and 'shame' are said to be forms of disgust directed towards the self (Power & Dalgleish, 1997). Typically, within the literature self-disgust is defined as "*disgust directed towards the self*" (Overton et al., 2008; pg.379). However, these definitions are not useful in providing a concrete definition or understanding of what self-disgust is and how it differs from other emotions. Additionally, they assume an inherent knowledge of the disgust literature.

Whilst research (as discussed earlier) suggests that disgust plays a role in depression, current studies propose that it is not general disgust sensitivity but rather self-disgust that effects the development of depression, whilst contributing to unhelpful cognitions (Overton et al., 2008). In fact, in Beck's (1967) cognitive triad of depression, the negative evaluations of the self is likened to a 'feeling of disgust with himself'. It is this self-disgust that is required to generate and maintain negative cognitions by creating a negative interpretative bias (Davey et al., 1998).

As highlighted above, internalised weight stigma refers to anti-fat stereotypes generally, whereas self-disgust refers specifically to disgust stereotypes and attributes and how an individual directs these towards themselves. For the

purposes of this study, an extensive literature search was conducted to identify key words that were predominantly used in research. This list was designed to ensure that participants were able to meaningfully label emotions that they had experienced towards any aspect of their self (physical appearance, personality or behaviour). For further details please see the method section (chapter 3).

As already discussed, self-disgust is predominantly linked to how one perceives or evaluates themselves. Therefore, this section will now consider the relevance of self-perception on the research topic in question.

2.5 Obesity and perspective taking

2.5.1 Self-perception

The perception of oneself as overweight or obese has consequences for an individual's self-self relationship. The beliefs, attitudes and behaviours that they hold towards other obese individuals (i.e., societal weight stigma) may impact on how they relate to themselves (i.e., internalised weight stigma), and consequently the lifestyle choices that the individual's make. As explained previously, self-disgust is one component of internalised weight stigma and is typically facilitated by how an individual views themselves. This 'viewing' themselves is usually done through mental simulation and is how one may 'see' themselves in their minds eye. It is referred to in literature as visual perspective taking.

Visual perspective taking is defined as the use of mental simulation to 'see' past, present and future events (Libby & Eibach, 2011). It is argued that the way in which we recall past events has a significant impact on the meaning we attach to them and, thereby, how those events affect us in the present and the future. This is because memory is retrieved from the visual perspective and is incorporated in one's self-concept thereby shaping identity and self-representations (Sutin & Robins, 2008). Visual perspective influences the way autobiographical memories (i.e., events recollected from personal

experiences) are used to regulate emotions and maintain a coherent identity over time. Additionally, the way that we 'see' present and future events also contributes to the beliefs and attitudes that we have about the world and ourselves, and the behaviours that we engage in. Event images and their meanings are therefore defined by visual perspective taking.

Autobiographical memories are often recalled as images from two distinct perspectives: an observer/first person perspective and a field/third person perspective (Lau et al., 2009; Nigro & Neisser, 1983). For clarity, the observer/first person perspective will be referred to as the 'I self' perspective and the field/third person perspective will be referred to as the 'me self' perspective (Sutin & Robins, 2008).

Research suggests that the third person perspective is automatically used for up to one-third of autobiographical memories recalled and the first person perspective is used for two thirds (Nigro & Neisser, 1983). Nevertheless, people are able to switch between these two perspectives, although how 'controllable' this is, is not clear. With this in mind, it is hypothesised that when choosing one perspective over another (whether spontaneously or via own choice), it is because of the meaning attached to that perspective when it is initially coded (Libby et al., 2014). For example, a 'me self' imagery may be related to disavowing responsibility for undesirable past events (Sanitioso, 2008), or to greater shame in individuals with low self-esteem (Libby & Eibach, 2011). Furthermore, this shift in perspective occurs depending on whether one wishes to understand the experience of an event's concrete details ('I self'), or its relevance to the broader context ('me self').

In relation to emotions, Libby & Eibach (2011) suggested that individual factors be considered. For example, it is important to understand whether emotion is primarily evoked by concrete features of the situation or by the meaning of the event in relation to one's life. In the former, the 'I self' and in the latter, the 'me self' imagery would increase emotional response. Thus, clinician judgement would be required to proceed when deciding a line of intervention.

2.5.2 The 'I self' perspective

An 'I self' image is where the individual views the situation through their own eyes, almost as if re-experiencing the event. The image consists of concrete features of the environment and is understood from a bottom-up perspective. Images that are observed from this perspective include affective reactions, sensory responses and physical sensations (Libby et al., 2005). Additionally, planning and goal directed behaviour have been linked to the mental simulation of future events (Libby et al., 2011; Vasquez & Buehler, 2007), with 'I self' events being better predictors of future behaviour, for example, making health choices (Rennie et al., 2014). This has important ramifications for bariatric surgery patients as successful outcomes are dependent on major changes to eating behaviour and lifestyle.

The literature suggests that individuals who experience weight stigma are more likely to recall these events from an 'I self' perspective (Ratcliffe & Ellison, 2013). This perspective is associated with having a negative impact on psychological wellbeing (Lau et al., 2009). For example, recollection of memories from his viewpoint is linked to higher levels of avoidant cognitive strategies such as rumination (Williams & Moulds, 2007) as well as being indicative of depression (Kuyken & Howell, 2006). Furthermore, frequently taking an 'I self' perspective primes the generation of negatively biased self-images that provide inaccurate depictions of the event (Spurr & Stopa, 2003). There is also evidence to suggest that how individuals remember negative experiences such as social exclusion influences the negative emotional impact of the experience (Lau et al., 2009). Therefore regularly adopting an 'I self' perspective when recalling past events can be maladaptive and thus hinder recovery from negative events.

Research suggests that negative behaviours using this perspective are likely to yield negative results whereas positive behaviours suggest positive outcomes (Libby et al., 2005). For example, guided imagery techniques are

more beneficial when practiced from a first-person perspective (Hackmann et al., 2011).

In relation to self-disgust, this may suggest that negative experiences that are recalled using an 'I self' perspective are more detrimental and potentially have undesirable consequences for future behaviour. In which case, interventions need careful consideration. For example, discussing healthy behaviours using an 'I self' stance might be helpful.

2.5.3 The 'me self' perspective

A 'me self' image is understood as a top-down event with abstractions taken from a broader picture incorporating an individual's personal identity, such as their preferences and values (Libby et al., 2014). The image is composed of a detached spectator's perspective (i.e., seeing self as an object, where concrete descriptions are present, with less emotional and sensory detail (Lau et al., 2009)). It is debateable as to whether one is looking through their own eyes or through someone else's when adopting this perspective (Libby & Eibach, 2011). Nevertheless, it is clear that this perspective is dependent on our private knowledge of our self rather than how people actually perceive us (Chambers et al., 2008), which makes it subjective and not based on a reality 'out there'.

This perspective serves as a 'distancing function' from both psychological and physical pain (Sutin & Robins, 2008). It is hypothesised that situations that are either highly emotional or stressful at the actual time of the event are much more likely to be recalled as 'me self' images (Nigro & Neisser, 1983). This perspective is usually self-distanced and an objective interpretation of the event with a dampened impact on the individuals current emotional state (Libby & Eibach, 2011).

The 'me self' perspective can be useful in facilitating behaviour that is value-consistent. For example, using this type of imagery can ensure occurrence of actual behaviour as perceived such as voting (Libby et al., 2007) and

improving intergroup interactions (Crisp & Husnu, 2011). More significantly, in relation to eating behaviour, a study that manipulated the perspectives of participants at a deli counter where the choice was between potato chips or an apple as a side item, found that participants choice behaviour corresponded more closely to their preferences when they pictured making the choice beforehand form the third person perspective.

In terms of self-disgust, using a 'me self' image to better align an individual's behaviour to their personal identity may help to reduce levels of distress and improve the individual's long term outcomes such as eating behaviour. It may also contribute to how individuals negotiate their environment and interact with people. For example, whether they are able to take public transport given the smaller sized seats available, which they may not have been able to use prior to their weight loss.

2.5.4 Implications for perspective taking

Literature suggests that the above perspectives are not fixed and individuals can change perspectives or be supported to learn how to switch between perspectives. By exploring different perspectives such as when recalling self-disgust experiences, it is possible to elicit different emotional responses (Lau et al., 2009), which may facilitate recovery towards better psychological well-being. One area in which this is already done is in the area of PTSD where imaginal exposure when recalling traumatic events involves using the 'me self' perspective as opposed to the 'I self' perspective (Kuyken & Moulds, 2008). This third person perspective serves to distance the individual from events that is incongruent with their current self (Libby & Eibach, 2002).

Recalling experiences of self-disgust using the same perspective could potentially keep individuals 'stuck', whereas manipulating autobiographical memories could possibly change their views and behaviours in the present and future. Often, where individuals are unsure of their role in the future such as what they may do or feel in a given situation, using mental simulation can help to answer these questions (Gilbert & Wilson, 2007; Libby et al., 2014) by

influencing their cognition, emotion and behaviour. This is crucial for planning and goal-directed behaviour, especially when considering the significant lifestyle changes that are needed to be made and maintained post bariatric surgery.

In relation to bariatric surgery, there are various implications. For example, by manipulating the memories of past events (e.g., using 'me self' imagery to connect with individual's broader values), hence changing the present and future views of their self, situations and behaviours. Additionally, weight-stigmatising systems can be targeted using self-evaluations to improve psychological well-being within the broader context, such as policy, public health campaigns and media representations of obesity.

2.6 Proposed study

2.6.1 Rationale and aims of current study

The literature review illustrates a good framework for understanding the psychological concepts of self-disgust and visual perspective taking. However, research has yet to examine the connections between these, especially within the bariatric population and therefore there is a clear gap, which this study will aim to understand further. Moreover, little is understood about the implications of self-disgust for post-surgical care and the maintenance of weight loss. Nevertheless, considering the current evidence base as above, it was hypothesised that the implications may be many. Primarily, as stated above, societal norms in the Western world dictate that individuals who are obese experience disgust being directed towards them, both overtly and covertly. These individuals are likely to have experienced stigmatising conditions for a large period of time before losing weight via bariatric surgery. This may have multiple levels of impact in regards to how an individual cares for themselves, as well as how others care for them post-surgery. For example, if the individual views their body as 'disgusting', this may have significant repercussions for making and maintaining positive lifestyle changes. Hence, interventions may need to be adapted in light of this.

Research emphasises a strong correlation between weight stigma, psychological distress and poor eating habits amongst adults seeking bariatric surgery (Wott & Carels, 2010). Nevertheless, it is unclear how this is affected post weight loss, and whether experiencing weight stigma and body shame could be detrimental to weight loss treatment outcomes. Additionally, whilst much has been written about internalised weight stigma, there is a distinct lack of research in how these processes manifest in individuals (both as a person who is obese and as a previously obese person) and the implications of these. Even less is understood about self-disgust. Moreover, it is unclear how individuals respond when they transition out of weight-stigmatising environments, especially in relation to self-disgust experiences.

Research suggests that bariatric surgery produces consistent levels of success, such as a reduction in co-morbidities and mortality rate (Buchwald, 2005). However, studies have usually excluded experiential accounts; consequently this study aimed to interview individuals. The current research interviewed patients that had bariatric surgery, with a focus on self-disgust, and examined how these experiences manifest within the individual in regards to visual perspective taking. Hence, the hypotheses discussed in this section are tentative as it was hoped that this study would elicit information that will be helpful for clinicians and services.

2.6.2 Research questions

The present research aimed to answer the following questions:

1. What are bariatric patients' experiences of self-disgust pre and post surgery?

2. What visual perspectives do bariatric patients take when talking about their experiences of self-disgust?

CHAPTER 3: METHOD

3.1 Overview

This section will describe the research methodology and epistemology of the current thesis project. An argument for adopting a qualitative approach to this topic will be made and relevant factors in identifying participants will be highlighted. I will also highlight the key areas of ethics that were pertinent to this topic, as well as the analytical approach that was taken. I will conclude by reflecting on the research process and drawing attention to some of my values and assumptions that may influence this project.

3.1.1 Epistemological considerations

Adopting an epistemological position enables one to consider the validity and reliability of the claims to knowledge by better understanding the objectives of our research and what is possible for us to find out (Willig, 2001). This study draws upon a critical-realist ontological framework, which posits that whilst there is a 'real' world, reality is not directly accessible (Willig, 2008), but rather mediated via socio-cultural meanings. The critical-realist or the contextualist stance views experiences as subjective accounts influenced by an individual's own contexts including their wider social, political and historical context (Bhaskar, 1989; Finlay, 2006). Additionally, as an experiential qualitative research, this study assumes that language is used to communicate the individual's version of reality (i.e., their lived experiences, perspectives and practices). This position therefore enables both the researcher and the participant to accept their own realities and be transparent about how those realities influence their interpretation of the data.

The research questions posit that data will give us information about the individuals' reality but that they may not be fully aware of all the factors that are influencing their experiences of self-disgust such as their expectations of the outcome of surgery, their cultural beliefs about obesity and their pre surgery pre-operative experiences of disgust. Hence a number of different

sources were drawn upon to form a cohesive understanding of people's experiences, such as clinical experience and the wider literature.

3.1.2 Adopting a qualitative approach

The need for psychological input in bariatric surgery is well documented (National Confidential Enquiry into Patient Outcome and Death bariatric surgery report, 2012; NICE guidelines, 2006). In practice, psychology provision varies significantly across the UK (Ratcliffe et al., 2014) and so, it is imperative that the practice of clinical psychologists considers the realities of those whom they treat so that they can better address their psychological needs. Currently, the main focus of research in bariatric surgery has focused on quantitative studies, with some qualitative studies. A number of these have been carried out pre-surgery (e.g., Homer et al., 2016) or have focused on specific experiences related to a particular type of surgery such as laparoscopic gastric banding leading up to the time of surgery (Pfeil et al., 2013).

Whilst some researchers argue that quantitative methods are more 'objective' and can be better used to generalise findings to a wider audience, they can at times reduce multifaceted issues to a limited number of variables, which may appear superficial given the lack of human perception and complexity. Furthermore, with the lack of research in the current topic, there are no testable theories as yet. According to the author and the specialist bariatric surgery team's knowledge, research into self-disgust and visual perspective taking in the bariatric population has not yet been conducted (quantitatively or qualitatively). Furthermore, the experiences of people undergoing bariatric surgery in the UK is lacking, with assessment, treatment and evaluation predominantly based on evidence from other Western countries such as the USA. Whilst these may be relevant to an extent, the UK context is arguably different and needs its own consideration, particularly given the growing rates of obesity and thus, bariatric surgery. Hence, this study aimed to use qualitative methods to understand some of the physical, social, psychological,

cultural, historical and interpersonal context in which self-disgust and visual perspective taking is conceptualised and made sense of post-surgery.

Qualitative research focuses on the phenomenological experiences of individuals with its methods aiming to develop understanding of complex phenomena (Marshall, 1996; Willig, 2008).

"*Qualitative research methods lend themselves to understanding participants' perspectives, to defining phenomena in terms of experienced meanings and observed variations and developing theory for field work*" (Elliott et al., 1999, p. 216).

In regards to the current study, a qualitative methodology enabled the exploration of a new area of research that allowed interviewees to describe and explain their experiences in a meaningful way. Interview questions were tailored to participants' needs, with as much time as they required thus ensuring depth and detail to the data collected. The research direction and framework was therefore flexible enough to be revised as new information emerged throughout the interview. Being responsive and using open-ended questions enabled participants to expand on their responses. Furthermore, allowing individuals space to share their experiences non-judgementally equipped researchers and clinicians to understand what meaningful change might look like.

3.2 Recruitment site and participant identification

The recruitment site used for this study is a bariatric surgery service in a London NHS Trust. Referrals are made by GPs and specialist healthcare professionals, with the service being accessed by adults over 18 years old. The decisions, for whether to proceed to surgery or not, are made by a multidisciplinary team consisting of surgeons, anaesthetists, a clinical nurse specialist, psychologists and dietitians. Within this service, over 400 surgeries are performed per year including gastric bypass, gastric band and gastric sleeve. It is important to note that whilst psychology provision varies

significantly across the UK (Ratcliffe et al., 2014), this service has a more integrated pathway with psychological input provided pre and post surgery.

Participants were identified by health care professionals (e.g., Surgeons, Nurses, Clinical Psychologists or Dieticians) after having undergone bariatric surgery. Purposive sampling (i.e., specific people were selected) was employed to identify a sample of participants who met the inclusion and exclusion criteria.

3.3 Inclusion and exclusion criteria

The inclusion and exclusion criteria for the study were generated based on the findings from the literature review and in-depth discussions with both clinicians at the service and research supervisors. The following inclusion criteria were agreed upon:

Adults who have undergone bariatric surgery
Bariatric surgery was a requirement of the study; therefore all participants had to have had a gastric band, gastric bypass or gastric sleeve.

Maximum of two years post bariatric surgery
Research suggests that weight loss stabilises at two years post bariatric surgery (Sjostrom et al., 2007). Upon discussion with my field supervisor it was agreed that this would be the upper limit for recruitment to ensure that experiences of life pre-surgery could be recalled most successfully.

At least 50% excess weight loss
Weight loss is a crucial component of this study. As participants are expected to consider the impact of their weight loss in relation to self-disgust, an objective measure was required to define 'weight loss'. Research suggests that the average excess weight loss at two years is 58.6% (van Hout et al., 2008).

Understand verbal explanations and written information in English

This study will be conducted using verbal and written English only; therefore it is imperative that participants are able to engage using both these means. Moreover, the epistemological position and the analytic approach being used posits that data is situated and analysed within its psychological, social, cultural, historical, ideological and political context. Thus, understanding the meaning attached to the language used is essential.

Additionally, the following exclusion criteria were enforced:

More than one type of bariatric surgery

Having more than one type of surgery is uncommon and usually indicates additional complications. As the purpose of this study was to explore self-disgust, additional confounding factors that could potentially influence the results were eliminated.

