A qualitative exploration into the psychological support following weight loss surgery

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ABSTRACT

According to the World Health Organisation, more than one in ten adults worldwide are obese (WHO, 2012), increasing the risk of comorbidities, resulting in public health concern worldwide. Unless medical intervention is offered preventing obesity, it is likely that it will cost the National Health Service (NHS) around £50 billion pounds by 2050. The increasing costs to the NHS more contemporarily include the cost and need for bariatric surgery. Therefore, the aim of this research is to ascertain whether people who have weight loss surgery, specifically, a gastric bypass, are offered enough psychological support post-operative. Such support has been proven essential, as losing the amount of weight with such procedure results in life changing physical and psychological experiences, therefore, support dealing with such changes is essential. A qualitative methodological approach was used with the expectation of receiving rich and meaningful data representing both participants' worldviews. Semi-structured interviews incorporating two female participants both over eighteen years were conducted allowing the incorporation of questions about the participant's beliefs and attitudes. An interpretive phenomenological approach (IPA) was used offering the researcher an understanding of the amount of psychological support received post-operatively, aiding them in accomplishing their weight loss goals and positive psychological well-being.

KEY WORDS	BARIATRIC SURGERY	PSYCHOLOGICAL SUPPORT	OBESITY	INTERPRETIVE PHENOMENOLOGICAL APPROACH	NATIONAL HEALTH SERVICE

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Introduction

Weight gain and obesity are major health issues and have been increasing dramatically since the 1970s (WHO, 2012), contributing to the risk of comorbidities and thus, resulting in global public health problems (Kopelman, 2000). Recent results by the World Health Organisation have reported that more than one in ten adults worldwide are obese (WHO, 2012), and there is fear that this figure will increase. Obesity incurred costs to the National Health Service (NHS) in the UK of around 4.2 billion in 2007, resulting in Butland et al. (2007) arguing that this is an unnecessary cost to society and could be spent elsewhere. Butland and colleagues predicted that if obesity was not addressed, it would incur costs to the NHS of around £50 billion pounds by 2050. Moreover, McCormick and Stone (2007) argue that it is not only the NHS that is incurring costs, as financial costs to the individual through loss of earnings due to ailments as a result of obesity are estimated to be between £2,350 and £2,600 million pound per year. The increasing costs to the NHS more contemporarily include the cost and need for bariatric surgery.

This study is interested in individuals who have undergone bariatric surgery, specifically a gastric bypass, a procedure that changes the digestive system's anatomy to promote weight loss. It is concerned with the aftermath of such a procedure, particularly the amount of aftercare provided in the form of psychological support. This procedure produces significant weight loss and has been rated as one of the best treatments for obesity (Weineland, Arvidsson, Kakoulidis & Dahl, 2011). Medical co-morbidities - ailments resulting from obesity - have either been eliminated or significantly decreased once the procedure has been performed. Weineland et al. (2011) also argue that positive improvements in psychological functioning are witnessed, as people who have undergone this surgery report an enhanced quality of life equating to positive well-being.

As previously mentioned, obesity is resulting in a global public health problem that may be attributed to psychological and/or environmental factors. It is argued that obesity is a result of consuming a high intake of calories, especially energy-dense foods, increasing portion sizes, high sugar carbonated drinks, fast food consumption and little or no physical exercise (Rosenheck, 2008). Obesity, in certain cases, can also be attributed to genetics, medical reasons, speed of metabolism or mental illness (Cutler, Bleich, Murray, & Adams, 2008). Neural mechanisms may be another important factor contributing to overeating, as the body has developed two systems, one to signal hunger and one to signal satiety (Nevid, 2011). The lateral hypothalamus is activated when glucose levels decrease, resulting in hunger feelings. Consuming food enables raised glucose levels, triggering the ventromedial hypothalamus, informing the body of satiety and therefore, inhibiting further food consumption (Nevid, 2011). However, Wickens (2000) argued that overeating can also be associated with the individual's brain producing too much neuropeptide Y, a neurotransmitter found in the hypothalamus.

Having considered biological influences on obesity, it is also reasonable to look at how this issue can also be attributed to social influences. Although awareness around obesity has increased and it is now accepted as a medical condition, obese individuals are still suffering prejudice and discrimination (Puhl & Brownell, 2003). Social identity theory can be applied to obesity, as research suggests that society

refers to obese individuals as an 'out-group', while individuals who are not obese are identified with the 'in-group'. As obesity is not in keeping with social ideology, it is not surprising that obese individuals experience social isolation and feel that they are being ostracised (Miller, Rothblum, Felicio & Brand, 1995; Strauss & Pollack, 2003). Stigma towards obesity is usually by way of stereotyping and developing one's social identity by making comparisons between group memberships. Obese individuals are seen as an inferior 'out-group', while normal weight individuals are considered the 'in-group' and favourable to society (Puhl & Brownell, 2003). Devastating consequences on the individual's psychological well-being, quality of life and self-esteem have been attributed to the stigma and discrimination experienced by obesity sufferers (Puhl & Heuer, 2010). Such negative attitudes towards obese individuals can result in them becoming less likely to partake in any health-promoting activities (Amy, Aalborg, Lyons & Keranen, 2006) and reluctant to engage with public health messages around obesity, and thus failing to address the problem (Lewis et al., 2010). According to Bayer (2008), there can be positive outcomes to stigma and discrimination towards obesity, because suffering this negative behaviour could inspire changes in eating behaviour. It has been recently argued that negative associations towards obesity could result in people being motivated to engage in weight loss activities (Latner, Wilson, Jackson, & Stunkard, 2009). It was argued that administering shame to people who are already suffering anxiety and depression as a result of obesity is an acceptable approach (Triggle, 2010). However, in contrast to the above, research has indicated that obese individuals withdraw and internalise negative feeling directed at them from the 'in-group', and more importantly they accept the negative stereotypes that are attributed to them associated with obesity and accept that they are the 'out group', (Greener, Douglas & Van Teijlingen, 2010):

> *"obese people passively agree with the major construction of obesity as their own fault, because that is how they have been inculcated socially. They rarely publicly challenge the social construction that weight is the result of personal weakness."* (Rogge, Greenwald, & Golden, 2004 p:312).

Attribution theory can also be applied to prejudicial and discriminatory behaviour towards obese individuals, as society makes attempts to attribute obesity to a cause, usually the individual (Puhl & Brownell, 2003). Members of society can attribute the cause of obesity to internal controls in the obese individual, arguing that people are accountable for their own weight and that it is their own fault (Corrigan, 2006). As obesity is not in keeping with societal ideology, stigma and discriminatory behaviour towards obesity and obese individuals are therefore witnessed throughout and across society. This reinforces Puhl and Heuer's (2010) assertion that negative psychological well-being, self-esteem and quality of life are a result of stigma and discriminatory behaviour towards the obese individual.

