EXPERIENCES OF FOOD AND RELATIONSHIPS AFTER BARIATRIC
SURGERY: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Stephen David Hoole

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School of Medicine
Academic Unit of Psychiatry and Behavioural Sciences

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

Introduction: Two particular areas which appear to create psycho-social tension following bariatric surgery are changes to food use and relationship dynamics. Food and eating are known to play significant roles within interpersonal relationships; however such roles after surgery are largely underreported. This study therefore aimed to explore participants' experiences of the roles of food and eating within the context of their interpersonal relationships, following bariatric surgery, along with how people might manage these experiences.

Method: A qualitative design was used, comprising semi-structured interviews with a homogenous sample of seven adult participants, recruited from a local bariatric support group. Interviews were recorded, transcribed verbatim and analysed using an Interpretive Phenomenological Analysis (IPA), in order to generate themes based on participants' lived experience.

Results: There were three overarching master themes that emerged following the analysis of data: 'Disruption to usual social eating', 'Food as a creator of conflict' and 'Food as a connector'. Disruption to usual social eating was characterised by a sense of embarrassment due to physical illness after eating. Such disruptions acted as a cue for change, with some embracing this and others resisting it. Either way there was a sense that participants tried to make the best of their new situation in a way that worked for them. The second and third master themes of conflict and connection existed on a continuum and were dependent upon the impact of and reactions to disruption. Hence, food could assume the role of being a source of conflict or a connector within relationships. Tools which seemed particularly important for managing experiences linked to this continuum were showing pride in the changes, facilitating communication through the use of humour and using food as a gift.

Discussion: The findings were consistent with literature around food being closely linked to emotion and a source of maintaining identities/social bonds. Prior to surgery it may be useful for services to offer systemic assessments for prospective patients and significant others, so that the disruption to social eating and modified roles of food can be adequately prepared for. Other group based interventions may also be considered such as programmes with a mindfulness component; these may provide people who typically resolve emotional and social distress by turning to/using food, with alternative coping skills.

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CHAPTER ONE

Introduction

Bariatric surgery is an increasingly well-known and used form of treatment for individuals with obesity and is considered to be an effective method of reducing overall body mass and improving physical health problems associated with obesity. There is a growing literature base which has investigated the effectiveness and safety of different types of surgery, and has resulted in the development of safer and less invasive laparoscopic surgery methods with faster recovery times. Research on the positive medical and physical outcomes for the majority of patients is therefore reasonably robust; however, less literature is available on the longer term psycho-social outcomes. What there is indicates some unequivocally positive psychosocial outcomes, however, there are also changes which are more challenging and create tension. Two particular areas which appear to create tension following bariatric surgery are changes to food and relationships. As will be demonstrated, outside of bariatric surgery, food and eating are known to play significant roles within interpersonal relationships; however, an area which doesn't appear to be represented in the bariatric surgery literature is how the roles of food within interpersonal relationships change post surgery and the possible implications this may have.

Literature review

Obesity: The Context of Bariatric Surgery.
Obesity is defined as: "...a term used to describe somebody who is very overweight with a high degree of body fat" (NHS Choices, n.d.). This is typically measured using a summary measure of a person's height and weight (kg/m^2) known as Body Mass Index (BMI). An individual would be considered to be obese if they fell within the 30–40 BMI range; whilst those people with a BMI >40 would be considered to be 'morbidly' obese.

Obesity poses a problem due to the many adverse outcomes linked to a person being classified as obese. There is a wealth of literature documenting the physical health implications associated with obesity including: hypertension, hyperlipidemia, sleep apnea, type 2 diabetes, cancer, stroke and heart disease (Chang et al, 2014; Buchwald et al, 2004; Reedy, 2009). There are also links to disability and premature death (Garip & Yardley,

2011); mental health problems such as anxiety, depression & suicide often linked to poor self esteem (Thomas et al, 2010); and discrimination & social isolation.

Obesity is a growing global issue which the WHO (2012) reports has doubled in size since 1980, with more than one in ten of the world's adults now classified as obese. In a recent article published in the Lancet, Ng et al (2014) estimate the UK prevalence of obesity in men at 23.4% - 25.7%, and in women at 24.2% - 26.6%. These figures support those of the NHS Information Centre, Lifestyle Statistics (2012) who had previously stated that 26% of adults and 29% of children aged 2–15 years can be classified as obese. Ng et al (2014) say that not only is obesity increasing, but there have also been no national success stories in treating it in the past 33 years. Consequently, the academic literature and popular press have dubbed the obesity problem an 'epidemic' (Buchwald et al, 2004; Mokdad et al, 1999; Fabricatore & Wadden, 2006; Le Billon, 2012).

As a result a keen focus on weight management has become commonplace both in everyday society, i.e. via commercial diet plans/exercise routines (Fabricatore & Wadden, 2006); public health guidance, i.e. through 'Managing overweight and obesity in adults – lifestyle weight management services' (NICE, 2014); and government policy, i.e. through 'Healthy Lives, Healthy People: A call to action on obesity in England' (Department of Health, 2011). Unfortunately for some, simple instructions to diet and exercise fail to provide adequate weight management strategies. In these cases, as a result of a high BMI and/or associated risk factors (Reedy, 2009), more invasive treatments are required, such as a pharmacological option known as Orlistat (NICE, 2006). The literature suggests however that both 'diet therapy' and pharmacotherapy are relatively ineffective treatments for obesity (Aarts, Hinnen, Gerdes, Acherman & Brandjes, 2014; Buchwald et al, 2004). If this were true, other than prevention, only a group of surgical interventions known collectively as bariatric surgery are left as a current viable option for the successful treatment of obesity.

What is Bariatric Surgery and who is it for?
Bariatric surgery is an umbrella term for a number of surgical procedures aimed at placing physical restrictions on the amount of energy the body can either ingest as food, or absorb as nutrients. Bariatric surgery is recommended following the failure of non-surgical weight loss interventions in morbidly obese individuals with a BMI of >40, or a BMI of >35 plus associated co-morbidities. In addition, for those with a BMI of >50, surgery is recommended as a first line option (NICE, 2006; Dent, Chrisopoulos, Mulhall & Ridler 2010). Surgery differs from weight management programs in that the amount of food that

can either be ingested or absorbed is immediately restricted, depending on the type of surgery. If surgery works as intended, this physical change can result in rapid and significant weight loss (Dziurowicz-Kozlowska, Wierzbicki, Lisik, Wasiak & Kosieradzki, 2006).

Frequency of Bariatric surgery.