Revisional surgery performed

As above, revisional surgeries usually suggest medical complications and therefore were excluded.

Adults that are currently in psychological therapy

As the Clinical Psychologist was also the field supervisor, it was decided not to include participants that were currently engaged in psychological therapy. Additionally, as the lead researcher had been an Assistant Psychologist in the service prior to starting clinical psychology training, it was important that participants had not had any previous contact with them in order to avoid any ethical dilemmas from arising.

3.4 Procedure

3.4.1 Refining the interview schedule

The interview schedule (Appendix B) was developed following a comprehensive literature review and discussions with my supervisors.

Additionally, a poster presentation of the study was presented at a one day conference for health care professionals working in bariatric care (Management of the bariatric patient; 2015) at the University of East London. During this presentation, clinicians were consulted about the current study. Moreover, a pilot interview was conducted with a colleague who had experience of working with the target audience to ensure that the interview design and research questions were appropriate (Turner, 2010). Whilst this interview was not used for data collection, the procedure followed was exactly the same, including gathering consent and providing debrief.

The above process enabled feedback on the content of the interviews, as well as the researcher's interviewing skills. This was important as the research interviews are influenced by the personal idiosyncrasies and biases of the researcher. The consultation process enabled key areas to be identified, which was then used to guide the researcher. It was agreed that the interview schedule was appropriate for this study and therefore did not require further changes.

3.4.2 Recruitment

As I had previously worked in the service as an Assistant Psychologist, the team of Health care professionals (e.g., Surgeons, Nurses, Clinical Psychologists or Dieticians) were already known to me. Both my supervisor and I approached members of the team to discuss the study and ensure that they were on board, especially in relation to recruitment. I discussed the inclusion and exclusion criteria (section 3.3) and gave them the relevant information including the participant information sheet, consent form and sources of information and support (Appendices C, D and E) so that these could be used to guide their conversations when they approached patients.

3.4.3 Recruitment process

After our discussions of the study with the team as outlined above, individual clinicians approached patients during routine clinic appointments and

introduced the study to them. At this point patients were given the opportunity to not take part should they wish, without it affecting their routine care. Those patients that gave verbal consent were then contacted by the researcher to discuss the study further and answer any questions. The researcher arranged a date, time and place for the interview (NHS Trust or UEL) with those who were interested in taking part in the research. Issues of safety and risk were considered. For example, timings of interviews were within working hours and supervisors were aware of this information, as well as when the interview ended. Some of the participants requested information to be sent to them via e‑mail for consideration before taking part. Information sheets (Appendix C), alongside the consent form (Appendix D), were sent as requested.

3.4.4 The interviews

Prior to starting interviews, information sheets (Appendix C) alongside opportunities to ask questions, were given. Interviews only began after a consent form (Appendix D) had been signed. Individual face to face, semi-structured interviews lasting between 30-101 minutes were used for the study. These were recorded using a dictaphone and was transcribed by the researcher at a later date for analysis.

A brief introduction helped to build rapport and collect demographic information which included age, gender and ethnicity (for further detail see Table 2). The interview schedule (Appendix B) was guided by literature on obesity, self-disgust and visual perspective taking as well as discussions with research supervisors and health care professions working within the field. After building a rapport and collecting demographic information, participants were supported in constructing their own definitions of 'self-disgust' through words selected from the disgust literature (Appendix F). Participants chose a range of emotions and/or behaviours that they had experienced towards themselves. Interviews attempted to address both pre and post weight loss disgust with a focus on the meaning of these for the individual.

Once participants identified examples of situations where they had experienced self-disgust, they were presented with two images (Appendix G) and asked whether either of these perspectives were taken when they recalled these scenarios. Thus, visual perspective taking was elicited in the study via the use of pictures to differentiate between 'I self' and 'me self' events. These pictures were inspired by Libby and Eibach's (2011) and Libby et al.'s (2009) distance-controlled action photographs which were used to measure and manipulate visual perspective. These images demonstrated that people process information differently according to the visual perspective adopted. The photographs used in the current study were of the researcher positioned according to first and third person perspectives.

Once interviews were completed, participants were fully debriefed and further sources of information and support were provided (Appendix E). If participants became distressed, they were encouraged and supported to contact the relevant clinician and/or access further psychological treatment if they wished to. Moreover, participants were given the opportunity to have a copy of their transcripts once transcription was completed at a later date, as well as have a copy of the completed thesis. All participants declined the transcripts but asked to be contacted when the thesis was completed.

3.5 Ethical considerations

3.5.1 Ethical approval

This study received full ethical approval from the Health Research Authority Bromley North research ethics committee on 11th June 2015 (Appendix H) and University of East London on 19th August 2015 (Appendix I). Additionally, the NHS Research and Development department of the NHS recruitment site also granted approval for the study to take place on 7th July 2015 (Appendix J).

3.5.2 Informed consent

All participants were involved in discussions with their clinical team and given time to think about their involvement in the research. They were assured that their involvement or non-involvement would not have an impact on the care and support provided by the service. They were also actively encouraged to consider the potential impact of the study on their emotional and psychological well-being. Prior to starting the interviews, an information sheet (Appendix C) was provided and a consent form (Appendix D) was signed.

The information sheet (Appendix C) highlighted the purpose of the study, why the participant was invited to take part, that participation was entirely voluntary, what the research would involve, where the research would take part, whether there were any potential risks involved and how confidentiality and anonymity would be maintained. Furthermore, contact details of the research team were provided as well details of independent organisations should there be any concerns or complaints. Additionally, participants were informed of how the results of the research would be used.

The consent form (Appendix D) outlined the participants' understanding of the study and what they were being asked to do, their permission for the interviews to be recorded via a dictaphone, for the research team to have access to the data as well as their right to withdraw at any stage of the study without any negative consequences to the care that they were receiving from the service. The sources of information and support were offered to participants, alongside a signed copy of the consent form.

3.5.3 Confidentiality and anonymity

Demographic information, consent forms and research data were kept confidential at all times through the use of encrypted memory sticks and files, locked storage environments and anonymising data. Whilst in the same location i.e., UEL, signed consent forms were physically stored separately to other data collected.

The information sheets explained how the use of pseudonyms would help protect the identities of participants, both on the audio files and the interview transcripts. The researcher transcribed all interviews. In addition, all identifying information was anonymised in transcripts, thesis extracts and any related publications. All data will be destroyed after five years.

3.5.4 Distressing interview experiences and disclosure of risks

Whilst the purpose of the study was to generate data that was beneficial, it was anticipated that some participants may find the interview questions negative or distressing. This was highlighted in the information sheet and discussed verbally before progressing with each interview. It was explained to participants that should they become distressed during the interview, they would be offered a break, the opportunity to reschedule or withdraw.

After completion of the interview, participants were verbally debriefed and offered contact details for further support, as well as encouragement to contact the relevant health professional, if relevant to their situation. They were also given details of the researcher should they want to contact me again after the interview. It was anticipated that confidentiality would only be broken in consultation with the research supervisors if there were serious concerns about a participant's or a member of public's safety, and would always be discussed with the participant beforehand where possible.

3.5.5 Withdrawing data

All participants were made aware before, during and after the interview that there was no compulsion to take part in the study, and that any data generated during the interview could be withdrawn at any stage of the process, including after the interviews had been conducted.

3.6 Analytic approach

3.6.1 Transcription

All interviews were audio recorded and later transcribed orthographically (i.e., with a focus on the words that were used as opposed to how they were used) by the researcher. Transcripts were analysed using thematic analysis (Braun & Clark, 2006). Transcription of audio-data was based upon Braun and Clarke's (2013) notation system, with key themes being identified at a semantic or explicit level, with the implications of themes discussed in section 5. These were guided by the university supervisor at the University of East London and the field supervisor (Consultant Clinical Psychologist working within bariatric surgery). All identifying information was removed. Furthermore, the coding and key themes were confirmed by both supervisors to ensure high inter-rater reliability. Additionally, each interview was listened to several times, whilst reading the relevant transcript.

Furthermore, an inductive, exploratory approach was taken. In line with this approach, themes were not driven by a theoretical interest, but rather curiosity about the experiences of people that have undergone bariatric surgery (i.e. data driven). Hand-written notes and a reflective journal aided the analysis process as recommended by Braun & Clark (2006).

3.6.2 Thematic analysis

This study followed the process of thematic analysis (TA) as outlined by Braun & Clark (2006).

TA was first introduced in the 1970's (Merton, 1975) and has since continued to be developed (e.g., Braun & Clarke, 2006; Joffe & Yardley, 2004; Tuckett, 2005). Thus leading to a wide range of theoretical frameworks, from essentialist, contextualist (phenomological, critical-realist), to constructionist (thematic discourse analysis; Taylor & Ussher, 2001).

TA is a theoretically flexible method (Braun & Clarke, 2006) in that it can be used for most types of research interests and theoretical perspectives. It can be suited to a variety of qualitative data (e.g., interviews, Kitzinger & Wilmott, 2002; focus groups, Braun, 2008; qualitative surveys/questionnaires, Frith & Gleeson, 2004), thus addressing a range of qualitative research questions, such as those in relation to people's experiences and their understandings and perceptions. It is a method for identifying and analysing patterns of meaning (Braun & Clarke, 2006).

There are six key phases of TA (Braun & Clarke, 2006) that are pertinent to this study:

Phase one: Familiarising yourself with the data and identifying items of potential interest
Notes were made before and after each interview with the potential areas of interest identified at each stage (see Appendix K). Furthermore, during the transcribing stage, notes were made to guide the analysis and familiarise the researcher with the data.

Phase two: Generating initial codes
Throughout the familiarisation process, codes were actively sought using a variety of methods including pen and paper, highlighters and post-it notes. These were done individually for each interview and the data was again examined by listening to the interviews and reading the transcripts. A list of identified codes is included in Appendix L with examples of coded data in Appendix M.

Phase three: Searching for themes
After the initial codes were identified, they were clustered together to identify potential themes (Appendix N). These clusters were then reviewed to ensure accuracy. Themes are defined as capturing "*something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set*" (Braun & Clarke, 2006;

pg.77). During this stage the relationships between codes, subthemes and superordinate themes were explored.

Phase four: Reviewing potential themes
Themes were rigorously checked to ensure their quality by checking whether there was enough coded data to support each theme. Additionally, relationships between themes were considered in relation to the entire data set. This was a fluid process whereby codes and themes were deleted, added and changed as appropriate.

Phase five: Defining and naming themes
Each theme was labelled by taking into account the description and the overall 'story'. Finalised themes were organised using thematic maps into four overarching themes and ten subthemes (e.g., Braun & Clarke, 2006; Terry, Braun & Farvid, 2012; see Results section 4.3).

Phase six: Producing the report
Finally, the analysis was related to the research question, the literature and the wider context by using selected examples to illustrate themes.

3.6.3 TA compared to Interpretative Phenomenological Analysis

Whilst on the surface both TA and Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) appear to be similar, there are distinct features that make TA a better process of analysis for this study. TA and IPA are both concerned with meaning and process; however TA is a method whereas IPA is a methodology. Silverman (1993) defines a method as a specific research technique and a methodology as a general approach to studying research topics. IPA has a specific framework with analytic procedures that must be followed, whereas TA is a theoretically flexible method which can be adapted in numerous ways.

IPA has specific epistemological and ontological positions (critical-realism and contextualism). It is a phenomenologically focused approach to the

interpretation of experiences that adheres to a relativist ontology. It therefore does not question individuals' experiences or how it relates to the external reality (Willig, 2008) but rather accepts them as 'truths'. TA on the other hand is not connected to a particular theoretical outlook; hence it can be applied using a range of epistemological and ontological positions. This means it can be deductive or inductive. Moreover, IPA requires the sample to be homogenous with a small number of participants whereas this study took an inductive approach alongside a mixed sample (e.g., age, gender) which meant that TA was more appropriate.

As an analytic method, TA can be used to identify, analyse and report patterns within the entire data set (Braun & Clarke, 2006). It analyses the whole data set at each stage thereby identifying patterns of meaning across the entire data set. Conversely IPA takes an idiographic approach which means that each data item is analysed at a time with focus on the individual participant and then the patterns across the data set are explored. The focus of this study was the patterns across the whole data set, as opposed to individual characteristics of interviews. Hence, similar or different experiences of self-disgust across the data set are more likely to be explored in depth using TA.

TA enables a systematic and transparent system for capturing latent meanings, in a way that reliability and validity checks can be made to see how results were reached by examining the coding frames. It assumes that people engage with issues that are socially constructed but may have a material basis nonetheless. Thus, by locating data within its context, TA allows a better understanding of the contextual factors that may be influencing patients' experiences, hence promoting interventions that are not solely dependent on the individual. Additionally, TA requires the researcher to be familiar with their data via active reflection and choice making. This means that assumptions made by the research team will be recognised and therefore less likely to affect the outcome.

3.7 Reflexivity

To ensure a good standard of qualitative research, reflexivity is crucial as it enables the researcher to recognise and critically reflect upon their own contribution to the research process (Spencer & Ritchie, 2012; Willig, 2008; Yardley, 2000). During the research process, the researcher becomes embedded within the research and therefore it is impossible to separate the researcher from the research. Hence, it is essential "*to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research*" (Nightingale and Cromby 1999; pg. 228).

Willig (2001) recognises the importance of two types of reflexivity: personal reflexivity and epistemological reflexivity. She identifies personal reflexivity as reflecting upon the way in which we have shaped the research (e.g., through our values and experiences), as well as how the research may have affected and changed us. Epistemological reflexivity on the other hand, enables us to reflect upon the assumptions that we draw upon during the course of the research (e.g., about knowledge) and the implications of these on the research and its findings. Both personal and epistemological reflexivity have been integral to this study and an attempt has been made to capture the essence of this within this report. One such example is through the use of a reflective diary alongside the analytic process to identify how I engaged with the study, the data generated and the outcome produced (see Appendix O for example).

In addition to the reflective diary, I used reflective exercises (Braun & Clarke, 2012; Hesse-Biber, 2007) that encouraged reflecting prior to starting analysis especially in regards to:

➢ any assumptions that I hold in relation to the research topic
➢ my values and life experiences, and how they might influence the way I read and interpret the data

These exercises helped me to develop a 'richer' understanding of the data. Of note are my pre-research experiences of working with patients within the service. These patients sometimes received a variety of complex, and often contradictory messages. For example, whilst being perceived as a 'success' medically and socially for losing their excess weight, some of the patients carried their previous negative experiences with them and continued to be influenced by these. I was particularly interested in their experiences of self-disgust and the relationship between their physical and psychological/emotional self. However, given that I had worked within the service for two years, and the inclusion criteria consisted of a maximum of two years post bariatric surgery, I had to exclude some of the participants due to previous contact as an Assistant Psychologist. This was important as the presence of a researcher can influence the responses of participants especially given my previous employment within the service and thus, my connection to providing a good or bad service.

CHAPTER 4: RESULTS

4.1 Overview

This chapter presents the findings of the analysis. It will begin by outlining the demographic data collected from participants, and then go on to present the overall thematic map with each theme and sub-theme identified and discussed. Examples from the data will be used to illustrate each point in turn.

4.2 Participant characteristics

Eight semi-structured interviews were conducted in line with research on data saturation (Guest et al., 2006). The data was collected between September 2015 and January 2016 with interviews lasting between 30-101 minutes. The interviewees consisted of two male and six female participants with an age range of 25-60 years. Participants identified with a range of ethnicities and relationship status', and had either had a sleeve gastrectomy or a gastric bypass within the last 12-22 months with an excess weight loss between 52-79%. This resulted in a reduction of BMI from 42-74 to 29-47. Table 2 summarises the demographic information collected. Pseudonyms have been used to ensure anonymity of participants.

Table 2: Demographic information of participants

Name	Age	Gender	Ethnicity	Relationship status	Type of weight loss surgery procedure	Time since weight loss surgery procedure (months)	Duration of interview (minutes)	BMI before procedure	Current BMI	Excess weight loss (%)
Moira	54	Female	White British	Separated	Sleeve Gastrectomy	17	101	54	39	52
Simone	59	Female	British Ghanaian	Single	Gastric Bypass	13	30	45	35	52
Gohar	35	Female	British Lebanese	Married	Sleeve Gastrectomy	18	52	45	32	66
Robin	25	Male	British Italian	Separated	Gastric Bypass	19	65	49	35	59
Kay	60	Female	White British	Divorced	Gastric Bypass	12	80	63	43	57
Caitlin	50	Female	British New Zealander	Single	Gastric Bypass	15	84	58	32	79
Andy	57	Male	White British	Married	Gastric Bypass	14	70	42	29	76
Amy	47	Female	White British	Single	Sleeve Gastrectomy	22	88	74	47	54

4.3 Thematic map

In line with Braun and Clarke's (2006) recommendations, reflexive dialogues throughout the analytic process enabled the themes to stay relevant to the research questions whilst developing a patterned response from the data set. Both research and clinical judgement were utilised to ensure that the analytic process was rigorously adhered to as described in the Method section.