Whilst the discussion in the preceding paragraphs is primarily from the perspective of social psychology, it is important to note that Schachter's (1971) Externality Theory can also be applied to obesity. The theory incorporates emotional responses to overeating, including depression, anxiety and boredom (Ogden, 2003). In support of this theory, Bruch (1973) proposed the psychosomatic theory of eating behaviour. He

argued that individuals could overeat as a result of internal states, such as anxiety and depression, being misinterpreted as hunger signs. This theory was centred on early learning experiences, suggesting that if these experiences were problematic, then the individual could not progress psychologically, thus resulting in faulty hunger signs. These faulty signs may cause the individual to associate negative feelings with false perceptions of hunger: therefore, unpleasant bloating feelings can result in overeating. As previously mentioned, obesity results in stigma and discriminatory behaviour, and according to Bruch's psychosomatic theory, the negative internal feelings will encourage overeating. A study in support of this theory was conducted by Macht (2008), involving a non-clinical sample of twenty-three females and monitoring their emotional state and motivation to eat over a six-day period. Results found that both levels of hunger and the motivation to eat were significantly increased when participants were exposed to negative emotions.

Schachter's Externality Theory (Schachter, 1971) offers an explanation for overeating by suggesting that some individuals are more responsive than others to external cues. For example, higher response rates to external stimuli, such as smell, taste and sight, are strongly related to individuals overeating compared to internal cues, which result in individuals eating to satisfy hunger and satiety, and thus being less likely to overeat (Ogden, 2003). However, in contrast, Redden (2008) argues that external cues can also be used as a preventative to overeating. Redden claims that this can be achieved if the individual pays conscious attention to the detail of what they consume. He argues that instead of focusing on a meal as a whole, there is a need to break it down into its detailed constituents, as being conscious of what is being consumed can reduce the desire to overeat.

Antelman, Szchetman, Chin and Fisher (1975) wrote about stress being an important finding connected to eating behaviour, and Greeno and Wing (1994) later supported these findings in a review of stress-induced eating. Michaud, Kahn, Musse, Burlet, Nicholas and Mejean (1990) reported the association between stress and overeating in a study involving children on exam days. They reported that calorie intake was significantly increased on the day when children were preparing for an exam and that the children were reported to particularly consume high fat foods. Although these findings are plausible, Connor and Armitage (2002) argue that the individual approach to eating as a result of stress is different for each person. As stress has differing effects on individuals, and each individual has their own way of dealing with stress, therefore, it should not be generalised that overeating is attributed to stress.

It has also been argued that social eating can be attributed to a particular pattern of eating behaviour compared to eating alone. Herman, Roth and Polivy (2003) compiled a model to determine whether people who ate with others would use them as an indicator or social cue as to what is acceptable and what is excessive. As previously seen, social factors can be influential; however, it is important to note that these influences can go either way, and the individual can either increase or decrease food intake (De Castro, 1990). Goldman, Herman and Polivy (1991) argue that an individual's eating will increase if the person they are eating with increases his or her intake and they are familiar with them, or reduce if the other person reduces his or her intake. It is also likely that if one wants to leave a favorable impression, one will reduce the intake of food in front of the observers (Vartanian, Herman, & Polivy, 2007).

Research has argued that the relationship between food intake and social influence is concerned with relationships between co-eaters. De Castro (1994) reported that when friends and family are eating together, they are more likely to consume more food, compared to eating with colleagues or less familiar people. Recent research by Salvy, Jarrin, Paluch, Irfan, and Pliner (2007) supports previous studies by reporting similar findings, arguing that food consumption is increased when eating with family and close friends, compared with less familiar people (Salvy, et al., 2007), thus reinforcing the claim that the presence of others can influence our eating behaviour.

Drawing on the theories mentioned so far, it is apparent that emotional arousal is a main contributing factor associated with overeating resulting in weight gain. Again, emotional arousal has been found to influence eating patterns, as it is usually a result of an individual not being able to differentiate between feelings of stress and feelings of hunger. Reinforcing this theory, O'Connor, Jones, Conner, McMillan and Ferguson (2008) were interested in the effects of daily hassles on eating styles and eating behaviour. Their findings suggest that daily hassles can contribute to increased food consumption, particularly when they are associated with fear of failure, work and interpersonal hassles; these are also specifically linked to an increase in snacking behaviour involving foods that are high in calories and easily accessible.

The theories above offer examples of why the obesity problem has arisen and why it is still increasing, reinforcing the major concern for public health. As mentioned earlier, bariatric surgery has been popularised and offered as a weight loss method, displaying good results. An initial assessment is administered, ascertaining whether the individual is well informed and motivated to lose weight, and most of all, determined to change their eating behaviour and lifestyle (National Institute for Health and Clinical Excellence, 2010). Although this assessment is used, people who suffer from obesity are experiencing all the negative attributes that accompany obesity. Therefore, people are sometimes desperate, and may say they understand the risks of the procedure and that they can do what is necessary for a successful outcome, when in reality they have not understood that their contribution is essential. The criteria for severely obese individuals is to have a BMI>40, and moderately obese individuals presenting high risk comorbidities, such as diabetes or sleep apnoea, should have a BMI>35, according to the National Institute for Health and Clinical Excellence (NICE, 2010). The most common form of bariatric surgery is the gastric bypass, after which a vast amount of weight loss in the first few months following the procedure is witnessed (Welbourn & Pournaras, 2010). According to NICE (2010) patients should have a pre-operative assessment and be given advice, and post-operative patients should receive aftercare, advice and support. Healthcare professionals should endeavour to keep patients well informed of the risks, as research has indicated that patients who are well aware of the whole procedure display better long-term weight loss (Welbourne & Pournaras, 2008); however, there is little research to confirm that patients receive good advice and aftercare.

Research has found that post-surgery processes parallel infants' weaning (Throsby, 2008), arguing that this process allows the individual to re-learn their eating habits, enabling sensible changes, which are imperative for success. Long-term studies have found that post-bariatric patients attribute weight loss to greater eating self-efficacy; however, this can weaken when weight loss slows down (Batsis et al., 2009). According to McMahon et al. (2006), the importance of behavioural changes,

eating patterns and adopting physical activity should be reinforced to patients, as well as offering on-going psychosocial care. Weight loss surgery has produced evidence of success: for example, the mean percentage weight loss for an individual who has undergone gastric bypass surgery is 67% over a twelve-month period (O'Brien, McPhail, Chaston, & Dixon, 2006). There is also evidence that it enhances quality of life, positivity in mood and improvements in general health and helps to change eating habits (Ogden, Clementi, Aylwin & Patel, 2005). Although it appears that weight loss surgery is producing strong positive effects on individuals, it is important to note that not all cases equate to successful outcomes.