Where obesity is an ever increasing public health concern, bariatric surgery is becoming hailed as a solution for treating this 'obesity epidemic'. Despite this increased prominence, surgery is used relatively infrequently, with less invasive treatments for obesity such as diet, exercise and medication being favoured as the first line options. Ahmad (2013) suggests that around 5.4% of adults in the UK are eligible for bariatric surgery, however the NHS reportedly funds bariatric operations for less than 1% of adults who can be classed as morbidly obese in the UK (The Association of Upper Gastrointestinal Surgeons, 2011), with many patients turning to the private health sector in order to access this service. This of course has cost implications to the individuals themselves of between £5000 and £15000 depending on the type of surgery opted for (NHS Choices, n.d.). As the prevalence of obesity increases however, more people are likely to investigate surgery as an 'effective' treatment for obesity, i.e. successful weight reduction with improvements in co-morbidities (Chang et al, 2014; Colquitt, Picot, Loveman & Clegg, 2009; Buchwald et al, 2004).

Types of Bariatric surgery.

Broadly speaking there are two groups of bariatric surgeries which can be distinguished according to their mechanisms of action (Brethauer, Chand & Schauer, 2006; Kerrigan, Magee & Mitchell, 2011). There are 'restrictive procedures', such as the laparoscopic adjustable gastric band; and the 'malabsorptive procedures', such as the biliopancreatic diversion with or without the duodenal switch. Biliopancreatic diversion operations are technically difficult and often lead to nutritional deficiencies. They are therefore performed relatively rarely even in the USA (Brethauer, Chand & Schauer, 2006), where surgery is more common. There is however also a third type of procedure which incorporates both mechanisms, the 'Roux-en-Y divided gastric bypass', which is used in both the UK and the USA; it is currently considered the gold standard amongst weight loss surgeries (Berends & Janssen, 2014). In the UK the 3 main procedures utilised are: the adjustable gastric band (Figure 1.), the Roux-en-Y gastric bypass (Figure 2.) and the sleeve gastrectomy (Figure 3.). The sleeve gastrectomy is one of the newer restrictive procedures which has gained popularity over recent years and can be used as both a standalone procedure, or as a pre-cursor to the full gastric bypass operation in patients whose severe

obesity makes the bypass technically difficult or unsafe (Dent, Chrisopoulos, Mulhall & Ridler, 2010).

Figure 1. Adjustable Gastric Band (Berends & Janssen, 2014)

Figure 1 is an image of an adjustable gastric band operation. In this purely restrictive procedure an inflatable silicon band is inserted laparoscopically and placed around the gastric cardia. This creates a small pouch in the stomach with an adjustable outlet that restricts the consumption of food and slows its progression through the digestive system. Because food remains in the pouch, it provides a person with the feedback of being satiated and thus limits the amount of food ingested. The band is connected to a reservoir which is implanted in the abdominal wall in order that that it can be easily accessed to adjust the inflatable band by adding or removing saline. This allows a balance to be struck between the level of restriction and the associated adverse effects (Kendrick & Dakin, 2006).

Restrictive procedures are the safest form of bariatric surgery in terms of long term complications (Shamblin & Shamblin, 1987; Hsu et al, 1998, Agius, 2014), with around 1 in 2000 deaths post operatively; a figure Kerrigan, Magee & Mitchell (2011) report as low for abdominal operations. Agius (2014) report operative mortality as being between 0.05–0.1%. Mechanical complications are however reported to arise at a rate of 11.6% and may include

outlet obstruction, band slippage or band erosion which would all require further surgery (Agius, 2014).

Figure 2. Roux-en-Y Gastric Bypass (Berends & Janssen, 2014)
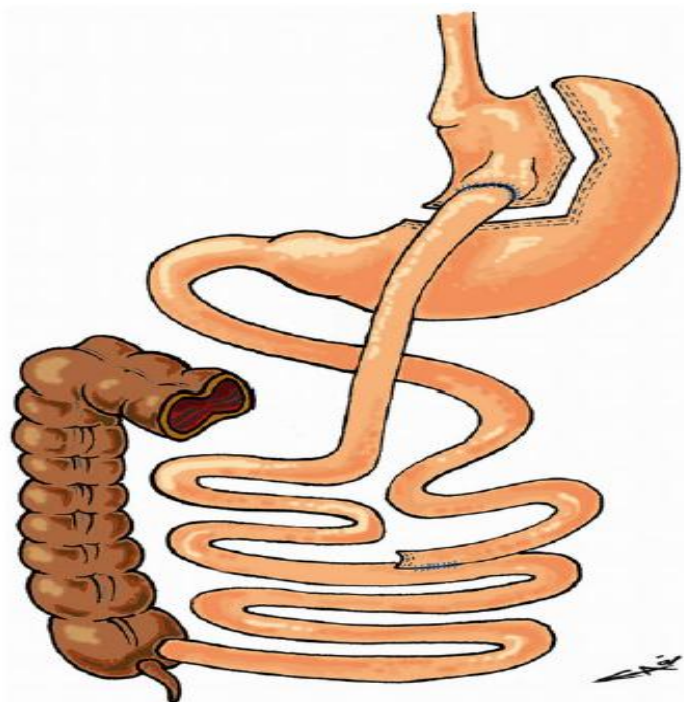
Figure 2 is an image of a Roux-en-Y gastric bypass operation which combines restrictive and malabsorptive mechanisms of action. In this procedure the stomach is surgically reduced in size, with a small pouch being created at the top (i.e. the restrictive element). This pouch remains connected to the oesophagus at one end and is connected to a Roux limb at the other, i.e. bypassing the rest of the stomach and the initial section of small intestine (i.e. the malabsorptive element). The rest of the stomach and the initial section of small intestine drain via a bilipancreatic limb that connects further down the small intestine to create the Roux-en-Y.

The risks involved with this type of surgery are higher than for restrictive procedures, with complications including anastomotic leakage, (i.e., leakage at the site where the jejunum is joined to the stomach pouch), ulcers, bowel obstruction, internal hernias, roux limb ischemia, deep vein thrombosis, pulmonary embolism and nutrient deficiencies (Hsu et al, 1998; Kerrigan, Magee & Mitchell, 2011; Agius, 2014). Anastomotic leakage, occurring in around 2 to 3% of cases, is a serious complication requiring further surgery and is the leading cause of mortality after a gastric bypass. Total

mortality rates following gastric bypass are however relatively low, with estimates lying between 1 in 200 and 1 in 400 depending on the expertise of the surgeon (Kerrigan, Magee & Mitchell, 2011). Agius (2014) report operative mortality as being up to 0.5%.