Familiarisation with the data was key to the development of the initial codings. This was achieved by listening to and transcribing the interviews, keeping handwritten notes and having regular discussions with my supervisors. These codes were continually refined to form themes and sub-themes. In total, four themes and ten sub-themes were identified across the transcripts; a summary of these themes and sub-themes are presented in Figure 2.

```
                    ┌─────────────────────┐
                    │     Increased       │
                    │ sensitivity to body │
                    │        size         │
                    └─────────────────────┘
              ┌────────────┼────────────┐
┌──────────────────┐ ┌──────────────────┐ ┌──────────────────┐
│ Negative childhood│ │ Societal shaming and│ │ Denigrating obesity by│
│ experiences of body│ │ exclusion of 'the obese'│ │ rewarding weight loss│
│      weight        │ │                    │ │                    │
└──────────────────┘ └──────────────────┘ └──────────────────┘
```

```
                    ┌─────────────────────┐
                    │  Manifestations of   │
                    │     self-disgust     │
                    └─────────────────────┘
              ┌────────────┼────────────┐
┌──────────────────┐ ┌──────────────────┐ ┌──────────────────┐
│ Revolted by the body│ │  Hatred of the self │ │  Self-directed blame │
└──────────────────┘ └──────────────────┘ └──────────────────┘
```

```
                    ┌─────────────────────┐
                    │     Discovering      │
                    │        self-         │
                    │    determination     │
                    └─────────────────────┘
                   ┌──────────┴──────────┐
          ┌──────────────────┐ ┌──────────────────┐
          │    Connecting     │ │     Becoming      │
          │ differently to self│ │ autonomous within │
          │    and others     │ │                   │
          └──────────────────┘ └──────────────────┘
```

```
                    ┌─────────────────────┐
                    │   Living with and    │
                    │    beyond disgust    │
                    └─────────────────────┘
                   ┌──────────┴──────────┐
          ┌──────────────────┐ ┌──────────────────┐
          │ Finding ways to   │ │ Learning to resist│
          │  protect the self │ │      shame        │
          └──────────────────┘ └──────────────────┘
```

Figure 2: Thematic map of themes relating to people's experiences of self-disgust

Each theme will now be discussed with reference to excerpts from interviews. To improve readability brief interjections, pauses and repetitions have been omitted. Additionally, the pseudonyms and location of quotes in the original transcripts have been provided at the end of the extract. Pseudonyms have also been used when participants have referred to friends, family and places to ensure anonymity.

4.4 Themes

4.4.1 Theme one: Increased sensitivity to body size

A recurring theme throughout the interviews were the way in which people became sensitized to negative associations in relation to their body size. Inherent in this were the ways in which societal members related to them in relation to their weight; whether this was through labelling them as 'fat' during their childhood, excluding them from social activities for being obese or increasing quality time with family members as a reward for losing weight. All the participants recognised the importance of the role of social stigma in facilitating their experiences of disgust.

4.4.1.1 Sub-theme one: Negative childhood experiences of body weight
Participants recalled detailed experiences of social stigma related to their increased weight during their childhood. Many of the interviewees themselves did not remember being 'fat' but rather being told by others about their increased weight in relation to other children and/or their siblings. Interestingly, for some of the participants, these experiences did not appear significant at the time. Instead, years later as a teenager or an adult when their weight became an issue for them, they were reminded of these early childhood experiences. For others however, these experiences made a significant contribution to how they perceived themselves in relation to other people, as well as how they viewed their bodies.

For Moira, her earliest recollection of stigma was at the age of eight during a family holiday when a family friend made a comment about her weight, to her dad, in her presence. This event was significant as it was the first time that a reference to her weight had been made, and one that subsequently shaped her own view of herself as "*fat*".

> *I can always remember thinking "I was fat" right from early. From eight years of age when we went to visit family, and in Ireland they call you a 'heifer'…That was the first time I heard 'God John, she's a heifer.' At that age it doesn't stick in. I'm big but nobody's ever said 'you're a fat child'. Then as I got older, I still saw myself as fat.* (Moira: 21-28)

Whilst this was an important memory, it was not until Moira was older that she started to question and understand what this comment actually meant.

> *Sounds like that was a significant thing at eight…?* (Interviewer: 29)

> *Yeah…you're going to visit family, going home to Ireland. It's not until you're older you know what they're saying. I hadn't taken it in. When I got older I thought 'why are you calling me a heifer?'* (Moira: 30-36)

> *Do you think it made a difference at the age of eight?* (Interviewer: 37-38)

> *No but it came back. It was a memory that came back because I thought that I was fat.* (Moira: 39-40)

In addition to the above comment, Moira also experienced observations of her weight by family members in the form of jokes. Whilst these were consistent throughout her childhood and clearly a significant memory, she described them as being "*just joke*s" and "*not vicious*".

> *My dad would say things like "your bum's so big you'll bounce off the pavement" you know, "you'll crack the pavement". But it wasn't vicious, he wasn't being vicious, it was just dad's joke.* (Moira: 108-110)

This piecing together information from childhood was common amongst interviewees. For Caitlin she also remembered "*always being told to lose weight*" (128) both at home and at school. She reported that her "*mind didn't feel fat but she was always told she was fat*" (132). This highlights how some people are judged and labelled as children before becoming aware of their own physical appearance. Even in terms of her behaviour, Caitlin remembers doing the same things as other children in spite of being told that she could not do them.

> *I could still do everything else that all the other kids could do and it didn't hinder me at all. And again, you know it's this thing that if you're fat you're unfit, if you're fat you can't do anything, but I didn't think like that. I was doing everything else that any other kid could do.* (Caitlin: 136-140)

Additionally, people around Caitlin expressed concerns regarding her health on a regular basis even though her weight was not a problem at the time. Her sister for example, would always remind her to be careful about her weight as otherwise she could have health problems in the future.

> *She would always talk like you're gonna have to be careful of your weight, I don't want you dying, you're gonna have a heart attack, you're gonna have this, you're gonna have that.* (Caitlin: 116-118)

These reminders might have been well-intentioned, but only served as a reminder of her difference to the other children i.e., "*being the biggest in the class*" (136).

4.4.1.2 Sub-theme two: Societal shaming and exclusion of 'the obese'

A recurring theme throughout the interviews were participants' experiences of being shamed and excluded due to their increased body size. Participants reported being objectified and vilified by family, friends and strangers alike, and this extended to healthcare and employment settings where negative attitudes and behaviours were expressed. Individuals spoke about being viewed as "*at the bottom*" (Caitlin: 642) of "*thinner*" people and therefore not valued as equals in social situations. This sense of being different subsequently affected the way that participants behaved and interacted socially, as well as privately.

All participants except one reported incidences of abuse by other people, including strangers, in the public arena. These were directed at the individual's weight and were mostly in the form of harsh and offensive language.

> *I'd be walking down the street, and you get "oi fatty!" or you get "Boom! Boom! Boom! You're breaking the cement".* (Amy: 275-276)

Many of the interviewees reported incidences on the bus where they were targeted by adults and children because of their weight. Moira and Amy spoke about taking up more space on a seat on the bus in comparison to a person with a smaller body, and how this often lead to abusive responses from other passengers. Moira identified a "*look*" that strangers often gave someone as an acknowledgement of 'being fat' and therefore somehow not worthy of being treated in the same manner as someone who was not obese. Whilst there were some uncertainties about whether these 'looks' always meant something derogatory, Moira thought that they did.

Sitting on the bus and you'd get some woman going *huffs* because you've taken up that little bit more so you'd push yourself over to the seat. Then they'd get off and shout. They just looked at me like I'm a piece of shit. Then your whole day is gone because you're in that zone where you're just like 'what the hell'. It feels like everyone's staring and a lot of the time they are. A lot of the time they are staring. It's not you imagining it, it's not because you smell, it's 'cause you're fat. (Moira: 385-391)

Amy was also familiar with these 'looks' and described a heightened awareness of her surroundings due to her size. She described the associations that people made between her weight and her characteristics and behaviour (e.g., being lazy).

I sit on a bus, and you'll sit there and you're tucking yourself into as small as you can. You'll see somebody walk up, and they'll look at the chair and look at you, and walk away. (Amy: 246-248)

You get on a bus, because large people are very, very aware of their surroundings because people look at them. You know, when we walk into a doctor's surgery, as a large person, and I'm still a big person, you got to make sure you got a seat with no sides. Because if you don't fit in that, people look at you. They automatically think you're lazy and you don't do nothing and you eat too much. (Amy: 227 – 231)

Caitlin also spoke about an incident on the bus where a group of young girls responded to her weight in a different way to Moira. Although words were not exchanged, it was clear that comparisons were being made between Caitlin's weight and that of Peppa Pig.

I was carrying a Peppa pig balloon home. I was on the bus and there were a couple of young girls, and they saw me and then saw the balloon, and they just burst out laughing and I just thought "you know what? I know exactly what you're thinking!". (Caitlin: 285-288)

> *When I saw them laughing, I knew what they were seeing – peppa pig balloon, me, you know?* (Caitlin: 304-305)

These incidents were regularly experienced by Caitlin and were especially detrimental when she was seeking employment, as she was frequently discriminated against because of her weight. Assumptions about her physical ability were made in spite of her previous qualifications and experiences.

> *I have really good qualifications, really good references, and I couldn't find a job, cause all they looked at me was "oh, she's so fat, can she manage the stairs?" It was quite insulting.* (Caitlin: 204-206)

More surprisingly perhaps, this shaming extended to after surgery as reminders of how the participant used to be. For Robin, there were often questions about why he had undergone surgery when he could have made the changes himself, suggesting that the surgery did not require any input on his part or that he had 'cheated'.

> *Why did you do that to yourself? You're still young, you could have lost the weight by yourself.* (Robin: 964-965)

Sometimes jokes were used as a reminder of how the person used to be, in spite of the person not wanting to be reminded or associated with obesity.

> *Obviously people make fun of me because of all the weight I lost. They still call me – the people that have been there for 9 years and it's like still "oh I remember you when you were big..." still bringing that up, bringing out flyers of me when I was big and stuff like that.* (Robin: 510-512)

One participant recalled experiences of never standing up for herself when she was obese as she did not want to appear "*rude*", and yet she considered her treatment by others as acceptable.

> *I didn't want to be…rude. But it was okay for everyone else to be rude*
> *with me.* (Moira*:* 335-336)

In addition to the general public, participants also reported being judged and blamed by healthcare professionals. They reported consistently having their health problems attributed to their weight, even when the concern was not directly related to their physical well-being. One GP made "*flippant remarks*" such as "*well, you really need to lose weight Mrs*" (Moira: 796). Due to such comments, one participant said that she "*dreaded*" going into the GP practice. She often left health concerns until they became urgent as she did not want to have repeated negative experiences.

> *I don't know why, I dread it. I would leave it till the very last moment*
> *when I was not coping at all to go to a GP, because I knew what they*
> *would say to me.* (Caitlin: 315-315)

More worryingly perhaps, Amy reported a recent incidence where she was rushed into hospital with severe abdominal pain. The medical team initially wanted to operate straight away but this later changed "*due to her size*" and she was discharged without any pain relief medication. Moreover, during her stay in the hospital, there were constant derogatory references made to her 'obesity' that made her feel negative about all the positive changes that she had been making. These types of comments could potentially set participants up to 'fail'.

> *I tell you what, all my weight loss that I done – they made me feel*
> *really, really little. She [nurse] said "well, you're rather a large lady" and*
> *I said to them "hold on a minute, I was an even larger lady before, but*
> *the thing is, if I'm in pain and this operation needs to be done then… it*
> *needs to be done. You shouldn't be looking at my size, that's not fair,*
> *you shouldn't be treating…" She [nurse] walked away from me.* (Amy:
> 480-485)

I do think it was my size. I do feel that if I was of the normal, in the range of normal, I would've had my operation done there and then. (Amy: 504-505)

4.4.1.3 Sub-theme three: Denigrating obesity by rewarding weight loss

One strong sub-theme that emerged post-weight loss was the constant reference to interviewee's former weight. Often positive comments were phrased in a way that depreciated individuals that were obese. For example, comments directed at Simone allowed her to realise that people did not like her before due to her weight.

Yeah, some people are polite they don't want to show you that they didn't like you before. But now they are telling me "you look beautiful now", you see. The way they are talking makes me know that before they didn't like it. (Simone: 74-76).

One participant spoke in depth about acquiring "*freedom of the body*" since losing excess weight. Her attention was focused on the impact of her '"*fat*" on others and possibly suggestive of seeing her previous self as offensive to others. Since losing weight she felt included by society and that she was no longer being judged for being obese.

That is sitting on the train and not filling the seat. It's sitting on the bus and not feeling like you're spilling over onto somebody else's seat. It's the feeling that people aren't judging you anymore, they're just looking at you. They're not seeing the fat, fat person who filled the seat. Not sitting there going *wheezing noises*. It is freedom, it is absolute freedom. (Moira: 706-710)

Gohar noticed a change in her children's behaviour post-weight loss. She started feeling valued by them as they started including her more in their lives through socialising. This was due to her children's perception of her i.e., not being like an "*old person*" as she was able to walk faster, dress differently and go out more.

How did you know that they [children] were embarrassed of you?
(Interviewer: 74)

You could tell by their behaviour. That they don't want me to pick them up or drop anything. Now she wants me to go out with her all the time, to be with her all the time. Because I've got an 18 year old. To go out with her, socialise more. Before, because I tend not to go out, she sees me like an old person. Because of the clothes, the way I used to dress up, the way I used to walk because I used to walk very slow. Now it's a bit faster. I tend to exercise with her. Before, it never used to happen. (Gohar: 75-80)

This change in perception was also noticed amongst other people, such as teachers who started mistaking Gohar as her daughter's sibling.

Now they're mistaking me with my daughters' sister. With all parents meeting… the first thing… I'm introducing myself to the teacher and she said 'Oh I wish I could have your parents.' I said to her 'I'm my daughter's mum.' She was really shocked and she said 'Oh I thought you were her sibling.' I said 'No, I'm her Mum.' (Gohar: 59-64)

Interestingly, one participant noticed that as her weight reduced, her healthcare treatment also changed; however, she could not identify how this had changed.

So GPs, as you get smaller you get it different, you get treated different. It is different. (Moira: 804-805)

Perhaps more pertinent to post-bariatric surgery where individuals had successfully made lifestyle changes and were doing well, comments such as "*we need to be careful*" (Moira: 1024) by bariatric specialists made them feel "*like it was a slur in a way*" (1028) as it suggested that they might "*become that big girl again*" (1029). Moira reported that she "*carried this around for*

weeks" (1029) and just wanted the professional to "*take a minute to get to know me, just don't remember that 123 kilo girl; remember the girl that's sitting in front of you. This is a different person*" (1026-1027).

4.4.2 Theme two: Manifestations of self-disgust

During the course of the interviews, all of the participants except two spoke about experiences of self-disgust. These experiences presented themselves in three ways; as revulsion of the body, as hatred of the self and as self-directed blame. When describing these experiences, a mixture of perspectives were taken; some interviewees used the first person perspective, some used the third person perspective and some used a mixture of both. Interestingly, these negative experiences were connected to theme one, in that participants' related the development of self-disgust to difficult weight-related events.

4.4.2.1 Sub-theme one: Revolted by the body
A common expression of self-disgust was related to hatred and dislike of the body. The body was experienced as 'disgusting' and 'revolting', and made the individual feel offensive to others in social situations. Almost all the participants spoke about how ashamed, disgusted and revolted they were of their 'obesity'. There were repeated themes of disgust directed towards the 'fat body', with several interviewees distinguishing between themselves as a person and their body as a separate entity. Of the two that did not talk about these experiences, one said that he had never had them and the other said that whilst she "*felt revolted looking at herself in the mirror*" (Caitlin: 534) she did not feel "*100% revolted at herself*" (Caitlin: 535). Interestingly, two of the interviewees disclosed that they continued to have self-disgust experiences towards their body post-surgery. Of these, one mentioned that he had never had any experiences of self-disgust prior to bariatric surgery. Furthermore, both of these experiences were linked to excess skin.

For Kay, she referred to how she perceived herself in her mind's eye and the inconsistency of this with how she looked physically, and for that she hated

herself. She repeatedly used the term "*fat*" to describe her body, alongside the "*disgust*", "*revulsion*" and "*shame*" she experienced when she looked at her body.

> *I don't [feel revulsion] now but I did then. Because…when I took my clothes off, that's why I never looked in the mirror. All this fat, everywhere. Everywhere, there is fat. I rarely stood and looked. Because when you are a big person, you don't look in the mirror. You don't look, you don't see. Actually stand there and see yourself because you don't want to, you're too ashamed, you feel disgusted, you feel revolted by the picture that's looking back at you. You have in your mind's eye that you are how you want to be. But when you take a real good look... I hated myself for how I got.* (Kay: 625-639)

Similarly for Amy, these feelings were the reason why bigger people did not look in mirrors. This was perhaps her way of protecting herself from the disgust she experienced when looking at her body.

> *Big people don't look in full length mirrors.* (Amy: 639)

Whilst pre-surgery, the disgust was directed towards the body fat as mentioned above; post-surgery it was directed specifically towards the excess skin, as opposed to the body as a whole. Kay reported that her experiences of self-disgust had generally reduced since her reduction in weight but at times, the excess skin did make her feel revolted. She repeated the word "*hate*" several times to illustrate how strongly she felt.

> *I do feel revolted. Revulsion, yeah. I do. I do feel disgusted. I feel disgust and I do feel hatred of it…I don't dislike, I hate it. I really do hate it. I don't dislike it, I hate it.* (Kay: 750-755)

The only participant to have noticed self-disgust experiences since losing weight was Robin. For him, it was also his excess skin that disgusted him, and this was especially prominent around his stomach. Whilst he did was not

able to identify any concrete examples of people's attitudes or behaviour, he frequently gave examples of people "*looking*" at him. This automatically led to him assuming that these "*looks*" were due to his "*disgusting excess skin*". Interestingly, Robin's description of these 'looks' were similar to the 'looks' described by people when they were obese.

> *I've noticed people looking at me…I'll automatically presume they're looking at me because of the skin. Just "look at him he's got skin around his stomach". Or even in the swimming pool, when I get out and they're looking at me, and it's like they're staring at me, and skin on the side of my stomach or whatever. I just think, "Oh they're looking at me and thinking "that's disgusting".* (Robin: 400-408)

Robin reported that since having bariatric surgery, the incidences of self-disgust had increased to "*almost every day*" (Robin: 309) due to the "*excess skin*" (Robin: 407). As a result of this, he spent more time ruminating:

> *I could spend up to an hour, thinking "why were they're staring at me? Do they think I'm not normal? Am I that horrible?"* (Robin: 425-426)

These experiences were recalled using a first person perspective and linked to having a choice. Previously, Robin thought that he had an element of choice where he could choose the lifestyle he led, however, with the excess skin he could not choose to get rid of it. For many participants, this element of choice was important and was often related to having control.