As weight loss surgery does not always result in success, people have reported feelings of being unprepared for changes to their body and lifestyle, and being completely unsupported by medical professionals once they leave the hospital (Ogden, Avenell, & Ellis, 2011). Ogden et al. (2011) argue that weight loss surgery fixes the body, but psychological issues relating to eating patterns or eating behaviour are not addressed. Therefore, any psychological issues that the individual has attributed to their weight still remain, even though the individual has lost what was supposedly the problem - weight - enhancing the need for psychological help. The individual also claims that self-esteem, coping and emotional eating are also still present. Therefore, Saltzman et al. (2005) argue that patients require multidisciplinary care and psychological input, which is not as yet being incorporated adequately in patient aftercare. According to the guidelines published by NICE (2010), surgery for obesity should be undertaken by a multidisciplinary team incorporating psychological support before and after surgery. However, Saltzman et al. (2005) argue that these guidelines are not being met, and more importantly are missing from weight loss packages provided by both the NHS and private clinics.

After researching the literature relating to bariatric surgery, evidence is offered relating to successful weight loss and well-being: however, these outcomes relate to short-term results. Little evidence is offered for long-term successfulness, although this may be due to bariatric surgery only being popularised over the last ten years. The aim of this qualitative research study was to investigate the extent of aftercare provided, by way of psychological support, once bariatric surgery has been performed. Qualitative methods were chosen to conduct this project, in order to gain an epistemological and hermeneutical understanding of the psychological support people are offered as part of their post-operative care. More importantly, it also investigated the support that is actually received. The following study incorporates an interpretative phenomenological approach, aiming for a detailed insight into the participant's worldview.

The main aim of this study was to ascertain whether there is enough psychological support offered to post-operative bariatric patients, and whether such support is necessary to maintain the weight loss and/or prevent weight gain.

Methodology

Rationale

The main aim of my research is to interpret the meanings that participants attach to the psychological support they receive after bariatric surgery, which will be used to gauge the quality of that support. Thus, a qualitative research methodology that allows for meanings to be interpreted has been chosen. The aim is to use this qualitative methodology to gather meaningful and valuable data that highlights each participant's attitude, motivations, feelings and beliefs as well as how these are affected by post-bariatric surgery psychological support. More specifically, the interpretivist approach will be applied, as it allows the understanding of the meaningful nature of the participant's life both socially and culturally with ease. The analysis of meanings that the participants disclose requires in depth interpretation, therefore, the interpretivist approach is the most appropriate for this study, ruling the scientific method out.

This study is interested in the quality of psychological support that participants received once they had undergone bariatric surgery. This research question means that it is necessary to understand and interpret the meanings that participants attached to post-operative support and aftercare. To interpret these meanings successfully, a double hermeneutical approach (Silverman, 2005) is necessary. Adopting this approach throughout the interviews means that the participant will be trying to make sense of their world while the researcher tries to make sense of the participant trying to make sense of their world (Smith, 2008). According to Scott (2002), the information that participants volunteer may not always be the truth, but we only have access to their version of the truth. Therefore, the researcher should consider their own epistemological choices and biases, as these will affect how participant responses are interpreted and the types of question asked.

Understanding the quality of psychological support that participants received after surgery will require access to the participant's world view. In order for this to be successful, engaging in *verstehen* (Max Weber) is essential, because this allows an insight into the participant's feelings, motives and perceptions by adopting an empathic attitude. The importance of remaining engaged and reflexive throughout this process is imperative and will be facilitated by keeping a reflective diary. The entries will follow the literature (Marsh, 2002; Silverman, 2005), and will be based on my thoughts and feelings about what participants have disclosed. This will allow me to reflect on how the interviews have affected me and how I should respond. The aim of this study is to assess the amount of psychological support a person receives once they have undergone bariatric surgery, specifically a gastric bypass. The research is interested in people's experience with psychological support after weight loss surgery and whether they are offered enough support.

As this was my first attempt at a qualitative study, prior to the scheduled interviews I recruited two friends to help me conduct pilot interviews and asked for feedback. They offered me good advice, which I accepted and applied to my real interviews. The obvious method was semi-structured interviews incorporating a topic guide, which was mainly used as the basis for conversation, allowing the participant to direct the course of the interview. This process allowed the participant to talk freely

without interruption, allowing me to gain in-depth and rich data. The Interpretive Phenomenological Approach (IPA) was then used for analysis: this was another obvious choice, as it aims to offer insights into how a person, in a given situation, makes sense of a given phenomenon (Smith, 2008).

Data Collection Methods

Semi-structured interviews were conducted with the view to gain rich, thick data, allowing the participants to tell their story freely, and then transcribed verbatim. The Interpretive Phenomenological Approach (IPA) was used for analysis, in conjunction with the interview style, as the two complement each other (Silverman, 2005). As mentioned, the interview choice was obvious, as I was interested in allowing the participants to offer a detailed version of their experiences. Although this can also be achieved via in-depth interviews and diaries, experienced researchers typically use this methodology. Structured interviews and questionnaires were much less suited and less likely to gain rich detailed data, which is necessary to a topic that is of such a sensitive nature. Therefore, the interview style chosen was appropriate for the study, as it would provide meaningful and valuable data (Smith, Larkin, & Flowers, 2009).

The interviews were prepared to last 45-60 minutes and were recorded using audio recording equipment. Warren (2002) states that the meaning of the equipment to the researcher is likely to be different to the participant. Therefore, confidentiality and anonymity were assured and it was reiterated to participants that only the researcher would have access to their interviews and recordings (King & Horricks, 2010). Contact was made with a weight loss surgery support group, and the founder facilitated access to the group and acted as the gatekeeper, aiding the recruitment of participants with ease. The participation information sheet (Appendix 2) was given to two possible voluntary participants who had undergone bariatric surgery, specifically a gastric bypass. They were two years post-operative and no longer had contact with the National Health Service, and they agreed to participate in the study. It was agreed that the first interview would take place in the premises used for the monthly meeting; the interview was scheduled for the following month. The participant agreed to meet the researcher an hour before the meeting in order for the interview to commence and a private quiet room was arranged.

Informed consent was gained by giving the volunteers the participant information sheet (Appendix 2), and explaining the nature of the research, and their involvement was agreed at this stage. A consent form (Appendix 3) was devised and given to the participants, who were then asked if they wanted to take part in the study, and if so, to sign and date the form. They were also informed that they could refuse to answer a question or part of it, and could withdraw their participation and data from the study at any time by using the contact details provided. The same topic guide (Appendix 4) was taken into both interviews, which was mainly used as the basis for conversation, allowing the participant to direct the course of the interview. Appendix 5 provides an overview of the questions that were designed to be asked; however, the interview was led by the participant, and therefore, only the first question was asked.