Figure 3. Sleeve Gastrectomy (Berends & Janssen, 2014)
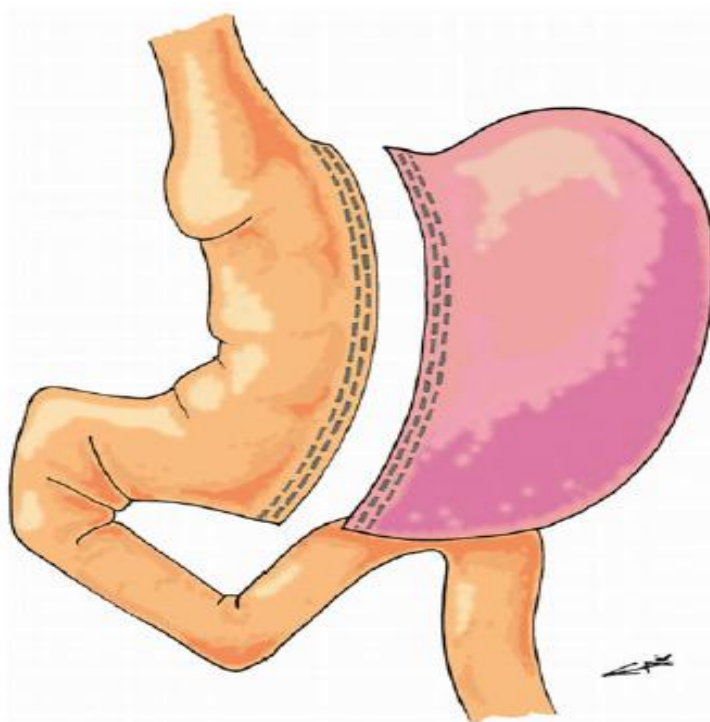
Figure 3 is an image of a sleeve gastrectomy operation. In this non-reversible restrictive procedure, surgical staples are used to resect 75% of the stomach (i.e. the greater curvature), leaving the lesser curvature of the stomach along with the antrum and pylorus. This creates a narrow gastric tube which constitutes the restrictive mechanism of action gained in a sleeve gastrectomy operation.

In terms of complications, this procedure does carry some risk of bleeding, ischemia and gastro-oesophageal reflux; however nutritional complications are reportedly rare. Agius (2014) reports operative mortality as being $0.33 \pm 1.6\%$. As noted earlier the sleeve gastrectomy can be used as a precursor to either a gastric bypass or a duodenal switch, in patients considered at more risk from these operations in the first instance.

Physical outcomes of bariatric surgery.

As indicated above, the physical outcome of bariatric surgery is dependent upon the type of surgery a person has undergone. In terms of weight loss, the procedures involving a restrictive and malabsorptive element have been found to be preferable to restrictive procedures in their own right. For example, Agius (2014) reported excess weight loss figures at five years post-operative for a number of procedures including the Roux-en-Y gastric bypass and the adjustable gastric band. The former produced excess weight losses of between 60% and 70%, whereas the latter produced excess weight losses of between 45.4% and 48%. That said the newer restrictive procedure, the sleeve gastrectomy, does appear to be comparable to the gastric bypass in terms of excess weight loss at 1 to 3 years post surgery (55% − 66%). In addition to weight loss there are also a number of other physical outcomes which result from bariatric surgeries. One such example is the improvement seen in the patient's symptoms of type II diabetes. Again there is some variation depending on what type of surgery was performed; however, the pattern appears similar to that of weight loss outcomes, i.e. the resolution of type II diabetes occurs in approximately 56% of patients two years after the gastric band, 66% of patients after the sleeve gastrectomy, and 80% of patients after the gastric bypass (Agius, 2014). Similarly improvements such as a decrease in triglycerides and total cholesterol, along with an increase in HDL cholesterol levels, were found to be greater in individuals who had undergone gastric bypass surgery, rather than gastric band surgery, at 10 years post-operative. Furthermore, non-alcoholic fatty liver disease improved the most in patients who had undergone gastric bypass surgery due to the greater weight loss seen in this group. Other examples of the positive physical outcomes of surgery are improvements in hypertension and obstructive sleep apnoea (Kushner & Noble, 2006).

Having described some of the positive physical outcomes of bariatric surgery, some of the less desirable physical outcomes must also be considered. Such physical outcomes include a condition known as dumping syndrome, which is a collection of symptoms that occur after eating carbohydrate rich foods that then pass to the small intestine too quickly, i.e. nausea, tachycardia, weakness and dizziness. Broadly speaking the more of the stomach that is removed the more likely dumping syndrome is to occur. Consequently dumping syndrome is common following the gastric bypass and may still be present following the sleeve gastrectomy (which leaves more of the stomach intact). Dumping syndrome is less likely to occur following a gastric band operation.

Nutritional deficiencies are also a physical complication of bariatric surgery, particularly procedures with a malabsorptive element such as the gastric bypass (John & Hoegerl, 2009). In bypassing the stomach and part of the small intestine, deficiencies can occur in iron, vitamin B_{12} and other micronutrients, requiring careful adherence to a supplement regimen. This is not such an issue with the restrictive procedures such as the sleeve gastrectomy and gastric band, however patients must still adjust their food consumption to ensure they are obtaining all the relevant nutrients from a significantly restricted diet.

Perhaps the most surprising physical outcome is that not all patients experience long term successful weight maintenance following bariatric surgery and some do not lose the amount of weight expected. Pories (2008) reported that such 'failure' occurred at rates of between 5-10%; however this varied by the type of surgery and the intensity of follow up, with gastric banding constituting the highest rates. At around 18-24 months post surgery some patients begin to eat larger or more frequent quantities of certain foods, without experiencing the adverse effects previously encountered post surgery. This can contribute to a plateau effect, or even weight gain (Hsu et al, 1998; van Hout & van Heck, 2009; Burgmer, Legenbauer, Müller, de Zwann, Fischer & Herpertz, 2014). This suggests that for some, the way food is perceived and used may not be lastingly changed at a psychological level following bariatric surgery. This can be highlighted by the link between obesity and Binge Eating Disorder (Leahey, Crowther & Irwin, 2008). Although binge eating to the extreme following surgery becomes difficult due to the restricted stomach size, Powers, Perez, Boyd & Rosemurgy (1999) report that most patients say they would still overeat if they didn't experience the adverse side effects of vomiting and early satiety. Furthermore, Leahey et al (2012) suggest that food cravings do not reduce to normative levels, especially for high fat and fast foods, despite surgery. This finding is supported by Guthrie, Tetley & Hill (2014), who evidenced the persistence of food cravings post surgery, finding them to be in line with those of overweight dieters. This literature therefore appears to tally with Hsu et al's (1998) findings that once vomiting and dumping are overcome, some bariatric patients can revert back to unhelpful eating habits or Binge Eating Disorder.