> *I chose to be that way. I chose to eat, I chose to – instead of cooking something healthy, going and getting a takeaway. So it was my choice, I made myself that way. Whereas now, I can't choose to get rid of the skin. I can't change anything, to get rid of it. So I've tried everything, but it just won't go so it's just there.* (Robin: 606-609)

For Simone, it was these experiences of disgust and revulsion, alongside her health difficulties that led her to a "*do or die*" (67) attitude whereby she

decided to have bariatric surgery despite feeling scared of the potential negative consequences. Again, this may have been related to taking control back from a situation where she felt out of control.

4.4.2.2 Sub-theme two: Hatred of the self

For many of the participants there were distinct differences between the body and the self. Kay, for example identified revulsion (as discussed above) towards her body as well as hatred towards herself.

> *I hate myself as a person.* (Kay: 643)

Moira also expressed disgust at her physical self, as well as the behaviours that were related to her obesity such as overeating. She linked these aspects to the person that she had become, especially in relation to not knowing how to break the cycle. Again, this was a combination of disgust towards her body and self.

> *Revulsion at myself because I'd have overeaten. Disgust because I would catch myself in the mirror, or I'd be out shopping, or my stomach would hit my leg as I was going up the stairs. Hatred because I just didn't know how to deal with it. I didn't know how to break it…and the loathing because I just didn't like who I had become*. (Moira: 356-365)

Gohar expressed hatred towards herself and the way she used to dress and look. Gohar associated these feelings to her behaviour and how she understood others' behaviour towards her. Even when her family behaved in the same manner towards her, Gohar interpreted these situations differently according to how she viewed herself as a person.

> *It's not that they've [family] never showed me. It's not that they didn't show me they're caring. They've always showed me they're caring. It didn't feel like it before. I've always hated myself. The way I was. The way I used to dress. The way I looked.* (Gohar: 178-181)

When talking about their experiences of self-disgust participants took both first and third person perspectives, often using one or switching between them. Interviewees initially identified which perspective they took by using Appendix G and then described these using examples.

Four participants recalled experiences of self-disgust using only a first person perspective. These incidences were often reported in detail as if they were being seen through their own eyes with the identifying thoughts and emotions recognised alongside this. For example, Gohar recalled a time where she experienced disgust as being connected to food with her hand reaching for crisps, which might suggest signs of gluttony. She repeatedly used the term "*lazy*" to describe herself and connected this to always "*thinking about food*". The disgust itself was intrinsically connected to her characteristics, and not her physical self. Perhaps this also indicated a loss of control whereby she was helpless in preventing herself from reaching out and eating those crisps.

> *Very big and chubby person. Just lazy. Just lazy, lazy, sitting down on the sofa. I see myself sitting down on a sofa with probably a bowl of something to eat. I'm picturing myself…I think I was the biggest I've ever came across. Yeah, just sitting down with a bowl of crisps…I see it as my hand…that somebody is just thinking of about food. And all I thought of back then is food. That's all I used to think about.* (Gohar: 240-265)

For Robin it was a different experience. He reported having minimal self-disgust experiences at his heaviest weight; the moments that he was able to recall were also related to food and perhaps indicative of gluttony:

> *The disgust after you've eaten God knows how many packets of crisps, and chocolate bars and stuff like that.* (Robin: 299-300)

Some of the participants conceptualised experiences of self-disgust with a third person perspective. Moira called this perspective "*me outside looking in*" (Moira: 469). For her, this perspective was about "*putting on a show or a front*"

(Moira: 478) whereby she was a different person, and not the 'real' Moira. She referred to others not knowing her as a person but instead making assumptions about her personality based on her weight. She then went on to say that there were two versions of herself – a public and a private self.

> *Definitely a front 'cause the make-up and the perfume…So I've got them on so you can't see who's in here...you know who's hurting. You know because this is on show, not this person in here. It was the outside person on show because you don't know me, you haven't taken the time to know what my personality is like. You don't know what type of person I am. You don't know if I'm a good person or a bad person. You've just got this picture – fat.* (Moira: 478-483)

> *I never wanted to be that, but it was easier to be that than to put myself on show. To put Moira on show, you know. Because behind closed doors I was Moira.* (Moira: 490-491)

4.4.2.3 Sub-theme three: Self-directed blame

All participants believed that they were wholly responsible for their situation and the difficulties that they experienced. Not only did they blame themselves for their increased weight, but they also felt judged and blamed by other people. This self-directed blame was often used to justify other people's abusive behaviour towards them and was a significant feature of how interviewees expressed self-disgust.

Many of the participants frequently associated blame with gluttony, using evocative imagery and repetitive phrases to illustrate their negative viewpoints.

> *The only person you can really blame is yourself.* (Andy: 321)

> *Why did I let myself get in that position? Because it's only me. Nobody stood there, with my mouth open and force-fed me. Nobody did that. I did it myself. This is what...I've done this to myself.* (Kay: 643-65)

Moreover, the self-blame extended to justifying others' behaviour even when participants knew that an action was wrong. For example, in Moira's case she was repeatedly verbally abused by strangers (as illustrated earlier), yet she continued to think that she was deserving of this abuse as she had made herself obese and therefore put herself in a position where this was more likely to happen.

> *I made myself that* big*….I thought, you know, what came my way I deserve it because I'd put myself in the position where it happened.* (Moira: 340-381)

Similarly for Amy, she would often apologise for the bad behaviour of other people:

> *For no reason, I'll go "well I'm so sorry", and I've been called names. I've been like nudged, and I go "oh I'm really sorry", and they go "you're too fat, you're taking up too much room. You shouldn't be sitting here".* (Amy: 261-263)

This self-blaming attitude transcended into participants' behaviour at times. For example, Simone refused to go on a date for six years whilst she was obese for fear of being criticised about her weight. Once she started viewing herself differently (i.e., less critical and blaming of herself), she was able to start dating again.

> *Before this, my dear for the past six years I didn't want to for any dates. Now if you ask me, I didn't have that feeling…that I have to go out and later on they will criticise you [about weight], do that, do this, you know?* (Simone: 238-241)

> *People wanted, men come to me for dates, but I refuse. But now I go out for dates, everything.* (Simone: 228-229)

Perhaps more surprisingly, for two participants, excess skin post-surgery was viewed as a constant reminder of this self-blame. For Robin, this blame came in the form of a 'choice'; due to the bad choices that he thought he made when he was obese, he now had to deal with the consequences of these.

> *I chose to eat, become that big. Now it's my body's or somebody's way of showing me "well you ate, you deal with it". It's one of those – one of those things that you know, I've got to – it's a reminder of how big I was.* (Robin: 989-991)

4.4.3 Theme three: Discovering self-determination

A clear theme of self-determination emerged across all the interviews. Participants illustrated how they had gained control of their lives after losing weight; they were now making decisions about how to connect differently to themselves and others, as well as how to become independent. Perhaps this was one way in which power and freedom was taken back by participants, after feeling 'out of control' for so long.

4.4.3.1 Sub-theme one: Connecting differently to self and others
All participants reported that as a thinner person they were now 'different', and therefore they were doing different things to when they were obese. For example, some interviewees now experienced physical independence which meant that they were able to engage differently with their environment. Gohar reported that she had a new sense of freedom whereby she was able to engage positively with her environment as well as be included in activities that she was previously excluded from, such as socialising.

> *Now, I see myself as a completely different person as a whole. I could go out because I'm lighter. I can go out. Figures changed, I can put clothes on. Socialising a bit more. (*Gohar: 57-58*)*

For Simone, the changes came both internally and externally. Contrary to her view of herself pre-surgery as "*old*" (33) and "*not wanting to go out or do*

anything" (34), she now saw herself as a "*fit person, nice beautiful young woman*" (207). This change in her perception alongside the physical changes enabled her to walk again (203), to seek employment (310) and to start dating (236). Moreover, this image of herself was reinforced by other people when they made observations about her physical changes.

> *They surprised I got like this…people call me and say "oh, you look beautiful, you look young!" and so I'm happy.* (Simone: 171-172)

Robin's freedom came in the form of activities with his children. He was able to take part in their life more and feel included in their upbringing, whereas in the past he would have refused to participate as his options were limited due to physical restrictions as a result of his increased weight.

> *I take them [kids] everywhere that they want. I'll join in with them…Swimming, even running around in the park when it's nice and warm, going on holiday with them, before I never wanted to. I always said "no I'm not going. What's the point of me going?" Whereas now we're going on holiday, we're going here and there, we're going on rides at Chessington and stuff, whereas before, I wouldn't fit in the seat and now I can.* (Robin: 684-689)

All the participants remarked on how much more included they felt socially due to the reduction in their weight. Some suggested that this was because of a change in their ability or the way in which they viewed themselves, and others thought it was because of people's responses towards them. Most noticed a combination of both.

In regards to perspective taking, Gohar said that she had been using a third person perspective to see herself as "*a whole*" from an observer perspective since her experiences of self-disgust had stopped. For her, this was a positive shift as it allowed her to engage with others and move forward with her life.

Cause I picture myself as a whole. I do take pictures, I do tend to socialize, I do to go out. Just to move forward. (Gohar: 303-304)

4.4.3.2 Sub-theme two: Becoming autonomous within

All participants acknowledged how hard they had worked to change their lifestyles and meet their goals. They saw their roles as fundamental to the positive outcome of bariatric surgery and that this insight enabled them to become more independent and thus, take control of their progress.

Me, I've helped myself. (Caitlin*:* 1002)

Some of the participants reflected on this in relation to life post-weight loss and the differences that they were encountering. For Caitlin, this further validated her position of having been a lower status person socially when she was obese, and how his had changed since she had become thinner. As a result of this, her behaviour had also changed (e.g., standing up for herself when she would not have done so in the past).

Now I have a right to stand up and say, speak up whereas before when I was fat, because I knew people would give me this look, it was like they would shelve me to the bottom of the ladder in regards to when I would speak but now because I'm not at the bottom of the ladder…I know it sounds stupid but now I'm not at the bottom of the ladder, now I'm in the middle of the ladder and I have every right to speak, how I feel. (Caitlin: 641-646).

Interestingly for Simone, she spoke about some of the contradictory messages from her community. Whilst one community (Western) valued women who were slimmer, another (African) valued bigger women. This meant that ultimately she had to rely on herself and pursue what she wanted.

In African society…if you are a woman and you are big I think they like it. (Simone: 121-122)

> *African society you can't praise anyone. You have to praise yourself.*
> *They like it because of our clothes, you know, our dressing? If you are*
> *big it fits you more but, hey, who cares?* (Simone: 351-354)

For many participants, becoming emotionally independent involved changing priorities. Gohar spoke about not focusing on food after losing weight, as this was no longer a priority in her life:

> *I don't see food as a priority in my life anymore. I don't focus on food.*
> (Gohar: 50)

For Kay, this change in priority was linked to her hopes for the future. As she began to lose weight and gain positive health benefits such as reduced knee pain, she started to feel hopeful and thus, began to make plans for the future for herself and her loved ones.

> *I'm going to take my youngest grandson and my other grandson whose*
> *six, and we're going to go on an adventure. We'll take them to the zoo*
> *or to the park and we used to go looking for squirrels, not do anything*
> *with them but maybe go acorn hunting. We can get some squirrels and*
> *we'd do nature trails. I used to take them to the bunny park and we'd*
> *go to the museums all day long like I used to do with my own kids.*
> *That's what I want to do with them and I can't wait to do it.* (Kay: 1077-
> 1086)

In relation to becoming autonomous, two participants spoke about being flexible in the perspectives they used and switching between these during both negative and positive experiences. In fact, for one participant (Moira) once the self-disgust experiences reduced post-weight loss, she was less rigid in how she viewed herself and therefore able to utilise both first person perspective ("*inside*") and third person perspective ("*outside*"). She described this shift as becoming "*less foggy*". This enabled the 'real' Moira to resurface, without the need to hide aspects of herself.

It's me. It's clear. It's not foggy. I'm not on the outside looking in. I am the inside. I am the outside. I'm both. (Moira: 816-817)

This person sitting here now, is Moira. It's who I am. You know, I don't hide anymore. I still put my makeup and my perfume on but I don't hide, you know. (Moira: 503-505)

4.4.4 Theme four: Living with and beyond disgust

Interviewees spoke about a number of ways in which they continued living with experiences of disgust or moving beyond these. Participants described how they protected themselves and the ways in which they were resisting shame after being humiliated about their weight. These behaviours allowed them to reduce or better manage the effects of disgust on their lives.

4.4.4.1 Sub-theme one: Finding ways to protect the self

There were a number of ways that participants described protecting themselves from self-disgust both before and after losing weight. These ranged from avoiding looking at mirrors, using humour as a way of coping and isolating themselves from the public sphere. Some of these strategies were described as being helpful at the time, whilst others were thought to be unhelpful in the longer term.

As a result of the self-disgust attributed towards the body, many participants avoided looking at themselves in the mirror as a way of distancing themselves from their physical self. Even for participants who did not experience self-disgust, they still avoided looking in the mirror.

I didn't look very long in the mirror because all I would see are fat rolls and things like that. (Caitlin: 519-520)

A common coping strategy during stressful situations regarding obesity was the use of humour. Both Kay and Moira reported using jokes to manage difficult circumstances, as well as putting on "*a smile*". Moira spoke about

"*putting up a strong fight*" (382), as she had experienced so many of these situations, that in the end, she had to change in order to keep going. Additionally, she emphasised that whilst putting up a front, on the inside she just wanted it to stop.

> *One woman came up to me and said "Why are you so fat?" She said "you shouldn't be out, you're so fat". I didn't run away, I just said "you're amazing." she said "what's that?" I said "to come out without a paper bag on your head, I think that's amazing.* (Kay: 362-364)

> *You know, as I got older…I mean I had someone say to me "Oh god Moira, your arse is so big" and I'd say to him "Yeah it costs me a lot of money to get here". You know, put a smile on, make a joke of it. But inside you're thinking 'piss off, just piss off'.* (Moira: 382-385)

For both Moira and Caitlin the connection between people's responses and their body weight was clear (see section 4.4.1.2). It was these types of negative public experiences that led to most of the participants isolating themselves, particularly when they were at their heaviest weight. They reconfigured their lives so that they would only go outside if it was completely unavoidable. For example, Kay ensured that all her basic needs were met either online or through family members so that she did not have to step out of the safety of her own home. However, whilst this protected her from these difficult social experiences, they left her feeling further ashamed. Surprisingly, Kay refused to leave her home in spite of her daughter offering to support her to go outside.

> *I feel ashamed, I would hardly go out. My family would tell you...I didn't go out for two years, go out of the house, at all. I do all my shopping and everything online, I wouldn't do anything, I wouldn't go out. Pay all my bills and everything, they'd get it for me. And my daughter would say to me "mum, come, come out"' "'No, cause I always feel that people are looking at me."* (Kay: 108-112)

Gohar also avoided going out and would not socialise when she was at her heaviest weight.

> *I always stayed at home… never go out… felt down, lack of energy to go out. I don't socialise… I never used to socialise.* (Gohar: 29-30)

This attitude also extended to healthcare services such as visiting the Dental surgery. Amy did not go for an appointment for a number of years as she worried about her size and not being able to fit into the dentists' chair

> *I didn't go to the dentists for a number of years…because of my size.* (Amy: 598-602)
>
> *Because you were worried that if you went you might not fit in the chair?* (Interviewer: 604)
>
> *Yeah.* (Amy: 606)

Amy also described "*looking down*" from people's faces or ignoring their comments as ways of protecting herself.

> *If you look at a large person, they're always looking down. Because while they're looking down, they don't have to look at the disgusts on other people's faces.* (Amy: 241-242)
>
> *That's my way of protecting myself. Because some people would get upset, some people shout something horrible back, you know it doesn't help. It doesn't make any joy, you know that person's gone and they laugh at you then. They shout something more at you, I'm not going to waste my time on them you know.* (Amy: 322-326)

For many participants food was seen as a source of comfort during difficult times. Gohar described it as a "*cycle*" whereby when she was faced with challenges such as not liking the way that she looked or receiving negative comments, she would turn to snacking to help her feel better about herself:

If I want to get changed clothes-wise, nothing used to fit. If I had anything that fits, it will look totally wrong, so I ended up staying at home… start eating. It turns me on to food. Then weight carries on. It used to be like a cycle for me. Trying to come out or go out or whatever, seeing myself – I can't put anything on, I give up. Turning to food. I've always had issues with food, I always used to turn to food, snacking all the time. It's a comfort, to eat, it always used to be a comfort for me. (Gohar: 42-46)

If they made a remark, I used to go and tend to eat food. (Gohar: 98)

I used to go and comfort eat…just to make me feel better. (Gohar: 110-112)

Robin was the only participant that reported that he was happier when he was heavier, as he was able to do what he wanted, whereas since having the surgery he felt "*isolated from other people, because the way I think I look, and the way I think people perceive me to look*" (Robin: 152-153). This was because of his excess skin which he assumed other people could also see, even when he had his clothes on. Similar to the participants who expressed high degrees of self-disgust pre-surgery, Robin also felt hindered by his 'disgusting body', as a result of which he reduced his social contact and became more isolated:

So I'm not able to go out, not able to socialise as much as I was before. (Robin: 550-51)

Nevertheless, in spite of the difficulties associated with the excess skin, Robin said that on balance he had made the right decision as ultimately the pros outweighed the cons.