Upon concluding the interview, each participant received a full verbal debrief and a debrief sheet including two other support groups that might be helpful (Appendix 6).

This opportunity was used to reiterate the nature of the research and that they could withdraw their participation now or at a later date using the contact details provided. They were then asked if they agreed that the data they provided could still be used, and if they had any questions. The participants were offered the chance to read the transcript in order to remove or change the data they had provided. They were offered a copy of their transcript and a summarised version of the overall findings of the report. They were also informed that one copy of the dissertation would remain under the ownership of the University. It was reiterated throughout the whole process that confidentiality and anonymity were assured and a pseudonym with a participant number was given to ensure this. Also the data collected was kept completely safe and confidential and accessed by the researcher only. As the participants were recruited from a weight loss support group, and they were already receiving support, the debrief sheet (Appendix 6) included two more support groups that might be of interest. Following each interview, the data were transcribed immediately after, when full engagement of the interview is still present, and it was then analysed using IPA. Each set of data was analysed individually and then correlated (Appendix 7 and 8).

Participants

In order to conduct my research I had to recruit participants who had undergone bariatric surgery - specifically, a gastric bypass - and were over eighteen years old. There were no gender specifics, but participants were required to be two years post-operative, to ensure that there was no association to the NHS. After a vast amount of research within this area, I contacted the founder of a weight loss support group who facilitated my access to the meetings. As the topic is of such a sensitive nature, the founder acted as my gatekeeper, and as a result, I successfully recruited two female participants. They were both over the age of thirty-five and had both undergone bariatric surgery: specifically, a gastric bypass. As the topic was sensitive, I was extremely mindful of this when preparing my questions and began working on creating a trusting rapport when meeting my participants. People who have had weight loss surgery have been obese and this may have resulted in the participants experiencing lack of confidence, low self-esteem, anxiety and/or depression. Therefore, revisiting any periods of their life before their surgery may cause a small amount of discomfort and/or stress.

Ethics

Prior to starting my research, I consulted the British Psychological Society (BPS) guidelines for psychological research (Codes of Ethics and Conduct, 2009) to ascertain any issues that I needed to address prior to starting my research. Participant information sheets were devised (Appendix 2) with the view to gain informed consent from each participant. The nature of my research was explained and their involvement was agreed at this stage. A consent form (Appendix 3) was also devised, and the participants were asked if they still wanted to partake in the study, and if so, to sign and date the form provided. They were also informed that they could withdraw their participation and data from the study at any time by using

the contact details provided. They were also told they could refuse to answer any question or part of it throughout the interview.

The data collected is intended to be used in connection with my dissertation and may be used for publication purposes. However, the participants were informed prior to the interview that their confidentiality and anonymity were assured, and this was reiterated by allocating them a pseudonym as well as a participant number. The research supervisor and I will have access to the data collected, as well as any other examiner connected to the University. However, the recordings and transcripts will remain with the researcher, and will be kept in a confidential and secure place at all times. The participants were informed that any names or places mentioned in the recording would be changed in accordance with the requirements of confidentiality and anonymity.

Once the interview concluded, the debrief process occurred (Appendix 6), which included details of two more support groups. I took this opportunity to reiterate the nature of my research and ensured that they knew they had the right to withdraw their participation now or at a later date using the contact details provided. I asked if they were still in agreement that the data provided could still be used, and if they had any questions to ask. The participant was offered the chance to read the transcript in order to remove or change any data they were unhappy with, and a summarised copy of the overall findings of the report was offered. I also reiterated that one copy of the dissertation would remain under the ownership of the University.

Maximum consideration was given when preparing the questions, ensuring that they were worded in a sensitive manner. Those who have had weight loss surgery have suffered from obesity and are likely to attach negative feelings to their past, and revisiting these memories may be a little difficult for them. The whole process, from the idea for the study to recruiting participants, conducting interviews and analysing the data, was done with the view to ensuring that the participants' physical safety and psychological wellbeing was not compromised.

A Reflexive Thought

Prior to starting my research, I wanted to address any thoughts and feelings I have about my own weight issues, ensuring that I would not bias the interviews or the process of transcribing and analysing the data. As a child, I was mostly cared for by my grandfather, who was a baker, and my diet consisted of pastries, cakes and bread. Although I did not have a healthy diet as a child, I did not have what I would call weight issues until after I had my first daughter. My unhealthy diet caught up with me and as a result, the last fourteen years of my life have entailed weight loss and weight gain equating to yoyo dieting. However, having my own weight issues was one of the reasons I was interested in researching the topic for my dissertation, and as a result of this, I decided to keep a reflexive journal, making frequent entries with the view to eliminate any unconscious biases. Although I have concerns about my weight, I am not at the stage where I would consider or be considered for bariatric surgery: therefore, I am confident that an objective approach was used when preparing my questions for interview and interviewing, and that I remained objective when analysing the transcripts. The indexicality of meaning throughout was

imperative to this process, as I wanted to ensure that what was said and how it was said was interpreted in the correct context. A small amount of knowledge within the field of my research question was necessary in order to for me to successfully interact with my participant, and understand what they said by understanding the context.

Transcription and Data Analysis

IPA was used when transcribing and analysing the data collected. This was the obvious approach, as it allowed me to use an active sequence of interpretation to closely examine the participants' personal lived experiences. I had a duty to understand what each participant was telling me and understand the psychological meaning through interpretation (Reid, Flowers & Larkin, 2005).

Although transcription was lengthy and time consuming, it was extremely important that the transcription was verbatim, enabling accurate analysis. Any personal thoughts and feelings I had about the interview or experience at this stage were written in my reflective diary. A process of bracketing off occurred in order to suspend my own judgement whilst I undertook the transcription and analysis process (Husserl, 1999; 63-65). Prior to transcribing, I listened to the recording several times, imagining the voice of the participant, and attempting to immerse myself into the original interview.

The analysis followed, requiring a thorough and detailed analysing process in order to recognise emerging themes and how they merge. The transcript was read and re-read with the aim of entering the participant's world, remaining hopeful that any themes emerging would become evident, allowing them to connect with ease. Although the analysis is interested in the participant's discussion about their lived experiences and the meaning around them, it is important to note that the analysis is a result of the analyst's interpretation of the participant's discussion, thus resulting in double hermeneutics (Smith et al., 2009).

Initial analysis required me to note anything of interest in the left column of the transcript, encouraging me to engage with the text, with the avoidance of superficial reading resulting in noting what I expected to see (Smith et al., 2009). A pattern of descriptive comments and the language used followed, which mainly incorporated a phenomenological focus, resulting in the basic meaning that the participant intended. The next step involved re-reading the transcript, including the notes, and identifying emergent themes. According to Willig (2001: 55), it is here that psychological concepts are used and connections between themes are usually sought (Willig, 2001). The identified themes were clustered in the right-hand column, looking for an overall structure of my analysis. Assisting me in finding any connections was a list I made of all the initial themes in chronological order. I also used a simple colour code for each theme, helping me to identify and cluster themes with ease, incorporating the abstraction method. I identified patterns between developing themes, colour coded them and in turn they became super-ordinate themes.