From a physical health perspective therefore, bariatric surgeries clearly have some significant benefits in terms of weight loss and improvements in health conditions associated with obesity. Like all operations, however, they carry risks, not only from the procedure itself but also post-operatively. Choosing to undergo bariatric surgery, for all it is

becoming more well known and even 'fashionable' in some circles, is a major life decision. It has both short and long term consequences which people must have the opportunity to consider before going ahead. Perhaps this is one of the reasons why surgery, the most extreme of the 'medical' treatments for obesity, is performed relatively rarely in the UK National Health Service, when compared to the number of people eligible (The Association of Upper Gastrointestinal Surgeons, 2011). Surgery represents just one of several medical interventions for the treatment of the complex social, emotional and behavioural construct known as obesity. It is recommended as a last resort for all but the most at risk and severely obese individuals, with a range of psycho-social interventions preferred in the first instance (NICE, 2006).

Psycho-social outcomes of bariatric surgery.

Whilst the weight loss outcomes for bariatric surgery are well represented in the literature, less is known about the longer term psychological and social outcomes of this major surgery. Older papers considering this issue such as Bocchieri, Meana & Fisher (2002a), suggested that there were consistent sub-clinical post-operative improvements in mood and anxiety, but little improvement in gross psychopathology. More recent papers have however gone further in recognising that psychological disorders are higher in bariatric surgery candidates, than in other obese individuals (i.e. mood disorders, anxiety, alcohol use and personality disorders), and that there is strong evidence to suggest such disorders improve post-operatively (Pataky, Carrard & Golay, 2011; Sierra-Murguía, Vite-Sierra, Ramos-Barragán, López-Hernández, Rojano-Rodríguez & Torres-Tamayo, 2012). The general consensus is that following surgery, patients present with an increased level of self-esteem, self-confidence, assertiveness and expressiveness which leads to an improvement in their psychological state.

Research into the social aspects of bariatric surgery also suggests that outcomes are good (Bocchieri, Meana & Fisher, 2002a; 2002b), with studies focusing on how changes to a patient's body shape elicit a more positive response from their peer group, leading to possible increases in social contacts, activities, employment opportunities and a decrease in stigmatization. To illustrate, Sarwer, Wadden & Fabricatore (2005) state that the majority of patients report improvements in marital satisfaction and sexual functioning after surgery. They go on to say that there is some evidence of an increased divorce rate in bariatric patients, however they clarify that this is thought to be the dissolution of "very poor relationships" rather than helpful, supportive ones.

There are studies, however, which paint a more mixed picture regarding psychosocial outcomes. Hsu et al (1998) suggest that some people may struggle to develop the new social skills required to cope with increased social acceptance, or may resent the change in treatment they gain from their peers as a result of weight loss. Garip and Yardley (2011) found that one of the main tensions found by obese individuals when seeking to maintain weight loss is the need for social support vs. a desire for independence. They concluded that finding the right balance between support and autonomy may help people to maintain weight loss in the longer term.

Bocchieri et al (2002b) conducted a qualitative study using Grounded Theory which explored perceived psychosocial outcomes of bariatric surgery and identified a number of tensions created (see Figure 4).

Figure 4. Schematic representation of the grounded theory (Bocchieri et al, 2002b)
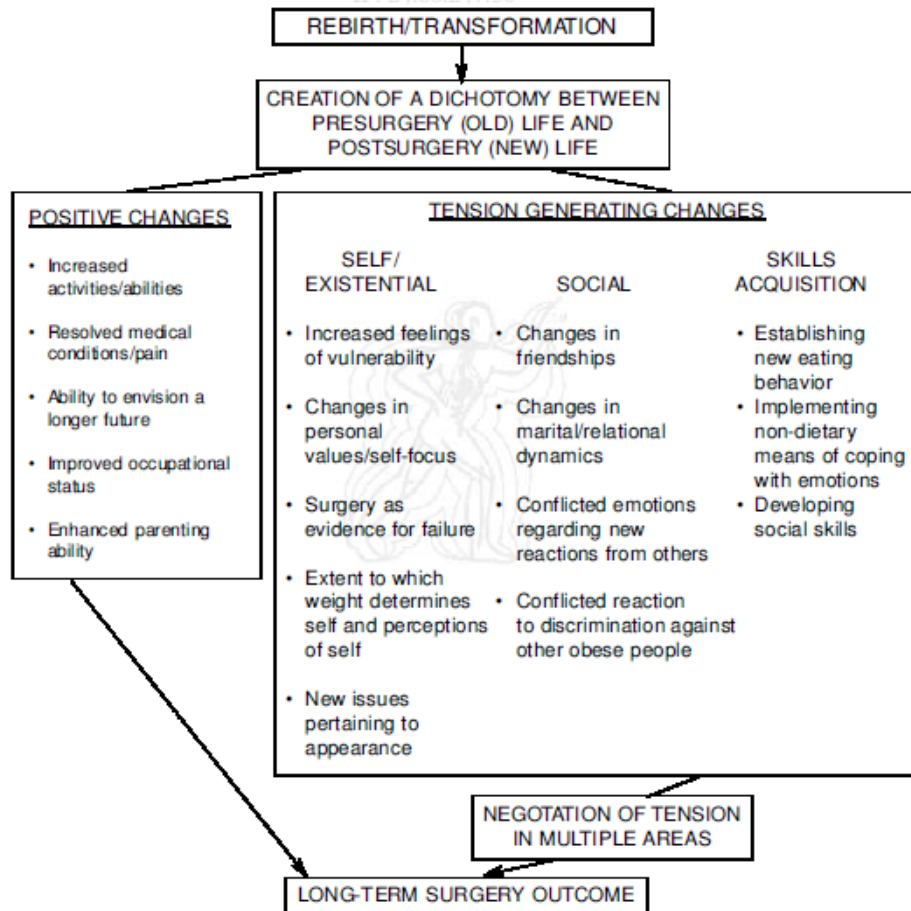
Generally speaking the model provides the reader with a broad overview of the changes a bariatric patient can expect to encounter following surgery. This appears to be the first study that offered participants the freedom to reflect upon their experiences of post-surgery life freely. As a result, both the positive and challenging aspects of having surgery were captured. This has paved the way for further research to look more specifically at particular aspects of the model, in order to begin to develop interventions aimed at improving psycho-social outcomes.