Thinking "well yeah you have got the skin, but you've still got your family" sort of thing and "you're still here to be with them". It's one of those weigh ups, what is good for you. (Robin: 657-659)

Through the course of the interviews a sense of strength and resilience was apparent in all participants. Even whilst describing difficult experiences, they were able to hold on to 'hope' and the idea of a 'better future'. Perhaps unsurprisingly, the key to resisting shame was by focusing on achievements instead. Life post-surgery, having lost a significant amount of weight, was different for all participants. Whilst this varied from individual to individual, there were some changes that were reported by everyone, including ways in which they were learning to resist shame related to their body. For example, participants were beginning to view their roles as helpful and thus were able to take more control of their situation.

With Caitlin, she attributed losing weight to gaining more confidence so that she could defend herself and stand-up for her rights. As discussed above, for Caitlin, losing weight was connected to where she was placed socially; from being at the bottom of the rung, she was now in the middle and therefore had more social importance and value. Moreover, whilst previously she referred to the "*looks*" that people would give her to prevent her from speaking out, now she was able to identify how hard she had worked throughout her life and thus was proud of her achievements.

> *I've worked so hard on my life and now I have every right to say, if something upsets me I'll say it upsets me, if someone says something wrong to me I'll say "don't speak to me like that!" whereas before because I'd get the look and I didn't have the confidence to say.*
> (Caitlin: 646-653)

Using self-talk and self-praise as encouragement was also a key mechanism for resisting shame. Kay in particular spoke about using these tools to keep "*moving forward*". This was especially useful when she was alone at home, as this had traditionally been a trigger point for either eating or not doing any exercise. It was this resolve that got her to seek surgery in the first place.

It did make me feel so depressed. I just wanted to stay in bed, but I thought 'no, I've got to pull my socks up; I've got to do something'. And that's when I made the appointment the next day to see the doctor because I was hoping she would do something for me. (Kay: 670-673).

Through their journey of improving their lifestyle, it was evident to other people that all participants had physically changed. Their excess weight loss ranged from 52-79% and thus, a significant amount of weight loss was achieved. This change was repeatedly met by others with praise and encouragement, which motivated them to continue with their progress. For Kay, who was already working hard to go out for frequent walks, the added praise from her daughter aided her determination to meet her goals.

I hadn't been to XXX up until this year for five years, shopping or whatever. And now I go into XXX. I've been three times this year. My daughter went 'woohoo! Mother you're out! You're out!' (Kay: 250-252)

Similarly for Caitlin, Gohar and Amy, it was the encouragement and feedback from others that was helpful.

I think encouragement…when people say "oh my God, what have you done to yourself? Look at all the weight you've lost." Words like that, the encouraging words were helpful as well. (Caitlin: 1092-1094)

Loads of people came across and told me that I've lost weight, I look better, I look good. I get good feedback. That's what keeps me going. (Gohar: 87-88)

They just go "We are so proud of you, we are so proud of you". (Amy: 408)

For Andy on the other hand, hearing his colleagues aspire to lose a similar amount of weight gave him a sense of achievement.

I still see the same people…most of them are going "I wish I could lose as much weight as you've lost". (Andy*: 1097-1098)

CHAPTER 5: DISCUSSION

5.1 Overview

In this chapter I will discuss the overall findings of the study and how these relate to the study's objectives. In line with a critical-realist ontological framework, I will suggest possible psychological theories to make sense of individuals' accounts as opposed to proposing any one 'correct way' of understanding reality (Lakoff, 1987). Furthermore, I will critically appraise the methodology and the quality of the study, as well as making recommendations for future research and clinical practice.

5.2 Summary of findings

The findings aimed to explore two research questions. Firstly, what were the experiences of self-disgust pre and post surgery. Secondly, what visual perspectives participants were using when talking about experiences of self-disgust. The present study suggests that losing a significant amount of weight through bariatric surgery and lifestyle modifications result in a variety of changes in how people view themselves and how others view them. The analysis suggested that bariatric patients do indeed experience self-disgust both pre and post surgery, and tend to use a variety of visual perspectives when talking about these experiences.

The themes highlighted how disgust emerged and manifested within the lives of individuals, how participants responded and managed feelings of self-disgust, and how they found ways to protect themselves and resist negative emotions such as shame. All participants agreed that life had on the whole improved for the better in relation to feelings of disgust, and that most of their expected goals had been met. However, two of the participants were left more disappointed than they anticipated by the amount of excess skin they were left with post-surgery.

Nevertheless, they still believed that they had made the right decision in spite of the new challenges that they were faced with.

5.3 Findings in relation to literature

5.3.1 Social stigma

The first theme, *Giving life to disgust*, encapsulates the many ways in which participants described disgust as developing and becoming recognised within their lives: the initial negative childhood experiences of their body weight, the societal shaming and exclusion associated with obesity and how individuals are rewarded for losing weight, but at the expense of denigrating their previous heavier selves. This theme gave a strong message of obesity being socially unacceptable and it emphasised the variety of methods, such as their families, through which these messages were communicated to individuals.

5.3.1.1 Weight stigma
As discussed in the Introduction section, weight stigma is a significant social problem and this was identified by all participants. The literature suggested that this type of social stigma can often lead to shame and self-criticism (Gilbert, 1998), even after a person has lost their excess weight (Latner et al., 2012). Societal judgements of 'the obese' (e.g., through media) as inferior and inadequate are also connected to low self-esteem (Gilbert, 1997). This is a crucial factor to consider in bariatric surgery, as losing the weight in itself is not always a 'success' to the individual. Moreover, the shame and self-criticism experienced can hinder a person's efforts to maintain control of their lifestyle, as well as regulate their emotions particularly when feelings such as self-disgust are so prevalent or pervasive.

Some studies have also shown links between the external devaluation of 'the obese' and their internal evaluation (Cooley, 1956). This theory proposes that

self-concept is a complex interplay of interpersonal interactions and how individuals perceive such appraisals. This means that repeated experiences of weight stigma might lead individuals to become 'hyper sensitive' to weight or even internalise weight stigma and, thus, fall into a vicious cycle. Consequently, this explains some of the reasons for interviewees reporting a mixture of weight stigma experiences and negative appraisals of their situations. However, this is evidently a two way process influenced by individuals' own contexts.

Interestingly, compassion is also relational; we are more likely to be compassionate towards ourselves if we can be compassionate towards others. Hence, people who are negatively judged and mistreated will struggle to be self-compassionate (Gilbert, 2009). However, Gilbert (2009) emphasises that this type of compassion needs to be genuine and empathetic and requires us to be open to the distress in others and ourselves. In practice, this may be difficult to achieve, especially given the nature of some of the services (e.g., GPs often see patients for ten minutes per appointment and consequently, remain task focused).

Participants described weight stigma as extending to employment and healthcare settings. This is in line with studies that concluded that employees who are obese are often categorised as being lazy, lacking self-discipline, less competent and emotionally unstable (Puhl, 2013; Roehling, 1999). These weight-related stereotypes indicate that employment, salary and promotion can be affected. Additionally, some studies have found that individuals who are obese are paid less (Loh, 1993), especially women (Pagan & Davila, 1997; Register & Williams, 1990), and are less likely to be promoted (Brink, 1988). Some of these studies are dated and would need to be replicated in order to consider the current context, especially within the UK; nevertheless, they illustrate some of the negativity and hostility that participants spoke about in their interviews.

5.3.1.2 Healthcare settings

In relation to healthcare professionals, the attitudes described by some of the participants may potentially affect their clinical judgement and prevent patients who are obese seeking help. One participant in particular said that she avoided medical attention until her condition became serious. Other interviewees spoke about healthcare professionals holding negative attitudes and prejudices against 'the obese', as well as lacking skills and training. This is not to say that health problems are not connected to weight but rather that they may be disproportionately attributed to weight. Some researchers suggest that individuals who are obese may be unhealthier in part because they refuse to seek treatment during early stages due to perceived weight stigma (Erdman, 1991; Hebl & Xu, 2001). The potential fear of criticism and blame, as in Caitlin and Amy's cases, may even contribute to the higher rates of mortality connected to obesity (Abe et al., 1976). However, it is not clear whether this perception is an accurate representation of the clinician's beliefs and attitudes, as some studies have suggested that patients often perceive their clinician's attitudes as more negative than that reported by the clinicians (Brandsma, 2005). Conversely, other studies have found that patients who are obese do indeed receive poorer care by healthcare professionals (Hebl & Xu, 2001). It therefore may be a combination of clients' own perception added to the negativity of staff that prevents them from seeking help and support.

5.3.2 Disgust

The second theme, *Manifestations of self-disgust,* highlighted the complex overlap of experiences that together presented as self-disgust. In particular, participants emphasised how their day- to-day living was affected by revulsion of their bodies and hatred of the self, and how these occurrences were driven by blame, by themselves and other people.

5.3.2.1 Internalised weight stigma

Research suggests that individuals who are obese may devalue themselves due to being part of a socially devalued group (Klaczynski et al., 2004; see section 5.2.1). As human beings cannot survive without eating, there are opportunities for experiencing weight stigma multiple times during the day whether in public or alone. These frequent experiences of stigma can lead to internalising social stigma. For example, Gohar's repetitive use of the word 'fat' in association with personality characteristics, such as 'lazy', demonstrated how she had internalised society's weight bias of preferring thinner individuals. Additionally, such internalised weight stigma can sometimes present themselves as self-disgust. For example, the way in which participants described their bodies when they were obese; they expressed their hated and repulsion of it, to the extent that they distanced themselves from their physical selves, as well as removed its presence from the social sphere so as not to cause offence.

5.3.2.2 Responsibility and blame

People that are judged to be responsible for their condition, such as obesity receive negative responses from others such as dislike, blame and low intentions to help (Herek, Capitanio & Widaman, 2003), as was evident in the current study. Weight is generally perceived as controllable, hence, responsibility and blame are attributed to those that are obese. Individuals that are obese are seen as responsible for causing and resolving their obesity (Puhl & Heuer, 2010). These attitudes may be connected to societal values that emphasise self-discipline and achievement, values that they might think are low or non-existent in people who are obese (Klein et al., 1982). Therefore, perhaps unsurprisingly, a strong sense of self-blame and guilt were found across interviews. Where blame for obesity was attributed outside of the individual's control (e.g., due to medical reasons as in Andy's case), higher self-esteem and less self-disgust were present. This is in line with research findings (Crocker, 1999), and suggests that the meaning of obesity influences individuals' self-esteem and self-confidence.

5.3.2.3 Compassion

The current study found that participants were extremely harsh and critical of themselves for 'not doing better'. Participants' responses to their own relapse and setbacks were self-criticism, self-disgust and self-hatred. This suggests that when people with weight problems struggle with their weight or their eating, they may become self-critical and self-hating, which can cause further difficulties with emotionally coping and maintaining healthy lifestyles and eating behaviours. This is similar to a qualitative study conducted by Gilbert et al. (2014) where they explored the understanding and use of 'compassion focused coping strategies' in people who suffer from serious weight difficulties. The participants recruited for the study were overweight with some of the participants recruited from a bariatric clinic. Semi-structured interviews were used to explore participants' understanding of compassion, their recall of experiences of compassion in childhood, their current experiences of receiving compassion from others, being compassionate to others, being self-compassionate and whether they would be compassionate or self-critical for relapses in overeating. Interestingly, the results suggested that compassion is related to 'caring' and being 'listened to', with recollections of compassion limited to practical health. From this study Gilbert et al., (2014) suggested utilising self-compassionate strategies such as mindfulness and turning to others for support. In practice though, this is difficult to do when the external environment is aggressive and there may not be avenues of support, hence it is not always easy to resolve these difficulties or make changes.

5.3.3 Visual perspective taking

Literature indicates that perceptions are more important than objective realities (Griffin & Ross, 1992), and that generally perceived weight-related mistreatment increases with increasing weight (Wotts & Carels, 2010). It is evident from the above that stigmatising beliefs are held by society about people who are obese. What is interesting is that people who are obese often also hold these beliefs about their peers (Hebl et al., 2008), and thus, this may be indicative of how they

might view themselves. In the current study, participants often commented on the weight of their peers, whether they were larger or smaller than themselves. However, in contrast to the literature, participants often expressed less stigmatising beliefs about their peers who were obese in comparison to their beliefs about themselves. In fact, because interviewees knew how difficult their experiences had been, they often did more to improve the lives of others.

Participants indicated that self-disgust experiences were viewed from a number of perspectives. These perspectives were hard to elicit as most of the participants were hesitant in identifying perspectives but instead wanted to focus on their experiences of self-disgust. Of those that did choose a perspective, most reported using a first person perspective, whilst some used the third perspective and others described being more fluid and utilising both perspectives. Some participants were able to give examples of specific incidents but the vast majority were more tentative in describing these events, or even speaking about self-disgust generally. One participant refused to identify any examples as she "*did not want to go there*". For her, it seemed as though by talking about negative experiences, it would hinder her progression as she "*wanted to move forward and not go backwards*". For those that did identify self-disgust experiences, they used words such as 'lazy' and 'fat' to describe themselves at those times.

Surprisingly, the literature review (see section 2.5.1) suggested that autobiographical memories are generally recalled using third person perspectives. This could therefore suggest that there was a certain meaning attached to that perspective when it was initially coded (Libby et al., 2014). This could also be explained by the fact that I as an interviewer asked to understand the experience of the event's concrete details, which are much more readily accessible using a first person perspective. Additionally, it may be a way for participants to distance themselves from the emotional response that taking a third person perspective may have evoked. Nevertheless, as research on weight stigma suggested, those that experience higher instances of weight stigma

recalled events using a third person perspective (Lau et al., 2009; Ratcliffe & Ellison, 2013) due to the negative impact of the experience.

As it was difficult to elicit visual perspectives, it does not identify to what extent these perspectives are utilised. Also, as this was just one incidence of recalling past events, it is unclear whether these are fixed or more fluid, and what meanings are attached to these perspectives, if any.

5.3.4 Self-reliance and resilience

Across all interviews, a message of strength and resilience arose. Themes three, *Discovering self-determination*, and four, *Diminishing the power of disgust*, focused on the many ways in which interviewees changed, gained autonomy and resisted shame and disgust. Increased positive and decreased negative social feedback meant an overall increased social status alongside the decrease in participants' weight. Whilst individuals were previously excluded from society, now they felt included socially thus positively influencing their self-esteem and self-confidence. Moira notably spoke about being split in two when she was obese; a private and a public self. Typical of people dealing with stigma with a defensive shield (Puhl & Brownell, 2003), Moira would hide behind her obesity. However, once her weight reduced, she no longer needed to hide and was instead able to become 'one', which then allowed her to live her life differently.

Coping strategies for managing weight stigma were found to be the same for both men and women; typically these included ignoring negative comments, using positive self-talk, using their faith, eating more and seeking social support. Studies suggest that in women positive coping strategies, such as using positive self-talk and social support, are linked to healthier psychological adjustment. In men these are related to higher depressive symptoms, and instead strategies such as crying or ignoring the situation were related to lower levels of depression (Puhl & Brownell, 2006). The current study supported some of these findings in

that women reported using self-talk and social support, whereas men often ignored the situation.

Puhl and Brownell (2006) suggest that psychological well-being is not dependent on the stigmatising situation itself, but rather the ways in which individuals cope with these experiences. Men and women are not different in terms of the level or type of weight stigma they experience or the types or amounts of coping strategies that they use. Nonetheless, they may choose to use different coping strategies to manage specific experiences of stigma and it is these coping strategies that might affect their psychological well-being in different ways.

Some of the coping strategies discussed in this study, such as overeating and the avoidance of social stigma through not socialising or going outside, were used as ways of protecting the self but were instead unhelpful and caused further distress. These strategies were usually linked to shaming and criticism of individuals, and served to regulate participant's emotions as well as to take back control of their behaviour. A positive alternative would encompass kindness, support and compassion from others (Cozolino, 2007). In fact, self-compassion (Gilbert, 2009) could increase positive ways of regulating emotions thus leading to positive thoughts and feelings about the self, and ultimately a more positive body image. However, given the current hostility encountered by people who are obese, a change in the environment needs to occur alongside the individual changes.

5.4   Implications

5.4.1 Implications for clinical practice and policy

Given the findings of the study, as discussed above, there are several implications for practice and policy. These will now be discussed.

5.4.1.1 Therapeutic interventions

There are several therapeutic interventions that have been proposed (e.g., Ratcliffe & Ellison 2013), with therapeutic orientations generally focusing on behaviour change such as using CBT techniques for thought challenging in order to change people's perspectives of their weight. However, for people experiencing high degrees of self-disgust, approaches based on decreasing shame and increasing self-compassion (e.g., compassion focused therapy; Gilbert & Proctor 2006) may be more beneficial in the long-term. As Gilbert et al. (2014) indicated, and as supported by the findings of this study, self-critical and self-hating responses are generally connected to poor weight regulation. Hence, assessments and interventions need to consider experiences of increased self-hatred and self-disgust, and the contexts within which these occur so that a preventative approach can be taken. As compassion focused approaches to eating are already being utilised for self-help (Goss, 2011) and are continuing to show effectiveness (Hofmann et al., 2011), these can be adapted to help develop strategies that increase self-compassion such as mindfulness training.

These interventions focus at the individual level with a significant focus on the role of agency. This in itself is not an issue, as clearly there is an important role for the individual to play within their health management, such as asking for support and advice in the first place. However, emphasising the individual's role ignores the wider contexts. Thus, to further improve efficacy and helpfulness, meaningful change needs to target multiple levels such as services and wider societal discourses.

5.4.1.2 Healthcare provision

Participants in this study reported being stigmatised in a variety of ways, including by family, healthcare professionals and peers. This suggests that stigma reduction needs to be tailored to a range of settings. Doctors were the most frequent source of stigma (as supported by previous research by Puhl & Brownell, 2006), alongside peers/friends, partners, parents and other relatives

(Puhl et al., 2008). Doctors need to be transparent and have discussions with their patients about the impact of weight stigma on their psychological well-being and their treatment outcomes. This needs to be done thoughtfully and sensitively, as a degree of overweight is not necessarily problematic for some individuals, whilst for others they may want to lose weight. To counteract the impact of interpersonal stigma, family members and close friends could be involved with assessment, formulation and treatment where possible. Early intervention, particularly where children are concerned, would help to strengthen relationships and build individual and collective resilience. This would help reduce stigma whilst supporting those that may wish to lose weight.