The four main themes that emerged are as follows:

1. Lack of psychological support

2. Identity

3. Social eating

4. Emotional eating

Data Analysis

Semi-structured interviews were used to interview two female participants, who had undergone bariatric surgery. IPA was used for analysis and an initial list of themes emerged, they were then clustered, allowing the emergence of the main themes. The main themes are as follows:

1. Lack of psychological support
2. Identity
3. Social eating
4. Emotional eating

The data will be presented systematically with each participant and each theme.

Participant 1 – Jen

Jen is forty-three years old and has been married to husband Jack for over twenty years. She has six children and one grandchild, and four of her children are still living at home. Jen has her own successful business designing and making candy buffets and sweet treats for all occasions. She currently runs her business from home, but she is looking to open her first shop in the near future.

Theme 1. Lack of psychological support

This theme was most prominent in Jen's transcript, although it did not appear until half way through, as it was relating to post-operative support, or lack of it, which was discussed later in the interview.

 'Ye, 'cos psychologically they still think they're fat and 'cos they've never been thin before they don't know how to deal with it' (Jen, 14. 311).

'I've never been offered any sort of psychological support, nothing, no CBT or nothing' (Jen, 16. 355).

'Ye, there's no aftercare, and there needs to be' (Jen, 17. 360).

'You lose the weight but your mind needs to catch up with the loss' (Jen, 17.360).

'So erm, you are still seeing yourself fat for years after and erm, ye know, it's just lacking, the help is lacking' (Jen, 17. 361).

Jen also discusses how important it is that people change their eating habits, and argues that there should be support to help with this change. According to McMahon et al. (2006), the importance of behavioural changes, eating patterns and adopting physical activity should be reinforced to patients, as well as offering on-going psychosocial care. However, Jen argues that none of what was supposed to be provided ever was.

'Ye, we haven't got fat making the right choices. We've got fat making the wrong ones so we have to change everythin, and get over stress and boredom an' that' (Jen, 19. 408).

Jen spoke about the need to know everything that the procedure entailed, and she argued that being well informed is the key to successful weight loss. She also states that everyone considering surgery should have a psychological evaluation, as seen in the quote below. It appears that National Institute for Health and Clinical Excellence (2010) is in agreement with this: however, little evidence is offered that that does occur.

'It's been awful, absolutely awful and I would change that everyone should have a psychological evaluation beforehand, and psychological support after' (Jen, 14. 295).

Jen is again reiterating the importance of knowing what to expect at the start of the surgery journey.

'From day one it's all about choices and getting yourself in the mindset of this being the last hope and I have to succeed' (Jen, 18. 400).

Theme 2. Identity

This theme first appeared on page one of the transcript, when Jen displayed an obscure self-concept, as she spoke of convincing the doctor that she was overweight when she was actually only ten stone.

'I convinced the doctor I was, erm, overweight, I was only ten stone' (Jen, 1.20).

This theme develops throughout the transcript, as she often makes reference to not feeling herself, and wanting to get back in control.

'I just wanted to be involved in me own life, I wanted to be me again' (Jen, 6. 124).

Image transition appears to be a difficult process for Jen, and the lack of psychological support is evident, therefore, the transition is difficult and psychological support is necessary.

'Well if some people have never known what it's like to be slim and then all of a sudden you've got this slim person looking back in the mirror at you, it's hard to take in' (Jen, 14. 209).

'I mean it was fifteen years, eighteen being big but it was still really hard to get me head round being thin around the fact that, oh my god I've got me figure back' (Jen, 14. 301).

'You lose the weight but your mind needs to catch up with the loss' (Jen, 17. 360).
Jen talks about remembering feeling confused about when she had lost weight, as she could not understand why she was still experiencing negative feelings, when what she saw as the main issue, weight, was dealt with through weight loss.
'It was still psychologically hard for me 'cos when I was fat I'd say "I feel down 'cos of my weight" but then when I lost the weight and felt down it seemed worse 'cos I didn't know why I felt sad' (Jen, 15. 316).

As well as issues around self-concept, Jen refers to social acceptance, or lack of it, as she discloses her feelings about being accepted in society.
'When people see a fat person or a big person, to me they automatically think lazy, er unkempt, an' I was never unkempt. I was stereotyped, I wouldn't go out in the end, I felt left out of everything' (Jen, 9. 181).

Engaging with the transcript has shown that this theme is prevalent throughout. It relates to social identity theory, as it is clear that Jen feels as though her weight restricts her to the 'out-group', whilst everyone else belongs to the 'in-group'. Her feelings of being out of control of her life can be attributed to her weight, as obese individuals experience social isolation and feel ostracised. Therefore, their feelings of not being in control are not surprising, and may result in overeating.

'When I did go out it was only the school for the kids, an' I could hear all the mums talking about goin' for a coffee and havin' a day out, but I wasn't invited. I know they thought I was fat and lazy and dirty' (Jen, 9. 183).

Theme 3. Social eating

Jen talks about how her eating behaviour differs depending on who she eats with. She states that she will not eat in front of her friends or family; however, she feels that she can eat what she wants in front of her sisters, who are family, and admits to eating excessively on her own.

'I was having people around visiting, I would feed them but wouldn't eat in front of them' (Jen, 3. 43).

'But once they'd gone home and the kids went to bed, I'd eat and eat' (Jen. 3. 45).

'It was funny though, 'cos if me sisters would come visiting, I'd eat in front of them, no problem' (Jen, 3. 46).

It has been argued that food intake is increased when eating with family and close friends, as opposed to colleagues and less familiar people: therefore, Jen's eating behaviour is similar to the findings reported by Salvy et al. (2007).

Theme 4. Emotional eating

This is the final emergent theme, and emotional eating for Jen is present all the way through this transcript. She displays a vast number of episodes of overeating, relating to an array of emotions. The more negative emotions were experienced, the more Jen would overindulge, gaining weight, and thus suffering more negative emotions.

'I felt sad and ugly and disgusting' (Jen, 7, 146).

'I hated looking at meself, I felt so ugly and fat' (Jen, 8. 156).

As Jen was suffering from depression and anxiety, her behaviour would result in eating more, resulting in her feeling worse.

'I was depressed and stressed out; 'cos of that I was eating more, and er feeling left out' (Jen, 9.188).

'I was so upset an suffering from anxiety an' stress' (Jen, 9. 190).

'I'd eat 'cos I was stressed and bored' (Jen, 9. 199).