The main theme to emerge from Bocchieri et al's (2002b) analysis was that of a re-birth or transformation, which marked a boundary between pre- and post-surgery lives. From this, a number of life changes were considered to be 'unconditionally positive'; however, a greater number appeared to create tension which although not necessarily negative proved challenging. These tensions were broken down into three categories: 'self/existential', 'social' and 'skills acquisition'. In the 'self/existential' category, tensions included: increased feelings of vulnerability, changes in personal values/self-focus, issues around appearance and issues relating to self concept. When combined with the 'social' tensions of changes to friendship and family relationships, as well as conflicting emotions about other's reactions, Garip and Yardley's (2011) finding that there is a tension between the need for support and independence is emphasized. On further inspection, Bocchieri et al (2002b) also point out that due to the much reduced stomach capacity in the more common forms of bariatric surgery, social and business functions which revolve around food may become awkward. These findings therefore suggest that tension may be linked to food and, indeed, Bocchieri et al (2002b), report a tension involving the establishment of new eating behaviours and social skills, as well as new coping mechanisms for emotional regulation which are not linked to eating.

While Bocchieri et al's (2002b) model gives a good account of both the positive and negative consequences of bariatric surgery, thus allowing a picture to be painted of an individual's route through surgery and their recovery process, it tells little about the finer details of individual experience. Why food causes tension, and the possible ways in which people adapt to cope with social eating, are still unclear. This may reflect the authors' focus on constructing a general model rather than investigating specific aspects of experience, which would have been difficult to do with the volume of data generated from the large 31 participant sample. The model generated therefore gives a good overview of post-surgery life, but lacks insight into the lived experience of these radical changes to an individual's

psycho-social world, something that an interpretative phenomenological analysis might provide.

Bocchieri et al's (2002b) model suggests that negotiation of these tensions, along with the more overtly positive changes, influence the long term outcome of surgery. Garip & Yardley (2011) suggest that socio-cultural factors such as community, home, work and culture may all facilitate or support successful weight loss. They say that by reorganizing one's surroundings (i.e. successfully navigating tension) to remove environmental barriers, weight maintenance can be facilitated. Van Hout, Verschure & van Heck (2005) for example, report that a significant positive relationship exists between marital satisfaction and weight loss, with those in solid marriages finding it easier to weather the changes after surgery and those in dysfunctional marriages struggling to do so. This therefore illustrates the importance of an individual's experience of their interpersonal food contexts following bariatric surgery, and the link between successful weight management and navigating the 'tensions' evoked. This will form the focus of the present study.

Social and emotional context of food and eating.

So far this review has discussed the context for bariatric surgery, the different types of surgery that are commonly used in the UK and the implications for the patients who choose to have these types of surgery. It seems apparent that both food and relationships play a role in these outcomes, however the nature of these roles is still unclear. As the literature base specifically detailing food and eating after bariatric surgery is relatively sparse, this research took an atheoretical approach. In reality this meant that a number of theories were explored as possible explanations for how food and eating might impact upon those who choose to undergo surgery. It is likely that elements of all these theories and models (and perhaps others not considered here) play a role in people's experiences after surgery; this is a reflection of the complex nature of the role of food within interpersonal relationships. An advantage of considering this range of theories is that it highlights the complex psycho-social nature of the recovery from surgery. To date the majority of research in this area focuses on the medical outcomes of surgery, however there is increasing interest in the psychosocial outcomes. As this is a developing area however, it is worth keeping an open mind, as the underpinning psychology around bariatric surgery and its recovery is yet to be fully understood. Thus this research was situated in a broad theoretical context. A further advantage to taking this approach is that it mediated against me adopting a particular theoretical position that might have biased my interpretation of participant experiences. A

disadvantage, however, of adopting an atheoretical or multitheoretical position, is that it leaves the research open to the criticism of having a lack of focus within data collection due to less focussed interview questions. Nevertheless, the focus of the following section will be to explore the social and emotional context of food and eating outside of the bariatric surgery literature, in order to generate some ideas about the possible psychological phenomena which may be involved.

Social influences on eating.

The socio-cultural environment in which the obesity epidemic has developed has been referred to as the 'obesogenic environment' and includes both an increase in the availability of energy dense food and a reduction in overall levels of physical activity. For example, Fox & Hillsden (2007) report that there are multiple sources of 'indirect' evidence for the emergence of an obesogenic environment over the last 50 years including: fewer 'industrial' based jobs requiring physical activity, pervasive labour-saving technology advancements, changes in work and shopping patterns creating a reliance on motorised transport to travel greater distances, increased ability to obtain and store food in the home, and reductions in walking and cycling. In addition, De Vogli, Kouvonen & Gimeno (2011) found an association between an increased prevalence of adult obesity and countries with a high density of fast food restaurants, while Mela (2001) suggests that there is a link between obesity and a penchant for energy dense foods. The Foresight report (Butland, 2007) highlighted that a key challenge society faces is how to re-shape the wider environment in which people live so that any present 'interest' in healthy living can become an achievable widespread goal.

When considering this in the context of bariatric surgery, the often unexpected outcome of weight gain which can occur at around 2 years post operative, becomes a little more expected. If an obesogenic environment pervades a bariatric patient's socio-cultural context, then it stands to reason that there may be a strong pull from others toward unhelpful eating habits in order to retain pre-established relationship dynamics, once the initial effects of surgery have been navigated.

In an early study, Rosenthal & Marx (1979) demonstrated that there was clear evidence in support of an idea that one person's eating behaviour can influence that of another. They found that when a person eats with an 'appropriate model' (i.e. one who places some limits on the quantity of food they consume themselves) they seem to eat half as much food as when eating with an 'inappropriate model' (i.e. one who eats

unrestrictedly). Thus, another person may act as a social inhibitor or social facilitator for eating behaviour.

Later studies (de Castro, Brewer, Elmore & Orozco, 1990; Redd & de Castro, 1992) continued to find similar effects with regard to 'social facilitation'. For example Redd & de Castro (1992), found that people tended to eat more in group situations than when alone. The reasons for this appeared unclear but there was a suggestion that dining in a group increases the likelihood of a 'big eater' being present, thus increasing the acceptable threshold for the amount of food consumed. Of course, other explanations for this may have also have been the case, such as social dining being more pleasurable, distracting or longer lasting. In a recent paper, de Castro et al (2012) suggest that overweight individuals tend to eat greater quantities of food when away from their home environment. This could possibly be due to a 'heightened responsiveness' to 'food related stimuli', or to the rise of the afore mentioned obesogenic environment, i.e. an increase in the availability of a variety of food types in ever increasing portion sizes (Smith & Ditschun, 2009).