The findings of this study suggest that many generic and specialist healthcare professionals either lack the necessary training and/or skills for working with people who are obese or hold discriminatory attitudes or assumptions. Negative professional attitudes need to be addressed as these may have implications for clinical judgements, diagnosis and treatment. Targeting the training and practice of professionals is one key way of addressing this. For example, specialist obesity services working with GPs would ensure better awareness and understanding of how to relate to people who are experiencing difficulties with their weight. As a first point of contact, GPs are the gateway to specialist services hence targeting their practice would mean that patients would be more likely to approach them when they are in distress.

Moreover, by increasing professionals' sensitivity and compassion, and reducing bias, prejudice and discrimination against people who are obese, such as through not dismissing clients' issues or relating them to the size of the individual, better care will be made possible. One avenue for this could be through specialist training and supervision. Also, challenging weight stigma when it occurs, and changing the way health professionals talk to one another and to patients will help. For example, using language that is jargon free and acceptable to patients will help individuals engage better. One particular study identified that

individuals who were seeking treatment for obesity preferred terms such as weight, BMI and heaviness as opposed to fatness, obesity and excess fat (Wadden & Didie, 2003). This demonstrates how medicalised language often forgets that there is a person at the other end of their intervention.

One interesting factor is that some healthcare treatments including bariatric surgery are restricted to individuals of a certain weight. Whilst this is an attempt to standardise practices and be fair to patients across the board, in reality it misses individual contexts and thus, it does not fully consider when weight becomes a problem for the individual. For example, a lower weight may affect some people's lives more seriously than others. By being more person centred, a better standard of care would be provided.

5.4.1.3 Environmental considerations

Weight stigmatisation goes beyond health services and into the wider society. One way in which this is communicated to individuals is through environmental restrictions; for example, the way that seats on buses and public toilets are designed or the way that doors in toilets open inwardly limiting the room for people to exit. These cater to a person of a certain size and reduce inclusivity. To target weight stigma, less restriction needs to be placed on people so that they are not repeatedly shamed for their body size.

The COBWEBS model (Tomiyama, 2014; see section 2.3.1) suggests that to exit the weight stigma cycle individuals must either reduce their weight and maintain this reduction, or regularly exercise. However, the model recognises that weight stigma leads individuals who are obese to avoid exercising. Thus, reduction in weight stigma alone is not sufficient, as there may be a point at which weight becomes a concern for individuals, in which case actions such as exercise may need to be taken. Therefore creating exercise environments that are less threatening, such as those that focus on health and well-being rather than weight, will enable individuals to exercise more comfortably and regularly.

Equipment also needs to cater to people of all sizes, and the general atmosphere needs to be one of acceptance and encouragement.

In relation to the design of the environment, many participants identified this as a barrier in accessing services. For example, dental surgeries were avoided by Amy due in part by the small chairs used. By accepting and accommodating different body sizes, individuals would be a part of society in a truly inclusive manner.

5.4.1.4 Societal discourses and social movements

Mainstream societal discourses are split in two; with the dominant narrative focusing on factors within a person's control (e.g., overeating). These continue to uphold and strengthen narratives of the individual being responsible for causing their obesity (Bell & Morgan, 2000), when in reality there are complex variables influencing obesity such as genetics, metabolic and neuroendocrine factors (Karasu & Karasu, 2010). These explanations are not widely understood and therefore individuals continue to be shamed for their weight being "*out of control*". To counteract the negative stereotypes associated with obesity, there are social movements such as the Health at Every Size UK approach (Bacon, 2010) to promote health and well-being, as opposed to weight-control (Bacon et al., 2002; Provencher et al., 2009). This movement aims to tackle shaming, self-blame and eating distress by incorporating mindfulness, compassion, critical thinking and nutrition science for all people, regardless of their body size. These movements are beneficial as they move away from body shaming, yet, they also place blame on the individual and therefore indirectly reinforce the status quo of responsibility ultimately being with the person.

Based on the findings of this study, programmes and groups need to consider wider societal discourses and their role in maintaining psychological distress. For example, targeting stereotypes and discrimination about body types from an early age (e.g., through schools) by moving away from problematic narratives

about body weight to appreciating body health, function and ability. Also, programmes need to move away from targeting individuals and instead work with communities and society at large that may be part of the excluding people who are obese. For instance, working with families to improve quality of life for everyone, given their individual and collective needs. Also, working with teams to improve team culture and relationships, thus indirectly targeting discrimination and prejudice.

The media also has a significant role in improving people's experiences and understanding. Often reports and documentaries focus on denigrating people for their struggles related to being larger (e.g., people not being able to leave their houses or becoming obese due to eating unhealthy foods). These reports perpetuate the pejorative messages surrounding obesity and possibly increase acceptance of body shaming. Instead, the media could be used to raise awareness and understanding of the causes of obesity as multi-factorial involving genetic, social, psychological and environmental factors, thereby reducing the focus on the individual as being 'lazy' and 'not trying'. It could also be used to encourage positive lifestyle changes without a total focus on weight.

5.4.1.5 Public health

Obesity is undoubtedly a public health issue with projected growth of 11 million adults in the UK by 2030 (Wang et al., 2011; see Introduction), therefore it serves that for meaningful change to occur, interventions need to incorporate public awareness strategies, especially in relation to how policy is implemented. The Department of Health has issued policy tools such as The Eatwell Guide (2016) and Government 5 A Day logo's (2016) in England for recommendations on healthy eating. The use of these tools are encouraged by Public Health England to ensure that organisations and individuals receive consistent messages. Additionally, there are measures to tackle salt and sugar consumption, with reports produced to explore service provision of weight management services for children, young people and adults (Weight management services: national

mapping, 2015). Interventions range from schools and colleges, with associations made between obesity and academic attainment in children and young people, as well as unemployment in adults. For example, the Department for Work and Pensions liken obesity to drug and alcohol addiction in that it is a "treatable condition" (2015), and therefore those who are obese can potentially be "treated" and supported back into work. The issue however, is that most of these programmes locate the problem within the person, and does not account for problematic systems and processes. More needs to be done to intervene at multiple levels from the individual, to services and beyond, whilst engaging with historical, social and political contexts of individuals and groups. For example, acknowledging that poverty has a role in what and how people eat, that lack of acceptance by society conflates people's sense of worthlessness and that repetitive macroaggressions in education, employment and wider society cause further harm.

5.4.2 Future research

The findings of the current study have a number of implications for future research; the key areas will be highlighted below.

5.4.2.1 Gender differences

The sample of interviewees were mixed; men and women of different ages, with different socio-economic and employment statuses. Therefore exploring specific demographic populations would help us to target our interventions more effectively. For example, investigating potential gender differences in the experiences of self-disgust and the coping responses utilised by individuals would be useful when tailoring treatment plans.

5.4.2.2 Cultural differences

Different cultures have differing notions of weight stigma based on a diverse range of body sizes. Simone in particular commented on the different norms

about weight expressed in Western societies in comparison to African communities. It also appears from the data that certain attitudes and prejudices are inherently part of Western societies, however it was unclear as to when and how these become discriminatory acts. It would be interesting to explore how different cultures conceptualise body shape and concepts such as self-esteem and self-disgust, and how these co-exist. Interestingly Simone decided to reduce her size despite messages from some people in her culture expecting her to remain how she was. Also, research focusing on the perceptions of weight stigma and interventions to reduce weight stigma would help clarify some of the questions raised in this study, such as how non-verbal cues are used to communicate prejudice and discrimination of people who are obese. For example, the 'looks' that participants in this study identified as communicating disapproval of their weight.

5.4.2.3 Healthcare settings
Given some of the findings from this study about healthcare professionals' attitudes and behaviour, further exploration of the extent to which negative stereotypes exist and what impact this has can be used to inform service delivery. This would need to incorporate health care practices and not rely entirely on self-report measures as done by most studies. Perhaps using focus groups with staff to explore how they use language to talk about people who are obese would be one way of doing this.

5.4.3 Dissemination

To make meaningful change, dissemination needs to occur at multiple levels, from participants and services, to the media and wider society.

Dissemination from the findings of this study were considered from the initial stages of its development. After the study was designed, it was presented as a poster at a conference (Management of the bariatric patient; 2015) to generate

discussion about the study's usefulness and relevance. Attendees included specialists working within bariatric surgery such as physiotherapists, nurses and dieticians; these perspectives were vital as multidisciplinary work is essential in bariatric surgery. Meaningful change is more likely to occur if there is an identified need and a willingness to adapt.

Now the study is complete the researcher will return to the service where data was collected to present the overall findings via a feedback session that will include a presentation. More importantly, interviewees will be emailed or posted a copy of the final version of this report, depending on whether they requested this at the end of their interviews. Also, a short summary report free of medical terminology, and jargon free will be constructed for participants.

It is intended for dissemination to also include services such as GP practices and dental surgeries; simple and easy to understand material explaining how to engage clients and improve their health needs regardless of their weight should be distributed, alongside opportunities for training and reflecting on their practice.

Media campaigns need to focus on improving everyone's health needs, as opposed to body shaming people that do not adhere to a set ideal. Through encouraging healthy living, people are more likely to benefit from additional support from family and friends, experiences less weight stigma and achieve greater psychological well-being through reduced shame and isolation.

5.5 Critical evaluation of the study

In this section, I will discuss the limitations and the quality of the current study.

5.5.1 Critical appraisal of the methodology

There are a number of writers that discuss the criteria required for good standards of qualitative research (Harper, 2012; Spencer & Ritchie, 2012; Yardley, 2011); these are flexible and open to interpretation and application and not standardised rules (Yardley, 2000; Yardley 2011). As it is beyond the scope of this report to discuss each of these criteria, I will attempt to outline Yardley's (2000) criteria in relation to the quality of this study and highlight areas that could have enhanced the study.

Table 3: Characteristics of good qualitative research (Yardley, 2000)

1. Sensitivity to context
Theoretical: relevant literature, empirical data, socio-cultural setting, participants' perspective, ethical issues
2. Commitment and rigour
In-depth engagement with topic, methodological competence/skill, thorough data collection, depth/breadth of analysis
3. Transparency and coherence
Clarity and power of description/argument, transparent methods and data presentation, fit between theory and method, reflexivity
4. Impact and importance
Theoretical (enriching understanding), socio-cultural, practical (for community), policy makers, health workers

Reflexivity is essential in adhering well to these characteristics. As discussed in earlier chapters, a reflective diary (Appendix X) alongside the analytic process helped identify and shape how I engaged with the research, the data generated and the outcome produced.

Sensitivity to context

Qualitative research emphasises the importance of context and the role of the researcher as subjective and open to biases. It positions the researcher's role as interactive and values reflexivity. The use of a journal (Appendix O) alongside regular supervision enabled me to consider how my values and assumptions influenced the data. In particular, as a person of average weight with little to no experience of the issues discussed in this study, I had to ensure that I remained sensitive and respectful of people's experiences. For example, I asked open ended questions and accepted people's experiences as their 'truths'. By reflecting on the power imbalance of the researcher-participant relationship, I was able to take a step back and allow interviewees to tell their stories. In this way, we were able to pay attention to their socio-cultural settings and co-create the research findings.

Commitment and rigour

This study was designed and conducted within three years. During this time I was fully embedded within the topic, with regular discussions both at the recruitment site and at university. This allowed for a thorough literature search, data collection and analysis, whilst continuously re-visiting the context. Additionally, constant reflections served to increase awareness of the research process and highlight areas of further development. As highlighted by Oakley (2000; pg.72) quality in qualitative research is marked by "*awareness and acknowledgement of error*". For example, during the course of the interviews I became aware that to elicit perspective taking, I would have to be more directive, therefore I decided against this and instead focused on the meaning of people's experiences.

Transparency and coherence

Reflexivity is an important trait of qualitative research that helps to identify quality issues by allowing researchers to consider their own experiences and motivations for partaking in specific studies (Yardley, 2000). In my explanation

prior to undertaking the study, I included my previous role in the service as an Assistant Psychologist during which I developed my research interests. This allowed me to own my position as a researcher with knowledge and skills in working in bariatric surgery, as well as allowing participants to locate me within a framework.

Impact and importance

Continuous discussions with clinicians working within the field ensured that the impact and the importance of the study in relation to theoretical and practical settings were consistently reviewed. Thus, ensuring that the findings were meaningful to the context and relevant to the services that worked with the client group. Ultimately, it was about framing data within its context, be it psychological, cultural or political.

As a qualitative analytic method thematic analysis has a number of benefits (see 3.6.2 and 3.6.3). However, some researchers have argued that due to TAs flexibility there is a distinct lack of guidelines in relation to what it is and how you do it (Boyatzis, 1998). In addition, not being theory bound makes it difficult to maintain consistency between different analyses. What complicates this further is that themes are not quantifiable measures but rather ways of capturing data that is relevant to the research question. This makes it all the more crucial to engage in the above and be clear and explicit about what you are doing. Moreover, a systematic method that is aligned to its philosophical and epistemological position needs to be adhered to (Reicher & Taylor, 2005).

5.5.2 Limitations and ethical issues

There are a number of limitations and ethical issues that are pertinent to this study; these will now be considered.

5.5.2.1 Recruitment

Firstly, recruitment for the study was via the clinical team; this was therefore reliant on the subjective judgements of individual members of the team (e.g., who they approached to discuss the research with and how they explained the study with potential participants). However, to increase internal consistency between the aims and epistemological basis of the research, inclusion and exclusion criteria were generated and discussed individually and collectively with the clinical team.

5.5.2.2 Alternative approaches to recruitment

An additional constraint to this study was the difficultly in recruiting a mixed gender sample; male interviewees were harder to access due to fewer men accessing bariatric surgery in comparison to women, less men being referred to me by clinicians to contact and reduced numbers of men wanting to participate (i.e., of eight participants, only two were male). Alternative means of recruitment could possibly be utilised to help with this, such as non-NHS organisations (e.g., support groups or online services). Also, this study was focused on a small sample based in one recruitment site; using multiple sites or across NHS and non-NHS sites may have been better in terms of recruiting a more diverse range of participants.

Interestingly, all interviewees expressed a desire to thank the team for their services and viewed the research as a way to 'help the team'. Being asked by their clinician to take part in a study could have meant that participants felt coerced or obligated into taking part in the study, especially considering that some people were still receiving care from the service. Also, I wonder whether participants knowing my relationship to the service might have affected the responses. Hence, an alternative route to recruitment could have been adopted, for example via non-NHS support groups independent of bariatric surgery services, which would have given participants more opportunity to decline without concerns of the decision impacting on the care/input they would receive.

Furthermore, one of the inclusion criteria for recruitment was an excess weight loss of at least 50%; these participants might have been highly motivated individuals who were doing particularly well and therefore were not representative of the experiences of all bariatric patients An alternative option would have been to recruit based on participants' subjective experience of difference due to changes in their weight.

5.5.2.3 Eliciting perspective taking

One vital limitation of the study is that visual perspective taking could not be elicited in the way that it was intended (i.e., qualitatively). Previously, this has only been done quantitatively. The design of the study proposed that pictures depicting first and third person perspectives would be used to collect data; whilst this was done, participants did not elaborate on these perspectives as they were too embedded within the narrative of the interview and therefore an attempt was made to be more directive, however, this was difficult to do. Perhaps an alternative way to explore visual perspective taking needs to be considered in future, such as the use of an objective measure to build on the current findings of the study.

5.5.2.4 Self-disgust

Asking participants about sensitive topics such as self-disgust needs to be done thoughtfully and considerately, as it has the potential to cause further psychological distress. It was therefore essential to ensure that individuals were not too distressed before, during and after interviews and that appropriate forums for support were provided (e.g., clinicians and services). This is discussed further in section 3.5.

5.5.2.5 Validation

A further limitation is that due to the time-bound nature of the study I did not have time for the validation process with participants; however this will be done before disseminating the findings to the service and participants.

5.5.3 Researcher reflexivity

An important method of assessing research rigour is through recognising and critically reflecting upon the researcher's own contribution to the research process (Spencer & Ritchie, 2012; Srivastava & Hopwood, 2009; Willig, 2008; Yardley, 2000). As discussed earlier, the on-going use of a reflective journal ensured transparency between the researcher and the data throughout the data collection and analysis process.

My experience of qualitative methods at an undergraduate level are a reflection of the little time that is sometimes allocated on the curriculum in comparison to quantitative methods. As a result, the majority of my personal experience pre doctoral training is of quantitative methods. However, at UEL I became more exposed to qualitative research and wanted to develop my skills in this area further. I was aware during this process of my inherent assumptions and biases associated with being 'scientific' and wanting to find 'truths'. Qualitative research challenged these views, particularly the critical-realist ontological framework that I drew upon. At times it was difficult for me to understand people's experiences without reference to a 'reality', especially given the nature of bariatric surgery in requiring concrete behavioural changes – one that I was familiar with given that I had worked in the service previously. I had become embedded in the medical discourse and the service viewpoint was at times difficult to shift whilst interviewing and analysing the data, particularly as some of these themes manifested during the analysis phase (e.g., the biological perspective of obesity and the CBT approaches used by psychologists). Nevertheless, by keeping a journal and having on-going discussions with colleagues and supervisors, I attempted to remain curious and open in understanding the meanings attached to participants' experiences and how they were mediated by socio-cultural positions.

In regards to data collection, the interviews and transcribing was done by myself. This allowed me to become familiar with the material and understand the context of the interviews. However, at times I wondered whether I had become too embedded within the material. At these points I attempted to 'step out' by either discussing these issues with my supervisors or writing in my journal. For example, due to the rich data generated in the study, it was difficult at times to separate codes into themes and sub-themes, hence, I took these codes into supervision and discussed their positioning. By being transparent and using supervision I was able to produce a cohesive narrative of the study's findings, as well as improve the inter-rater reliability. Supervision also aided my understanding of the analysis process, such as my frustration with the lack of 'how to' when it came to the actual analysis. Relying on my own subjective judgement at times appeared flawed, and the need to want to 'get it right' meant that I spent a huge amount of time checking and re-checking the data to ensure consistency and appropriateness of analysis.