'I was sad and lonely an' when I'd think about the day I'd had it made me feel worse an anxious an' stressed out' (Jen, 9. 203).

This type of eating behaviour from Jen, did return after her procedure, reinforcing the need for psychological support post-operative. This pattern of behaviour can be seen in Schachter's (1971) Externality Theory, as he argues that emotional responses result in overeating.

'But I was also feelin confused cos I'd lost the weight, but when I was confused I'd feel sad and I found meself wantin to start eating' (Jen, 15. 325).

'Me emotions ye know were goin mad and I was tryin to eat' (Jen, 15.227).

Her old eating behaviour would have returned completely only, a large part of the stomach is removed during a gastric bypass, therefore, it was restricting the eating behaviour as best as it could. Psychological support was essential for Jen at this point as,

'Cos me stomach had shrunk it was hard. It was hard with six kids ye know, an if I had a bad day with them, or missing me hubby, or I was emotional cos everythin was changing' (Jen, 15. 329).

'I'll be honest, I started eatin, and then I'd be vomiting, me body just wouldn't let me, but me head was tellin me otherwise' (Jen, 15. 332).

'Just all me emotions, I was stressed, I wanted to eat, I was angry, I was wantin to eat, ye know with the kids and runnin the house' (Jen, 15. 335).

Participant 2 – Meg

Meg is a 35-year-old woman from Liverpool, and is married to David. They have a three-year-old son together, and she states that she is the happiest she has ever been in her life. Meg returned to work after years of being a housewife; she works as a sales assistant at a famous supermarket, and is in the process of having interviews for a promotion at work.

Theme 1. Lack of psychological support

Once this theme emerged, it was evident that it was extremely important to Meg. She talked about the lack of support as a contributing factor for her re-gain in weight and the return of emotional eating. It is also evident that Meg experienced a vast range of confused feelings and was not sure of what to expect, reinforcing the lack of support given.

'I should have been feeling great an' I was feeling terrible' (Meg, 10.210).

'No nothin', I felt awful 'cos I'd lost weight and still wasn't 100% happy' (Meg, 12.252).

'Erm..well as I was losing more weight I was feeling different, and er on the outside I was smiling but I had mixed feelings an' no one to talk to really 'cos I didn't know anyone who'd been in this situation' (Meg, 12.260).

'I wasn't really goin' out even though I was in a 12 now and I felt weird 'cos I wasn't happy fat, an now I wasn't feeling happy when I was thin' (Meg, 13.275).

Meg recognised the need for help, but she was not sure where to go for it. Saltzman et al. (2005) argue that patients should be treated using a multidisciplinary approach with psychological input. However, it is evident that this is not as yet being incorporated adequately in patient aftercare.

'But I needed help, I knew I did, but I wasn't getting any and I felt no one cared' (Meg, 14.306).

'It was like, here's your op, get on with it' (Meg, 14.307).

'In the end I had to tell me mum an' then she just made me go to a meeting that was on the next day, an' she said she'd go with me' (Meg, 14.307).

Meg attempted to return to her emotional eating habits, as they were not originally addressed. McMahon et al. (2006) emphasise the importance of behavioural changes, eating patterns and adopting physical activity, as these are the keys to a successful weight loss journey. He also argues that it is imperative that on-going psychosocial care is offered. However, Meg's transcript does not include any of the above.

'I come clean about what I was doin' with the tea an' biscuits an' toast an' everyone understood an' worked with me to change the habit' (Meg, 15.321).

'I can honestly say I felt loads of emotions, I really felt better than I did when I had the op, like happy, ye know, I'd found proper help' (Meg, 15.323).

'Feeling on your own is horrible, and that's how I felt, on me own with no help' (Meg, 16.359).

Meg states that she was unprepared for the changes to her body and lifestyle, feeling completely unsupported by medical professionals. Ogden et al. (2011) reported similar findings to Meg's situation, and this is 2013: therefore, it appears that there have not been many improvements in this area.

'Definitely support afterwards' (Meg, 17.368).

'As I said I felt dreadful, ye know I was fat an' unhappy an' then as I said I was thin and unhappy, so seeing me thin and coming to terms with it really put me under pressure' (Meg, 17.368).

'I thought I was gonna feel great once the weight started to come off, but I didn't an' I didn't know why, but now I know I was lacking support' (Meg, 17.373).

'Oh an' erm, also I think you should have to be in like a support group before the op ye know, so you can ask questions an' have things made clear, like, ye know before you get it done' (Meg, 17.375).

'I can't stress enough that you need psychological support' (Meg, 18.400).

Theme 2.   Identity

This theme first appeared at the beginning of the transcript, when Meg started to talk about always having issues with herself and her weight, and it developed all the way through the transcript.

'I've had problems with me weight, from erm…since I can remember. I never liked meself, I was always having trouble with who I was' (Meg, 1. 18).

Meg repeatedly talked about not liking herself, and issues with her identity were evident.

'I was looking in the mirror an' I didn't like what I saw' (Meg, 3. 41).

'I just hated what I'd become, I hated meself' (Meg, 5.107).

'I hated meself' (Meg, 8.164).

Meg spoke about not wanting to go out and feeling that her weight was a restriction, resulting in her feeling oppressed and ostracised. Social identity theory is identified, as obesity has resulted in her feeling socially isolated and ostracised, and thus overeating.

'I never went out and I never worked 'cos I felt ashamed of me and the weight' (Meg, 3.56).

'An' ye know I even used to get me mum to bring the shoppin' in the end so I didn't have to go out, I was ashamed of meself' (Meg, 5.82).

Confused feelings were prominent, as Meg knew she should have been happy, but was experiencing feelings of sadness and having difficulty dealing with her new self.

'It was a brand new me an' I didn't know how to deal with it' (Meg, 17.371).

'I thought I was gonna feel great once the weight started to come off, but I didn't an' I didn't know why' (Meg, 17. 373).

Theme 3. Social eating

Meg talked about her eating pattern, and how it was influenced by her mother. Her eating behaviour replicated her mother's, regardless of whether she was binge eating or following a diet plan.

'Ye, like whatever me mum was doin' with food I was doin' (Meg, 2.30).

'We'd eat the same things, an' if she was piggin' out I was piggin' out, but if she was good I was being good' (Meg, 2.31).

Interestingly, Meg stated that if she and her mother were eating what they liked, they would buy the food and take it home so they could eat together in private. However, if they were following a diet plan, they were happy to eat in front of strangers at a restaurant, reducing food intake to leave a favourable impression for observers (Vartanian et al. 2007).

'If we were binging and we were out shoppin', we'd buy loads an' come home an' eat it before anyone else came home. But if we were bein' good we'd eat out' (Meg, 2.32).

'Well, if we were just eating what we wanted we'd go home to eat, but if we were being good we'd eat out, then we wouldn't feel ashamed overeating' (Meg, 2.36).