Herman and Polivy (2005) argue that hunger and satiety play a relatively small role in everyday eating, but rather it is the drive to inhibit eating to excess which plays the greatest role. This is achieved (or rather attempted) by implementing personal norms which are essentially situation specific rules for eating. Clendenen, Herman & Polivy (1994) demonstrated however that these personal norms can be overruled by social norms, i.e. participants in the company of others were facilitated to consume greater quantities of food than were lone diners. That said, Herman et al (2003, cited by, Herman & Polivy, 2005) also suggested that participants used social norms in an inhibitory way, to assess how much they could eat without overeating in a social situation (this may however be more than they would eat when relying on personal norms alone). Herman and Polivy (2005) emphasize this in modelling studies, whereby participants with no frame of reference for a particular situation tended to eat similar amounts of food to confederates; suggesting that intake was inhibited by and reliant upon social norms rather than hunger or satiety.

Studies have found that the relationships within a social group are also important for determining consumption. For example, eating with family and friends rather than strangers enhances the social facilitation of overeating due to less of an impetus to restrict food to create a good impression, (de Castro, 1994; Clendenen, Herman & Polivy, 1994; Salvy, Jarrin, Paluch, Irfan, & Pliner, 2007). Bevelander, Anschütz & Engels (2012) suggest that peers can 'trigger' an increase in food intake in the overweight and found that social norms

established by peers persisted over time, influencing the consumption of food in future trials. Salvy, Coelho, Kieffer & Epstein (2007) however suggest that it is in fact normal weight individuals who are more susceptible to social facilitation of overeating than overweight individuals, however this research was conducted with children rather than adults and thus must be regarded tentatively. Whether or not social facilitation has a greater effect on overweight or on normal weight people, the literature still suggests that peers may have a lasting effect on appropriate levels of food consumption throughout life. Christakis & Fowler (2007, cited by Salvy, Haye, Bowker & Hermans, 2012) support this notion; however suggest that it is more to do with a shift in the normative narrative surrounding the acceptability of obesity in general, as people see friends and family gaining weight over the years.

Herman & Polivy (2005) are also critical of the research into the social facilitation/inhibition of eating, saying that much of the research has in fact excluded dieters. Dieters, they suggest, have the personal norm of eating minimally rather than avoiding excess (although they often violate these 'restrictive' personal norms). Therefore in families, dieters may model their eating on the smallest eater in the group (rather than the largest) and thus measure their success of 'eating minimally' by eating less than that person. Indeed this still may be more than is required for a healthy energy intake and people can encourage others to eat more in order that they maintain their perception of minimal eating. In this sense social facilitation is still operating, however it is the person seeking to lose weight that is influencing others. One could hypothesise that this may well feed into a negative cycle whereby once a dieter's personal norms fail, they revert to using the social norms they have fuelled by encouraging others to eat larger quantities of food. Indeed Hermans, Herman, Larsen & Engels (2010) suggest that hunger may serve as a mediating factor in social facilitation in this case. Therefore a restrictive diet that leaves a person in a state of hunger may be more likely to result in the social facilitation of overeating.

When considering this research from a bariatric population's perspective, one can again see some potential difficulties which individuals who have undergone surgery may face socially. If individuals who are restricting their diet encourage others to eat, then it stands to reason that somebody whose diet is restricted by surgery may also encourage others to eat in order to justify an attempt to consume foods which may be inappropriate. In such cases this may make the adaptation to the influence of surgery on food and eating more difficult both personally and socially.

The above research highlights the complex nature of social facilitation/inhibition, which involves a number of different factors including: the number of people in a group, relationships within a group, whether members are overweight, and whether dieters are present. Of course, the impact that others can have on an individual's eating behaviour is far more complex than these constructs allow for. As touched upon, the status of a relationship (i.e. a friend over a stranger) plays a role in food and eating, but in addition to this the dynamic of that relationship also plays a vital role. For example, Markey, Gomel & Markey (2008) have suggested that in romantic relationships, partners can have the effect of reducing food consumption due to factors such as dissatisfaction with their partner's body when their partner is overweight. This finding only related to women who influenced male partner's weight, but nevertheless indicates that romantic relationships may be a source of support for those seeking to lose weight.

In contrast, family systems theory suggests that some patterns within family relationships can influence the development and maintenance of obesity and obesity can then serve to maintain the homeostasis of relationships. One way this may occur is through the regulation of the difficult emotional aspects of family life via eating, also known as 'emotional eating' (Walfish, 2004) which will be discussed in more detail later. Therefore a change in obesity, whereby one individual within the system rapidly loses weight due to a significantly modified diet, is likely to have implications for the wider relational context in addition to any personal implications. Perhaps then, a deeper understanding of these effects may aid the development of pre- and post-bariatric care packages that incorporate a more robust psychosocial element.

Food and identity.
Bisogni, Connors, Devine & Sobal (2002) argue that the role of food has long been recognised as a way a person assigns identity to their self and others and is dependent on factors such as ethnic identities, region, class, and family. They reported that identities related to the role of food and eating emerged as important characteristics of the person, which they say may provide health professionals with a better understanding of client predispositions to weight loss strategies. Indeed Newcombe, McCarthy, Cronin & McCarthy (2012) reported that men use eating to construct a specific socio-cultural masculine identity and suggest that this should be taken into account when promoting healthy eating to men. Bisogni et al (2002) say that: "Identities related to eating reveal what is of concern to clients, how clients organise food according to their own preferences, how they express themselves

through food, and the ways in which they manage eating situations" (Bisogni et al, 2002, p.137). Bisogni et al (2002) carried out a study designed to examine identity and eating from the perspectives of adults. They used in-depth interviews and a grounded theory approach to data analysis, in order to develop a conceptual model (see Figure 5), which sought to explain how identities are derived from and shape eating. They suggest that people hold many different types of identities related to eating and this variation results in people having individualised self identities.