Using reflection, I realised that participants used the word 'fat' and how I as a researcher never used this during interviews. I wondered whether this was because I thought it was a derogatory reference to negative experiences, and perhaps my lack of usage of the word was in itself minimising or sanitising people's difficult experiences. I also became aware of my frustrations of hearing how participants had been treated by society and my determination to make changes at a societal level, but knowing that this would be difficult. I had to remind myself that this research would go towards making a difference in people's lives.

5.6   Conclusion

The current study presented a thematic analysis of the experiences of self-disgust in relation to visual perspective taking with people who had bariatric surgery. The study suggests that there are clear biases against people who are

obese, leading to discrimination in settings such as education, employment and healthcare. Overall, the findings lead us to conclude that some people have multiple negative characteristics and associations attached to their weight, and they may be blamed and held accountable for their weight by society and themselves. However, shame and criticism clearly do not encourage positive well-being or quality of life, therefore it is counterintuitive to use these mechanisms.

This study demonstrates that qualitative research has much to offer health services, especially in regards to offering pragmatic solutions to working with people. For example, the study suggests that participants have difficulties in gaining compassion from other people including healthcare professionals, as well as being self-compassionate. Therefore targeting areas such as shame, self-disgust and self-criticism with a compassion focused intervention may prove helpful in making positive choices long-term. Key to these changes are moving from an individualistic perspective to incorporate wider systems and practices, to challenge the status quo and not be afraid to question dominant social discourses that are no doubt entrenched within our own belief systems.

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Yardley, L. (2011). Demonstrating validity in qualitative research. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 234-251). London: SAGE.

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7. APPENDICES

Appendix A: Search key words

Rationale	Database	Terms
Self-disgust and visual perspective taking in adults that have had bariatric surgery	PsycInfo PsycArticles PsycNet Scopus Wiley Journals Web of Science The Cochrane Library SpringerLink International Journal of Obesity Google Scholar PubMed Medline EBSCO	✓ "Disgust" AND "obesity" ✓ "Disgust" AND "bariatric" AND "surgery" ✓ "Self-disgust" AND "obesity" ✓ "Self-disgust" AND "bariatric" AND "surgery" ✓ "Self-disgust" AND "post" AND "bariatric" AND "surgery" ✓ "Self-disgust" AND "weight" AND "loss" AND "surgery" ✓ "Perspective" AND "taking" AND "obesity" ✓ "Visual" AND "perspective" ✓ "Visual" AND "perspective" AND "obesity" ✓ "Visual" AND "perspective" AND "bariatric" AND "surgery" ✓ "Visual" AND "perspective" AND "weight" AND "loss" AND "surgery" ✓ "Vantage" AND "perspective" ✓ "Weight" AND "based" AND "Stigma" ✓ "Weight" AND "Stigma"
	Google Google Scholar Yahoo	Disgust, self-disgust, weight loss surgery, bariatric surgery, obesity, visual perspective, vantage perspective, first person perspective, field perspective, third person perspective, observer perspective, weight based stigma, weight stigma.

Appendix B: Semi-structured interview schedule

Interviews will be semi-structured therefore the following is a rough guide. The exact way in which the interview unfolds will be influenced by the participant's responses.

Introductions: Re-iterate consent, confidentiality and that the participant may withdraw at any time. Check demographic information and agree approximate length of interview.

Activity: Participants to be supported in constructing definitions of 'self-disgust' using words selected from the disgust literature.

Main overarching questions:

➢ Individual experiences of obesity pre-bariatric surgery e.g. how did you view yourself when you were at your heaviest weight?

➢ Societal conceptualisations of obesity e.g. how did you think other people viewed you when you were at your heaviest weight?

➢ Experiences of self-disgust [first construct definition of self-disgust with individual participant] e.g. have you had any experiences where these emotions were elicited?

➢ Individual experiences post weight loss e.g. what is it like for you now that you have lost your excess weight?

➢ Societal conceptualisations post weight loss e.g. has the way other people view you changed?

Prompts: How do you understand these experiences? What sense do you make of that? Could you give me an example?

Debriefing: How do you feel about the conversation we've just had? Do you have any questions? You can contact me/research supervisor later if you have any questions.

Appendix C: Participant information sheet & consent form
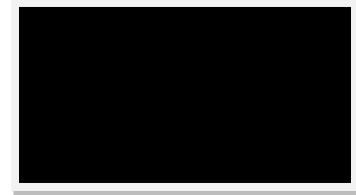
<u>PARTICIPANT INFORMATION SHEET</u>

How do post-bariatric surgery patients 'see' themselves?

I would like to invite you to take part in a research study. Before you decide whether to take part you need to understand why the research is being done and what it will involve. Please read through the following information carefully before deciding whether or not you would like to take part in the research. Talk to others about the study if you wish. If something needs clarification or you have any unanswered questions please do not hesitate to ask the researcher/research supervisor. The study is part of a Doctoral Degree in Clinical Psychology.

What is the purpose of the study?
The aim of the study is to try to understand the experiences of people who have undergone bariatric surgery. The purpose of which, is to learn how people perceive themselves, how people believe others and society perceive 'obese' people before and after losing weight.

Additionally, I am interested in exploring whether people have had difficult or negative experiences towards themselves and how people make sense of these experiences; whether they have changed the way people have done things in the past, are currently doing or hope to change in the future.

By understanding individual perspectives, services will consider making changes in order to improve people's experiences. Consequently, future practice may be altered to better meet the psychological needs of individuals accessing bariatric surgery.

Why have I been invited?
You have been invited to take part in this study, as you have had bariatric surgery and have lost a significant percentage of your body weight. I am interested in finding out how this change has affected your life.

Do I have to take part?
No. It is entirely up to you. If you do decide to take part, you may withdraw at any point without providing a reason for doing so. If you withdraw, all of the information provided to me by you, will be destroyed. If you do decide to withdraw, this will not affect the standard of care you continue to receive by the service.

What will I be asked to do if I agree to take part?
The researcher will invite you for an interview lasting between 60-120minutes. You will be asked to talk about your experiences. The questions will depend on what you choose to talk about, but they may include things like: what was it like for you when you were at your heaviest weight? How did you see yourself? How do you think other people saw you?

Where will the interviews take place?
Interviews will take place at the hospital where you had your bariatric surgery or at the University of East London (Stratford campus) depending on your preference.

Are there any disadvantages or risks to taking part?
Taking part in the interviews might make you more aware of the impact of your experiences. You may get upset if you are talking about something you find difficult or emotional. However, if you feel any discomfort or distress, upon completing the interview you will be given the opportunity to talk to the researcher about them. Additionally, I would be happy to contact someone at the hospital for you to talk to or provide contact details of other organisations that can offer you support.

What if I have any complaints?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (contact number: 020 8223 4174). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure or the UEL Ethics Committee. Details can be obtained from the researcher/research supervisor below.

Will the information I provide remain confidential?
All the information provided by you is completely confidential; all paper information will be kept in a locked filing cabinet. Your personal information will be kept separate from the interviews you complete, which will be given a code with no identifying personal information attached to them. Your real name will not be used in the analysis of the interview material or write up of the study, pseudonyms will be used instead. The interviews will be recorded on a digital recorder. This audio file and written transcripts will be saved onto a computer system which will only be accessible by the researcher and her supervisor through a password protected system.

Will the information I give be accessible to the clinicians/team in XXX Trust?

Only the researcher and her research supervisor will have access to the information you provide. Your clinicians will not be notified about your participation or the information that you have provided. Furthermore, your participation in this study will not affect your treatment. However, if you feel any discomfort or distress, I would encourage you to seek support from either a clinician in the service or any of the organisations attached.

What will happen to the results of the research study?

The results of the study will be written up as a doctoral thesis and submitted for publication in a psychological journal. In all written material of this study your identity will remain anonymous. The data will be stored for three years, following which time it will be shredded and disposed of.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. In addition, ethics approval has been obtained from the University of East London.

Who can I contact following the study if I have any questions?

If you have any questions or concerns, please use the following details:

The researcher XXX can be contacted at:
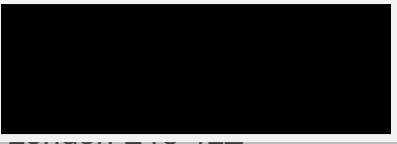
Telephone: XXX
E-mail: XXX

The academic supervisor Dr. XXX can be contacted at:

Telephone: XXX
E-mail: XXX

The research supervisor Dr. XXX can be contacted at:

XXX
XXX
London XXX
Telephone: XXX
E-mail: XXX

Thank you for taking the time to read this information sheet.
Please keep for future reference.

Appendix D: Consent form

<u>CONSENT TO PARTICIPATE IN A RESEARCH STUDY</u>

How do post-bariatric surgery patients 'see' themselves?

Please initial box:

I confirm that I have read and understood the information sheet for this study. ☐

I have been given a copy of the information sheet to keep. ☐

I have been given the opportunity to ask questions, to which I have received satisfactory answers. ☐

I understand what is going to happen and what I am being asked to do. ☐

I understand that only the researcher and her research supervisor will have access to the research data, to which I give my permission. ☐

I understand what will happen to the data once the research has been completed. ☐

I understand that my involvement in this study is voluntary and that I may withdraw at any time if I wish to do so, and this will not affect the standard of care I continue to receive by the service. ☐

I hereby fully and freely agree to take part in the research, which has been fully explained to me. ☐

Participant's Name (BLOCK CAPITALS) …………………………………………………….

Participant's Signature ……………….…………………………………………………………..

Researcher's Name (BLOCK CAPITALS) ………………………………………………………..

Researcher's Signature ……………………………………………………………………………

Date: …………………...

Appendix E: Sources of information and support

Sources of information and support

1) XXX Hospital Bariatric Surgery Support Group:

Held on the 3rd Tuesday of each month (except December) from 6–8pm in Room XX in the lower ground floor.

2) Telephone support:

The Weight Loss Surgery department psychologists run a telephone support service for all weight loss patients. This line is open from 11am–1pm every Friday. The service is available for patients to call to speak to a member of the psychology team for brief support or intervention.

To access this service please call XXX. If you have an urgent psychological concern please contact the Weight Loss Surgery department directly on XXX.

3) Weight Loss Surgery Information (Central London Support Group):

Email: centrallondonsupport@wlsinfo.org.uk
Website**:** http://wlsinfo.org.uk/help-and-support/support-groups

4**)** British Obesity Surgery Patient Association:

Website: http://www.bospauk.org/

5) Weight Loss Surgery:

Website: http://www.wlsinfo.org.uk/

6) Association for the Study of Obesity:

Website: www.aso.org.uk

7) National Obesity Forum:

Website: www.nationalobesityforum.org.uk

In an emergency please contact your GP or go to your nearest A&E department.

Appendix F: Words to construct the definition of self-disgust

Have you in the past or do you currently feel any of these emotions towards any aspect of your self (your physical appearance, personality or behaviour)?
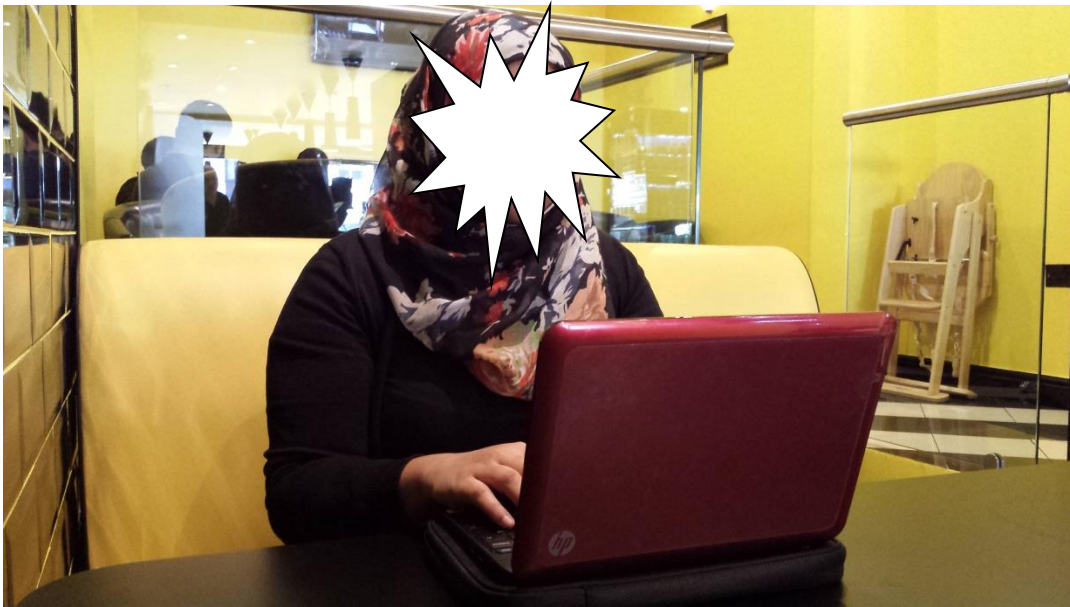
- Revulsion
- Disgust
- Dislike
- Hatred
- Valueless
- Loathing

Appendix G: Pictures to differentiate between 'I self' and 'me self'**

1. First-person perspective ('I self'):
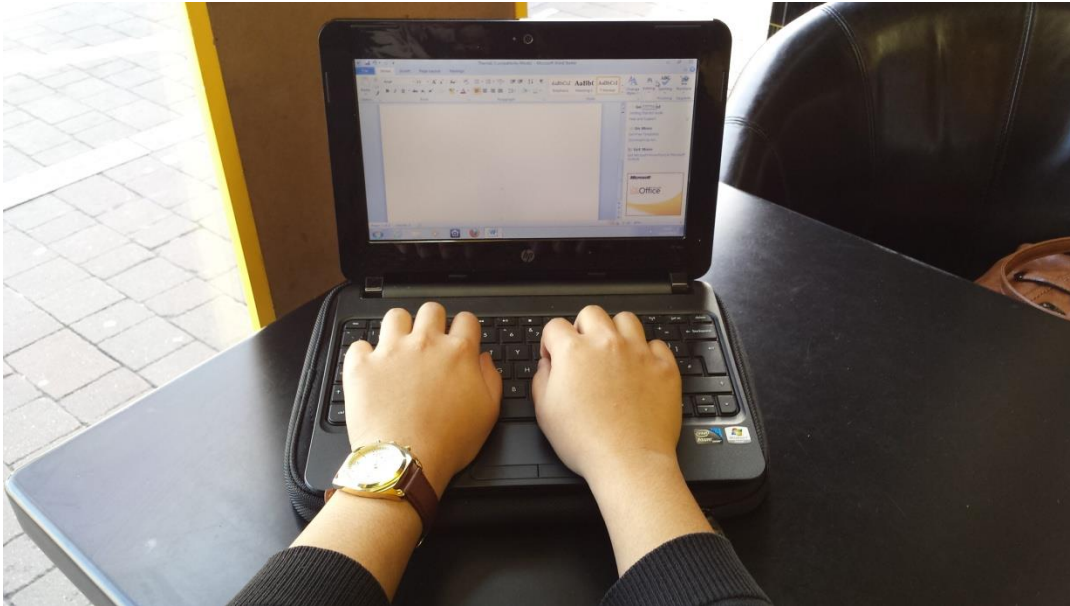
2. Third-person perspective ('me self'):

**Please note: pictures are of the researcher and have been consented for but anonymised for the purposes of preserving confidentiality

Appendix H: NHS Research Ethics Committee Letter

NHS
Health Research Authority

11 June 2015

Dear ████████

Study title:	Self-disgust and visual perspective taking: how do post-bariatric surgery patients 'see' themselves?
REC reference:	15/LO/0870
IRAS project ID:	177822

Thank you for your letter of 9th June 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager ███████████████████████
Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

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, subject to the conditions specified below.

A Research Ethics Committee established by the Health Research Authority

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UEL insurance and indemnity]	1	05 May 2015
Interview schedules or topic guides for participants [Interview schedule]	1	11 March 2015
IRAS Checklist XML [Checklist_05052015]		05 May 2015
IRAS Checklist XML [Checklist_09062015]		09 June 2015
Other [Appendix D: Words to construct the definition of self-disgust]	1	11 March 2015
Other [Appendix E: Pictures to differentiate between "I self" and "me self"]	1	11 March 2015
Participant consent form [Consent form & sources of information and support]	2	05 June 2015
Participant information sheet (PIS) [Participant information sheet/Invitation letter]	2	05 June 2015
REC Application Form [REC_Form_27042015]		27 April 2015
Research protocol or project proposal [Project Proposal]	1	05 May 2015
Summary CV for Chief Investigator (CI) [CV for CI]	1	24 April 2015
Summary CV for supervisor (student research) [CV for academic supervisor]	1	05 May 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

<u>Reporting requirements</u>

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

15/LO/0870	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to:

Appendix I: UEL Board of Ethics Letter

19 August 2015

Dear XXX,

Project Title:	**NHS Research study: 15/LO/0870: Self-disgust and visual perspective taking: how do post-bariatric surgery patients 'see' themselves?**
Researcher(s):	**XXX**
Principal Investigator:	**XXX**

I am writing to confirm that the application for the aforementioned NHS research study reference **15/LO/0870** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **19 August 2019**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NRES ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS ethical approval.