De Castro (1990) argued that influential eating behaviour can go either way, and that is exactly what Meg does. If her mother increased her food intake, so would Meg, and if she decreased her food intake, Meg would too.

Theme 4. Emotional eating

Meg recounted a vast number of emotional episodes throughout this transcript, and it is clear that this aspect has resulted in emotional overeating and weight gain. Any type of emotion or negative feelings would result in episodes of overindulgent behaviour.

'I'd do all the house stuff an' then er, then, I'd like be bored so I just used to eat an' me cookin' got better' (Meg, 4.81).

'I was always on me own, bored, and then when I started getting bigger I got more lonely but then I was just eating for nothing and I wasn't even hungry' (Meg, 11.230).

Meg was suffering from stress and anxiety, even after her procedure, resulting in her emotional eating behaviour returning. This reflects Schachter's (1971) Externality Theory, which claims that emotional responses result in overindulgent behaviour.

'I tried turning to food, ye know, erm, like I used to, but it made me feel really ill after I'd eaten' (Meg, 14.287).

'Erm, but then I was eating that much of them, secretly like, 'cos me mum would have gone mad an' I suppose I thought if I didn't talk about it and no one saw it I wasn't eatin' it' (Meg, 14.294).

'I was tryin' to eat for comfort wasn't I?' (Meg, 14.298).

Discussion

The aim of this study is to ascertain whether post-bariatric patients, who have undergone a gastric bypass, receive enough aftercare, particularly by way of psychological support. Bariatric surgery has been rated as one of the best treatments for obesity (Weineland et al. 2011), resulting in significant amounts of weight being lost and helping to cure medical comorbidities. It has been reported that gastric bypass patients lose on average 50% of their weight within the first twelve months following surgery (O'Brien et al., 2006): therefore, it is not surprising that bariatric surgery has become a necessary option for obese individuals.

Two female participants who had had a gastric bypass were interviewed, and the research gathered uncovered an array of findings, which have previously been of interest to other researchers. The following four themes emerged through interpretative phenomenological analysis: Lack of psychological support, Identity, Social eating, Emotional eating.

The most prominent theme in both transcripts was the lack of psychological support both participants experienced post-operatively. According to the National Institute for Health and Clinical Excellence (NICE, 2010), an initial assessment is required, ensuring that the individual is motivated and determined, with a deep understanding of the need to change their lifestyle and eating habits. However, evidence from the transcripts and the literature disagree with NICE (2010), arguing that the initial assessment is non-existent. Ogden et al. (2005) argue that there is evidence that quality of life, positivity in mood and improvements in general health are enhanced post-operatively, which was initially the case for both participants; however, Batsis et al. (2009) argues that positive experiences are short lived, as when weight loss slows down, positivity is weakened and negative feelings return. This is exactly what happened to both participants.

McMahon et al. (2006) argue that it is imperative that the individual receives the necessary help and support in order to succeed, and in support of this, Welbourne and Pournaras (2008) argue that the key to long-term weight loss is ensuring that health professionals make every attempt to keep patients informed of the risks concerned with; reverting back to their old eating behaviour, the consumption of certain foods, and that they should incorporate exercise into their new lifestyle. However, as lack of psychological support was the most prominent emergent theme throughout both transcripts, it appears that the necessary help and support for success was not received. In agreement with these claims, Ogden et al. (2011) reported findings that patients are unprepared for changes to their body and lifestyle, and more importantly they feel unsupported by medical professionals when they leave the hospital. This offers an explanation for why feelings of confusion are repeatedly reported throughout the interviews by both participants. Saltzman et al. (2005) argue that in order to achieve success, patients require multidisciplinary care and psychological input, which they believe is not as yet being incorporated adequately in patient aftercare. They also argue that guidelines set by NICE (2010), stating that obesity treatment should be undertaken by a multidisciplinary team incorporating psychological support before and after surgery, are not being met, and more importantly are missing from weight loss packages provided by both the NHS and private clinics.

Identity emerged at the start of both transcripts. The participants both talked of issues around how they look, how difficult it was to be accepted in society due to obesity, and not feeling as though they could live their lives. This can be explained using Social identity theory, as obesity is not in keeping with social ideology, so it is not surprising that obese individuals experience social isolation and feel ostracised (Strauss & Pollack, 2003). Recent research has indicated that obese individuals withdraw and internalise negative feelings directed at them from the 'in-group', and more importantly they accept the negative stereotypes that are attributed to them associated with obesity, and accept that they are the 'out-group' (Greener et al., 2010). Obese individuals' psychological well-being, quality of life and self-esteem can be significantly harmed as a result of stigma and discrimination attributed to them from society (Puhl & Heuer, 2010), and this can be seen in both participants' transcripts.

The lack of psychological support post-operative allowed negative feelings about themselves to return, only this time, both participants were full of confusion as they attributed any issues they had to their weight, and once the weight was lost and the issues remained, a vast amount of confusion occurred. The identity transition appeared to be rather difficult for both Jen and Meg, and they both argue that they were not prepared for the changes that they would experience. Jen had not psychologically caught up with her weight loss, she was obese for over eighteen years, her figure returned, and these feelings were hard for her to absorb and deal with. Therefore, psychological support post-operative was necessary for their well-being and necessary for them to accept their new identity.

According to Bayer (2008), there can be positive outcomes to stigma and discrimination towards obesity, because suffering this negative behaviour could inspire changes in eating patterns. Latner et al. (2009) agree, arguing that negative associations towards obesity could result in people being motivated to engage in weight loss activities. Triggle (2010) believes it is acceptable to administer shame to obese individuals; however, both participants in the present study would disagree and argue that feelings of shame and guilt have resulted in them feeling ostracised and overeating. Research by Greener et al. (2010) is also in complete contrast to the above suggestion by Triggle, as they found that obese individuals withdraw and internalise negative feelings. Therefore, labelling them is not going to encourage participation with public health activities, and based on evidence from the transcripts, both participants had suffered enough negative behaviour and nothing positive can come out of it.

According to Lewis et al. (2010), this is what prevents individuals from engaging with public health messages relating to obesity, and as a result, health-promoting activities are rejected. These negative feelings were experienced by both participants, and as they felt left out and that they did not fit into society, it is inevitable that they will not engage with such activities, reinforcing these negative feelings. Meg especially experienced these feelings post-operative, as she was refraining from going out again, therefore, support at this stage was necessary, and could have encouraged motivation, enabling engagement in weight loss activities, and enabled her to adapt back into society.