Figure 5. Conceptual model for the role of eating in identity (Bisogni et al, 2002)
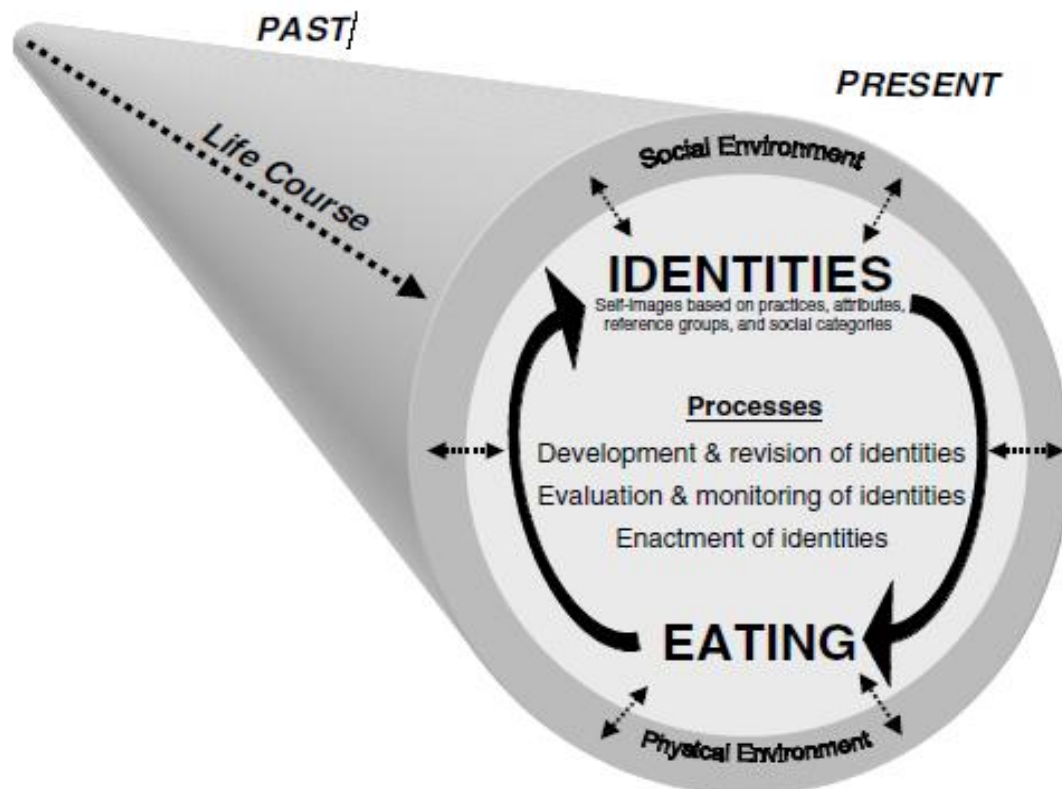
Identities regarding food clustered around three main themes in Bisogni et al (2002)'s study. The first of these was 'eating practices', whereby participants highlighted types of identities around the range of foods they found acceptable; such as being a 'picky' or 'fussy' eater. Others formed identities around the types of food consumed or preferred; such as being a 'fast-food eater'. Meal patterns, consistency of eating and quantity of food eaten were other descriptors, whereby a participant referred to themselves as a 'three meals a day person', or a 'regular' eater, or a 'hearty eater' respectively. The second main theme centred

around 'other personal characteristics' related to eating that were essential to identity. These included an orientation towards being healthy through food, food related body image, ability to control eating, satisfaction derived from eating, the prominence one assigns food, eating flexibility and physiological response to food. The last theme involved 'identities related to reference groups and social categories'. The identity descriptors here were reported to often relate to normality; that is how different an individual perceived themselves to be when compared to others, e.g. an 'average eater'. In addition, interpersonal relationships and roles were found to be sources of identities related to eating; for example, developing an identity of being a small eater after internalising others' views of you as such; or being a role model for children. Group association was also found to be a source of identity within this theme which included elements of age, gender, occupation, interest groups, and social class. It is therefore easy to see the likely profound impact of bariatric surgery as it disrupts the way food can be used to assign identity to self, others and relationships.

Three processes were linked to this conceptualisation of eating related identities and people varied in their implementation of these processes. The first, 'development and revision of identities', involves acquiring food related self-images over time and the stability or transition of these. Acquiring such identities over time involves participants individually interpreting the complex interaction of biological, psychological, and cultural aspects of food and eating. This process will therefore be influenced by many things including, previous eating practices, e.g. childhood eating experiences; life events, e.g. experience of food related health concerns; changing social roles, e.g. food and parenthood; and the current eating environment, e.g. descriptors assigned by others.

The second process is 'evaluation and monitoring of identities'. This involves the extent to which individuals would evaluate themselves by reflecting on their eating practices in comparison to reference points, such as: other people, past identities, or the type of eater they aspired to be. The third process, 'enactment of identities', involves the relative flexibility or rigidity in food related behaviours linked to identity. For some, much importance was placed on the stringent commitment to adhere to their identities within eating situations, with frustration occurring when this could not be the case. These people were often found to have the social support, time, and/or the financial resources to do this. For others, adhering to their identities was of less importance and enacting such identities was very situational, i.e. a parent adjusting their own eating identities to accommodate family eating, but when alone fulfilling them. So for bariatric patients their ability to

navigate these three processes and mobilise the necessary resilience, is likely to inform their experience of food in relationships and indeed their ultimate adjustment, post-surgery.

The relationship between identities and eating was reportedly influenced by the environment over the life course and vice versa. This is something Devine, Connors, Bisogni & Sobal (1998) had already suggested in a previous life course model whereby the 'personal and environmental forces' of: 'upbringing', 'roles', 'health', 'ethnic traditions', 'resources', 'location' & 'food system' all impacted on food choice trajectory and therefore the role of food in identity. Devine, Sobal, Bisogni & Connors (1999) went on to discuss 'ethnic traditions' in more detail and noted three important factors of: ideals, identities and roles which interact to have an impact on food choice. So the role of food is not just to create an identity for our self but also to align us to the cultural context in which we live.

Thus, eating and identity appear intrinsically linked throughout life; however this process is influenced by cultural, social and physical environments and vice versa. Food may therefore serve to draw people together in a particular environment to create shared identity as indicated by Bove, Sobal & Rauschenbach (2003) who write about the food choices of newly married couples. They report that individuals merge their 'personal food systems' to create a 'joint spousal food system' following marriage. Creating a joint spousal food system involves some level of convergence and conflict regarding food choice and is an important part of marital adjustment. Brown & Miller (2002) reported that early marital patterns in food choice persist over time, along with earlier patterns linked to childhood, as demonstrated in the attachment literature. They say that gender also plays a role in food preferences, For example, women who assumed the role of homemaker are more likely to defer to the family's or husband's preferences, whereas in a family where household roles are interchangeable between sexes, female preferences may be more apparent. Bove, Sobal & Rauschenbach (2003) report that food conflict was easier to resolve when both partners were united at either end of a diet–health continuum, i.e. when both or neither partner was mindful of the impact of diet on weight. In addition food conflict was more pronounced when partner's health and weight philosophies were inconsistent with actual food intake.

One key suggestion which resonates in the literature is that an 'ideal intervention' for weight management may include support from a person's peers in order to foster a positive environment for successful behaviour change (Garip & Yardley, 2011). This is in line with Raphael (2003) and Potvin et al (2003, cited by Hesketh et al, 2005) who argue that it is the social determinants of health that are most important for effecting change in

lifestyle behaviours. Although this research is from outside the bariatric literature one can quite easily see the relevance of it for this population. Given that support from others through shared food experiences appears so important for managing diet and weight, the acceptance of and adaptation to the forced changes that result from surgery, are also likely to be reliant on similar support. Indeed, Magdaleno Jr, Chaim, Pareja & Turato (2011) have recommended that partners be involved in the preparation for bariatric surgery in order that post surgery conflict does not jeopardise the positive changes weight loss can generate.