Please confirm that you have conducted your study in accordance with the consent given by the NHS Ethics Committee by emailing researchethics@uel.ac.uk.
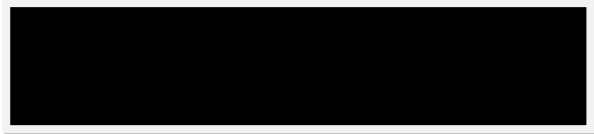
Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Appendix J: Research & Development Ethics Letter

███████████████████████████

24/06/2015

████████████

Consultant Clinical Psychologist
Bariatric Surgery Services

Dear Dr ████████████

Re: Notification of NHS Permission (R&D Approval)

R&D Ref: ████████
IRAS ID:
REC Ref:
Study Title: Self-disgust and visual perspective taking: How do post-bariatric surgery patients 'see' themselves?

I am pleased to inform you that the R&D review of the above project is now complete, and the project has been formally approved to be undertaken at ████████████████████████ NHS Foundation Trust under the terms of the enclosed Site Investigator Agreement. The documents reviewed are as follows:

Document	Version	Date
REC Favourable Opinion Letter		11.06.2015
REC Form	177822/779692/1/816	27.04.2015
Protocol	1.0	05.05.2015
Appendix A: Participant information sheet/Invitation letter	2.0	05.06.2015
Appendix B: Consent form & sources of information and support	2.0	05.06.2015
Appendix C: Interview schedule	1.0	11.03.2015
Appendix D: Words to construct the definition of self-disgust	1.0	11.03.2015
Appendix E: Pictures to differentiate between "I self" and "me self"	1.0	11.03.2015
Site Investigator Agreement (SIA)		17.06.2015
Evidence of Sponsor Insurance and Indemnity ("Notice of Ethics Review Decision")	1.0	05.05.2015

As you may be aware, the Trust is committed to achieving the national metric of recruiting the first participant promptly and finishing recruitment on time and on target. These metrics are reported to the Department of Health and published on our website, and there are financial penalties if we fail to achieve them. Therefore, your targets are:

Recruitment of first participant by:	01/09/2015
Recruitment of 12 participants by:	31/12/2015

Please notify the R&D Department of the date you consent your first participant. You will receive an email chaser every 10 working days until your target date and/or date of recruitment of first participant.

Version 4.0, 23.07.2014 Page 1 of 2

NHS Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, GCP and applicable NHS Trust policies and procedures. R&D standard operating procedures are available to download from the intranet or can be requested by emailing ██████████████████████

NHS Permission applies for the duration of the research except where action is taken to suspend or terminate the approval early. Where the duration of the study is to be extended beyond the period specified in the Site Specific Information (SSI) form, you must notify the R&D Department prior to the extension. Also please be reminded that you must notify us of any amendments and the study closure.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

I wish you well in your research. Please do not hesitate to contact us should you need any guidance or assistance.

Yours sincerely

Enc. Site Investigator Agreement

Site Investigator Agreement (SIA)

Non CTIMP nor Medical Device Study

████████████	████████████
Principal Investigator	**Trust**

Study Title: Self-disgust and visual perspective taking: How do post-bariatric surgery patients 'see' themselves?
R&D Reference: C&W15/058
Research Ethics Committee Reference: 15/LO/0870
Date of Issue: 03/06/2015

Please quote the above reference numbers in any communications relating to this project.

Whilst undertaking the above research study at the Trust, the Principal Investigator agrees to:

	Principal Investigator agreement
Regulatory compliance • Ensure that no research activities are undertaken at the Trust before the study is granted NHS Permission (R&D Approval) by the Trust. • Conduct and manage the above research according to the Research Governance Framework for Health and Social Care (2nd edition) • Ensure compliance with Ionising Radiation (Medical Exposure) Regulations 2000, if the above study involves ionising radiation. • Comply with the Human Tissue Act 2004, if the above study involves human tissue or other human biological samples. • Ensure compliance with the Data Protection Act 1998 and the Caldicott Principles. • Report all Serious Adverse Events (SAEs) in accordance with the study protocol and to the R&D Department. • Report all Serious Breaches of Good Clinical Practice/Protocol Deviations to the Sponsor and R&D Department. • Report all relevant research related incidents including all serious breaches via the Trust incident procedure, with copies being sent to R&D Department for information. • Read, understand and comply with all Trust related policies and standard operating procedures (SOPs) relating to research. Ensure compliance by all members of the research team with the latest version of any SOPs, as stored on the Trust intranet site.	*Please initial.*
Amendments • Notify the R&D Department of all amendments to the study, providing the amendment forms and supporting documents in parallel with the REC submissions. • Provide approval documentation from the REC when available. The R&D Department will acknowledge the receipt. • Notify the R&D Department of any amendments to financial arrangements. • Notify the R&D Department of any changes to the study team. • Implement the amendments and instigate change control processes once REC approval has been obtained and the R&D Department has confirmed continuation of the NHS Permission (R&D Approval). If the continuing NHS Permission (R&D Approval) email is not issued within 35 days of the receipt of all documentation and provided that all regulatory approvals are in place, the amendment can be implemented at the Trust. However, the R&D department, Finance or Divisional Directors may indicate that more time is required to process the amendment. If such indication is made, automatic implementation of the amendment is not permitted.	*Please initial.*

• Inform the R&D Department of the financial implications that the proposed amendment has. • Where the amendment incurs additional costs to the Trust, obtain Finance and Divisional Director sign offs before implementing the amendment. • However, the Trust reserves the right to suspend or terminate its NHS Permission (R&D Approval) for the above study if an amendment cannot be accommodated by the Trust.	
Recruitment and delivery • Recruitment of the first participant following receipt of a valid research application by the R&D Department within 70 days (this target date will be outlined on the letter of NHS Permission (R&D Approval). • Recruitment of the agreed target number of participants within the agreed timeframe. • Provide timely recruitment data to the NIHR directly or via the Chief Investigator or the Sponsor. • Provide recruitment data, as requested, to the R&D Department, within 5 working days of the request. • Notify the R&D Department of any issues, problems or delays with recruitment, and respond to queries from the R&D Department within 5 working days. • Prepare a recruitment recovery plan if requested by the R&D Department. • Acknowledge that NHS Permission (R&D Approval) may be withdrawn by R&D Department if study recruitment under performs.	*Please initial.*
Trial processes • Attend the Site Initiation Visit (SIV) and respond to all arising actions within 5 working days. • Set up and maintain an investigator site file in accordance with Trust Standard Operating Procedure. • Adhere to the study protocol and its subsequent amendments approved by the REC in the management and conduct of the above study. • Notify the R&D Department when the study closes to recruitment as well as when it is completed. • Comply with the Trust's Medical Records Policies and Procedures. • Assist the R&D Department with audits and inspections, conducted internally or by external regulators and monitors.	*Please initial.*

Failure to comply with the above terms will render your NHS Permission (R&D Approval) invalid.

Signed on behalf of the Trust:	Signed by the Principal Investigator
███████████	███████████
Date: 17 Jun 2015 .	**Date:** 16 – 6 – 15
Position: Research Operations Manager	

Please return this agreement to the R&D Department. The agreement will be countersigned and returned to you along with the letter of NHS Permission (R&D Approval).

Appendix K: Interview - initial coding example

15 Interviewee: That was the first time anyone had suggested it because as far as I was concerned it
16 was down to do it – try and do it again with food because I've had an on and off relationship with
17 food. Umm I had done every diet you can think of, boiled egg diet, cabbage diet, Cambridge diet. I
18 was on their programme where I was studied by them and –

[surgery] [Relationship c̄ food on & off (diets)]

19 Interviewer: Why were you on their diets? What was the reason, what drove you to do those diets?
20 Interviewee: The... the idea that I was fat. Even when I wasn't at my fattest, I was still fat compared
21 to other people. And... and I can always remember thinking that 'I was fat' right from early. I'd say
22 from... 8 years of age when we went to ... Island/Ireland to visit family, and in Ireland they call you a
23 'heifer', and a heifer is baby cow.

[labelling self as fat] [comparison to others] ['fat' from 8 y/o] [early years 'fat' – being labelled by others]

24 Interviewer: Is that the first time you had experienced –

25 Interviewee: That was the first time I heard 'God ▬▬ she's a heifer. ▬▬ s my dad, and at that
26 age it doesn't sick in, you know, I'm p...? I'm big, nobody's ever said 'you're a fat child' because it's
27 the sixties, people are born different. And then as you grow older, as I got older, I still saw myself as
28 fat. I had a tummy but I didn't actually have a tummy and that was –

[seeing self as 'fat'] [not directly told] [Comments by others (dad told by someone else)]

29 Interviewer: Sounds like that was quite a significant thing at eight that you remember it so vividly.

30 Interviewee: Yeah, it was very – because other things are so …….. you're going to visit family, you're
31 going home to Ireland. And then you've got someone going 'God Kristy, she's a heifer' and it's not
32 until you're older you know what they're saying. You know …

[significant but didn't know what it meant till older]

33 Interviewer: So at that age when somebody had said you hadn't taken it in or hadn't thought about
34 it

141

Appendix L: List of initial codes

1. Health as reason for surgery
2. Not fitting into clothes
3. Fitting into clothes
4. Food as comfort
5. Food as enemy
6. Body weight comparison to others by self
7. Body weight comparison to others by other people
8. Labelling self as 'fat'
9. Being labelled 'fat' as child
10. Making sense of childhood comments
11. Inconsistency of food availability in childhood
12. Sweets always around as a child
13. Jokes about weight by other people
14. Seeing self as 'fat' when not considered 'fat' by other people
15. Always being overweight
16. Impact of trauma
17. Weight as a form protection
18. Derogatory comments by other people
19. Abusive responses from strangers
20. 'The look' by strangers
21. Perception of other people by person who is obese
22. Negative self-image
23. Positive self-image
24. Blaming self for becoming obese
25. Other people blaming individuals for becoming obese
26. Feeling out of control
27. Feeling more in control
28. Fear of weight increasing again
29. Body as disgusting and revolting
30. Avoiding mirrors
31. Looking at mirrors
32. Associating characteristics related to obesity as disgusting
33. Exclusion from society
34. Inclusion by society
35. Exclusion by family
36. Inclusion by family
37. Using humour as coping strategy
38. Two versions of self (public and private)
39. Joining of the two selves
40. Isolating and hiding self from public sphere
41. Ashamed of becoming obese
42. Negative behaviour of strangers/family/friends
43. No future
44. Positive about future
45. Distancing self from experiences of disgust

46. Engaging socially
47. Physical independence
48. Emotional independence
49. Better quality of relationships post weight loss
50. Role of self as helpful
51. Negative attitudes of healthcare professionals
52. Positive attitudes of healthcare professionals
53. Feeling judged and blamed
54. Feeling scared about surgery
55. Discrimination in employment
56. Negative comments as reminders of difficult experiences
57. Cultural differences in perception of weight
58. Encouragement and praise as motivating
59. Feeling 'old'
60. Feeling 'young'
61. Change in behaviour in accordance to perception of self
62. Connection between 'being fat' and being 'lazy and depressed'
63. Being bullied as a child/adolescent
64. Increased confidence
65. Changing priorities from food
66. Feeling valued by family
67. Hatred and dislike of body
68. Hatred and dislike of self as a whole
69. Increased self-worth
70. Increasing quality time with family
71. Feeling responsible for weight reduction and maintenance
72. Food as central part of socialising
73. Negative experiences of public transport
74. Ruminating
75. Not burdening other people
76. Being resilient
77. Impact of obesity on family
78. Excess skin as reminder of blame for obesity
79. Learning to love self
80. Embarrassment for being obese
81. Feeling unworthy
82. Loss of hope
83. Regaining hope
84. Engaging differently
85. Using 'I self' to describe experiences of self-disgust
86. Using 'me self' to describe experiences of self-disgust
87. Switching between 'I self' and 'me self'
88. Being objectified and vilified
89. Being socially devalued
90. Increasing social status
91. Feeling hindered by the 'disgusting body'

92. Making the right decision to have surgery
93. Always thinking about food
94. Justifying other people's behaviour
95. Being deserving of people's scorn
96. Not accessing health services until last minute
97. Negative comments after becoming healthier
98. Being offensive to others
99. Using self-talk and self-praise as encouragement
100. Standing up against abuse
101. Being proud of achievement

Appendix M: Examples of coded data extracts

Code	Extract
Abusive responses from strangers (#9)	I mean that woman on the bus that abused me for being fat when she got off the bus she called me a fat cow because I wouldn't get up and give her the seat because I couldn't get up and give her the seat 'cause I would've taken up too much space on the bus (Moira)
	I've been abused that, I've been called names you know. I've been like nudged, and I go "oh I'm really sorry", and they go "you're too fat, you're taking up too much room. You shouldn't be sitting here". (Amy)
	One woman came up to me and said 'Why are you so fat?' She said 'you shouldn't be out, you're so fat (Kay)
	I was carrying a peppa pig balloon home, and I was on the bus and there were a couple of young girls, and they saw me and then they saw the balloon, and they just burst out laughing and I just thought "you know what? I know exactly what you're thinking!" (Caitlin)
	They said that 'You've put on weight' or 'you're too fat or… they used to say that… (Gohar)
Isolating and hiding self from public sphere (#40)	In the end, I just didn't go out at all. I stayed in the whole time. (Kay)
	I go after work every now and again, but I sort of try and keep away of those sort of (inaudible 12:58) situations. So I try and make excuses up, on stuff like that. (Robin)
	I always stayed at home… never go out… felt down, lack of energy to go out. I don't socialise… I never used to socialise. (Gohar)
	I always stayed at home… never go out… felt down, lack of energy to go out. I don't socialise… I never used to socialise. (Simone)

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Appendix N: Initial identification of themes

Initial grouping of codes from raw data to form potential themes.

Theme	Grouped initial codes
Negative childhood experiences of body weight	- Being labelled 'fat' as child - Making sense of childhood comments - Inconsistency of food availability in childhood - Sweets always around as a child - Always being overweight - Impact of trauma - Being bullied as a child/adolescent
Societal shaming and exclusion of 'the obese'	- Body weight comparison to others by other people - Jokes about weight by other people - Derogatory comments by other people - Abusive responses from strangers - Other people blaming individuals for becoming obese - Exclusion from society - Exclusion by family - Negative behaviour of strangers/family/friends - Negative attitudes of healthcare professionals - Discrimination in employment - Negative comments as reminders of difficult experiences - Negative experiences of public transport - Being objectified and vilified - Being socially devalued - Negative comments after becoming healthier
Denigrating obesity by rewarding weight loss	- Inclusion by society - Inclusion by family - Engaging socially - Positive attitudes of healthcare professionals - Feeling valued by family - Increasing quality time with family - Increasing social status
Revolted by the body	- Not fitting into clothes - Labelling self as 'fat' - Perception of other people by person who is obese - Body as disgusting and revolting

	- Hatred and dislike of body - Excess skin as reminder of blame for obesity - Embarrassment for being obese - Feeling hindered by the 'disgusting body' - Being offensive to others
Hatred of the self	- Body weight comparison to others by self - Seeing self as 'fat' when not considered 'fat' by other people - Negative self-image - Feeling out of control - Associating characteristics related to obesity as disgusting - Two versions of self (public and private) - Ashamed of becoming obese - No future - Feeling 'old' - Connection between 'being fat' and being 'lazy and depressed' - Hatred and dislike of self as a whole - Loss of hope - Using 'I self' to describe experiences of self-disgust - Using 'me self' to describe experiences of self-disgust
Self-directed blame	- 'The look' by strangers - Blaming self for becoming obese - Fear of weight increasing again - Feeling judged and blamed - Feeling responsible for weight reduction and maintenance - Feeling unworthy - Being deserving of people's scorn
Connecting differently to self and others	- Fitting into clothes - Looking at mirrors - Physical independence - Change in behaviour in accordance to perception of self - Engaging differently
Becoming autonomous within	- Positive self-image - Joining of the two selves - Positive about future - Emotional independence - Feeling 'young' - Increased confidence - Changing priorities from food - Increased self-worth

	- Regaining hope - Switching between 'I self' and 'me self'
Finding ways to protect the self	- Food as comfort - Weight as a form protection - Avoiding mirrors - Using humour as coping strategy - Isolating and hiding self from public sphere - Distancing self from experiences of disgust - Ruminating - Justifying other people's behaviour - Not accessing health services until last minute
Learning to resist shame	- Feeling more in control - Role of self as helpful - Encouragement and praise as motivating - Being resilient - Learning to love self - Using self-talk and self-praise as encouragement - Being proud of achievement

Appendix O: Extracts from reflective journal

After interview 1

First interview completed and it lasted almost two hours. Participant number one had a lot of things to say and there were areas that I wanted to find out more about, but the more I asked, the more she wanted to tell me and so I had to be selective about what I asked and to ensure that I stayed focused on the research questions. At times this made me wonder whether I was missing crucial data or that I was not asking the 'right' questions. However, it became evident throughout the interview that she had rich narratives around her weight and surgery, and she wanted to ensure these narratives were well portrayed. Having practiced the interview with a colleague beforehand meant that the interview flowed well, although I was struck by how difficult it was elicit visual perspective taking. After constructing the self-disgust definition, I asked for examples and then presented the images to distinguish first and third person perspective as protocol. However, the participant found it difficult to narrow down her experiences into either of these perspectives and I found that I had to repeat myself a few times before she was able to understand and explain how she viewed herself. It became apparent at this stage that to elicit such perspectives, I would need to be very directive and almost 'push' people to give answers. This did not fit the overall style of the interview or the epistemological position that the study was based upon, therefore I decided not to be as directive and potentially not gain the types of information I initially expected to.

After interview 3

As a British Asian woman I am aware of the popular notions of 'thinness' in the media and how bariatric surgery can sometimes be seen as an 'easy way out'. This is not always the case, and many people are negatively affected by these messages. For example, whilst not morbidly obese, I am aware that fluctuations in my own body weight can have a significant impact on how I 'see' myself and as a consequence, the behaviours that I engage in. Even though I know that thinness does not equate to being healthy, it is hard to get away from the powerful messages in the public domain. Capturing personal assumptions such

as this helped to identify my personal beliefs and attitudes so that I could be transparent in how I engaged with this study.