Another interesting emergent theme was social eating. The participants' eating behaviour differed significantly depending on whom they ate with. Jen talks about her

eating behaviour pre-operative, and states she will not eat in front of friends or less familiar people, but will eat excessively in front of her sisters or on her own. Whereas, Meg, pre-operative, is continually influenced by what her mother eats and follows her mother's eating behaviour. Meg will eat excessively in front of her mother and on her own, but like Jen, not in front of anyone else. Jen does not suggest that her sisters discourage her from eating: therefore, she eats to excess because she is comfortable in front of them. Jen also eats in private, therefore avoiding any social cues that may deter her from eating. As both participants eat with family or alone, there is no risk of leaving unfavourable impressions, which Vartanian et al. (2007) argue can be used to prevent overeating. This type of eating behaviour resulted in both participants overindulging, resulting in obesity, therefore, support post-operative could have prevented both Jen and Meg from trying to return to their old eating habits.

Herman et al. (2003) were interested to see whether eating with others could serve as an indicator of what is acceptable and what is excessive. Meg's eating behaviour can be associated with this model, as she mimics her mother's eating behaviour, and as this is mostly done in private, there are no social cues as to what is acceptable or excessive. Meg's eating behaviour can go either way, depending on her mother's influence, thus reinforcing the theory that influential behaviour can result in the increase or decrease of food consumption (De Castro, 1990).

The final emergent theme is Emotional eating, and both participants display an array of emotional eating habits throughout their transcripts. The more negative emotions the participants experienced, the more episodes of overindulgent eating behaviour occurred. The main emotions displayed were stress, boredom, loneliness and feeling ostracised, and these emotions were present in both participants' transcripts. Schachter's (1971) Externality Theory incorporates emotional responses to overeating and can be witnessed in both participants' transcripts pre-operative and more importantly post-operative. Interestingly, when both participants' experience negative feelings post-operative, they both try and return to their old eating habits, therefore, psychological support is essential to help them change their behaviour. Bruch's (1973) theory of eating behaviour argued that individuals could overeat as a result of internal states, such as depression and stress. As a result, these internal states can be misinterpreted as hunger signs: therefore, if the individual is experiencing high levels of such internal states, they are more likely to misread the signs and overindulge.

Antelman et al. (1975) found a connection between stress and eating behaviour in their early study, and Greeno and Wing (1994) supported these findings later in a review relating stress to eating behaviour. However, Connor and Armitage (2002) argue that stress affects everyone differently, and not everyone suffering from stress overeats, and it should therefore not be generalised that overeating is attributed to stress.

The first strength of the present study is that semi-structured interviews were conducted, allowing the participants to lead the direction of the interview and thus ensuring that the data collected was not subject to research bias. A further strength of this study is that it allowed the phenomena around bariatric surgery, obesity and why obesity is increasing to be explored, gaining a rich understanding of each participant's worldview by allowing them to tell their story freely.

A limitation to this study is that the results are not generalisable beyond the participants involved, and as it involved women only, the findings cannot be applied to men. Therefore, future studies could benefit from using both female and males. Another limitation was that it only looked at the gastric bypass procedure, and there are another three types of weight loss surgery that could be incorporated in future studies.

Only semi-structured interviews were used. It could be argued that the use of a single approach to collect data is a limitation: therefore, if this study were to be repeated, it would benefit from incorporating triangulation. Incorporating an additional method could highlight different themes and/or reinforce the original themes.

As the researcher, I conducted and transcribed the interviews myself, and then analysed the data incorporating IPA: therefore, the study is subject to my personal biases and interpretations, which will be discussed in greater depth in the section on reflexivity.

Reflexivity

The majority of my degree was based around quantitative research, and I thought that it would be beneficial for me to explore a research area that I was unfamiliar with. I was particularly interested in gaining a deep understanding of the participant's life world by attempting to access an inside view, by employing a questioning and empathic hermeneutics. As the participant tries to make sense of their world, I try to make sense of the participant trying to make sense of their world, employing a double hermeneutics.

While the process of preparing and writing a dissertation has been lengthy and demanding, it was also pleasantly rewarding. I kept a diary of my feelings throughout, as I wanted to make entries about my feelings before the interview and after. This allowed me to reflect on the whole process at a later date with the view to improve my technique and reduce bias. I re-read my entries before I conducted the second interview, and when I made further entries, I could see that my technique had improved, allowing me to approach some areas in a more confident manner.

As I prepared myself for my first interview, I experienced an array of feelings, mostly apprehension mixed with anxiety. I believed I was well organised for my qualitative journey; however, unfortunately, my interviews had to be rescheduled twice, due to unforeseen circumstances. As a result, my anxiety levels heightened and I questioned my own ability to conduct the interviews effectively. This was an unnecessary concern, as my participant was relaxed, honest and comfortable, and I embraced her attitude and quickly began to feel the same. As I was preparing to start the interview, she began to disclose some serious events that had happened throughout her childhood. I felt the only way to deal with this at the time was to try and bracket off in my mind what she had said to me so I could conduct the interview effectively. It also made me believe she felt comfortable talking to me and hopeful for an honest and in-depth account of her experiences.

I left the interview with increased confidence and a good understanding of my participant's life world. I listened to the recording several times, and once transcribed,

I re-read it several times in order to try and identify any prominent themes before analysis. I also recognised that in order to delve deeper, I could incorporate more wording, such as 'Can you tell me more about that?' and 'Can you explain your feelings and or experiences?' I made a list of changes that I would make to my interview approach and I familiarised myself with this before the second interview.

Conclusion

In conclusion, this research was interested in the amount of psychological support offered to individuals who have undergone bariatric surgery, specifically a gastric bypass, with the aim of gaining an understanding of whether there is enough post-operative psychological support. Semi-structured interviews were conducted, with the view to gain enriched data, allowing each participant to tell her story freely. The interviews were transcribed verbatim, immediately after recording, to retain familiarity with the interview and the participant. IPA was then used for analysis, in conjunction with the interview style, as the two approaches complement each other.

It is apparent that the evidence gathered via the interviews and literature provides an answer to the research question, arguing that there is not enough psychological support following bariatric surgery. The transcripts of both participants persistently argue that there is not enough psychological support, and no help to prepare for lifestyle and eating behaviour changes. The four key themes that emerged from the transcripts are lack of psychological support, identity, social eating and emotional eating.

One of the main issues around obesity is its cost to the NHS, and as obesity is rapidly becoming a worldwide public health problem, it is inevitable that the costs will rise significantly if it is not addressed. Bariatric surgery has successfully contributed to individuals losing enormous amounts of weight, resulting in initial relief and positive feelings. However, as the research and literature suggests, these benefits are only witnessed short-term: therefore, additional costs will be incurred by the NHS, as the main psychological issues are not resolved, rendering bariatric surgery just a treatment to aid weight loss. Therefore, this research is extremely beneficial, as it can be repeated on a larger scale with the view to giving individuals with obesity the correct treatment, including the psychological support required to deal with lifestyle and eating behavioural changes.

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