The roles attributed to food and eating.

The present research will look more closely at some of the themes that emerge around the roles of food within a relational/social setting following bariatric surgery. Deborah Lupton (1996) sums up the reason why it is important to consider food and relationships together in the following extract:

> **"The sharing of food is a vital part of kinship and friendship networks in all societies. The extent to which an individual is invited to share food with another individual is a sign of how close a friend or relative that person is deemed to be." (p.37)**

Lupton (1996) attests that whilst eating choices and preferences are inextricably linked to bodily experiences and physical feelings, these are not merely biological in nature but constructed or mediated by society and culture. This means that food plays more of a role than merely nourishment, and in fact has meaning in other areas of people's lives; i.e. love, hate, fear, anger, pleasure, satisfaction, desire. Lupton (1996) suggests that these feelings are: "central to individual subjectivity and the sense of distinction from others", but also allow people to manage relationships through food. Sahlins (1972, cited by Lupton, 1996) for example says:

> **"Food dealings are a delicate barometer, a ritual statement as it were, of social relations, and food is thus implied instrumentally as a starting, a sustaining, or a destroying mechanism of sociability" (p.37)**

One way in which Lupton (1996) says food is used to manage relationships is through bringing people into the same community through being members of the same food culture. The act of sharing beliefs and behaviours around food begins in early childhood where most people associate food with the family unit. Within this arena the major emotion linked to food is love, be that the tender loving feelings passed from mother to child during

breastfeeding, or the romantic love of preparing a meal for one's husband or wife on Valentine's Day. Indeed Morag Fraser (1994, cited by Lupton, 1996) argued that:

> **"Meal tables are the training grounds of a family, the community and a civilisation." (p.38)**

As is evident, the sharing of food between people inevitably involves it being used as a gift. Mauss (1990, cited by Lupton, 1996) argued that the use of gifts is an important way for people to create and reproduce social relationships within family and friendship groups. The family is the ideal place for food to assume such a role, as the giving of gifts within a family is considered an act of love or duty and not judged by the monetary value. The inspiration for using food as a gift in these contexts has been linked to the concepts of love, friendship and gratitude (Cheal, 1988, cited by Lupton, 1996), and reflects an investment of time, care and affection on the part of the giver. As Visser (1986. Cited by Lupton, 1996) notes:

> **"few gifts are as generous or as complimentary these days as the taking, on one's friends' behalf, of time and culinary trouble" (p.48)**

Indeed Lupton (1996) goes as far as saying that within families, food acts as a binding agent as well as a vehicle for expressing love. Charles and Kerr (1988, cited by Lupton, 1996) also point out that the gift of food is important for expressing affection and maintaining love and sexual attraction between partners.

As well as connecting people together, food can also be responsible for creating situations which are more challenging within a social setting. One area where this is the case is conflict which occurs between parents and children with regard to "forbidden substances" such as sweets. Lupton (1996) talks about such instances as a "challenge to parental authority" on the one hand and a marker of special events (birthdays) or broader family ties (i.e. grandparent relationships) on the other. It is easy to see how such a challenge could potentially cause problems for people who have undergone bariatric surgery, given how inextricably linked 'forbidden substances' are to predictable and regular special events like family birthdays and Christmas celebrations. In addition, a further area of potential challenge is the responsibility that comes with being engaged with other people socially through food. That is to say such relationships demand reciprocity in the making and sharing of food, which if not adhered to has the potential to be viewed highly negatively by others. Again, for individuals who have undergone bariatric surgery, being able to share the same foods reciprocally would be no longer possible and thus seems likely to be a possible source

of tension within social settings. Indeed Charles and Kerr (1988, cited by Lupton, 1996) reported that:

> **"rejection of food was hurtful, and this often provoked angry scenes or resentment" (p.54)**

Attachment & emotion in relation to food and eating.

So it appears important that people's interpersonal relationships and the role food plays within these are considered when attempting weight management, whether that is via diet control, or bariatric surgery. It can be argued that the basis for our adult relationships and the role food plays within them lies in early attachment. Anderson and Whitaker (2011) found that insecure attachment may be an unrecognized risk factor for obesity in children. Their study links eating without the associated hunger, to emotional regulation; i.e. as a means of managing negative emotions such as fear, sadness, anxiety and anger. This is consistent with the findings of similar studies (Macht, 1999; Macht & Simons, 2000). Anderson and Whitaker (2011) highlight the importance of attachment as the 'best behavioural marker' of having developed emotional regulation and suggest that insecure attachments may lead to obesity developing as a coping mechanism for poor emotional regulation. Sawkill, Sparkes & Brown (2012) offer support to these ideas by suggesting a link between poor attachment histories and using food to regulate mood in later life, which they describe as using 'food as therapy'. This further highlights that interpersonal factors are apparent in a person's relationship with food from early life and there appear to be links between eating and emotion.

Indeed this is not a new concept; Hilde Bruch (1955) is widely regarded as one of the first to identify that food and emotion are so closely linked. She writes that for some parents, feeding children can become 'overcharged with emotional significance' at the expense of other aspects of development. This can establish a precedent within family relationships whereby food is the only meaningful emotional narrative. This lays a foundation for future unhelpful eating behaviours which will give the impression of satisfaction and a relief from emotional 'tension'. Indeed, Canetti, Bachar & Berry (2002) reviewed the ideas surrounding the links between food and emotion and concluded that people classified as obese engaged significantly more in emotional eating than individuals of a healthy weight. The authors link this assertion to psychosomatic theories of obesity such as that of Bruch (1973, cited by Canetti, Bachar & Berry, 2002) who proposed that obese people overeat due to faulty hunger awareness resulting from an early disruption in the

learning process of differentiating hunger and satiation from other emotionally charged states. Canetti, Bachar & Berry (2002) also concluded that dieters engaged more in emotional eating, linking this to the restraint hypothesis developed by Herman and Polivy (1980, cited by Canetti, Bachar & Berry, 2002) who suggest that the balance between the desire for food and the effort to resist, has an impact on eating behaviour. They proposed a disinhibition hypothesis whereby restrained eaters may temporarily cease restriction due to certain disinhibitors such as: cognitions, alcohol, or strong emotional states.

Implications for a bariatric population.

Implications of this within a bariatric population become evident when the patient's identities regarding food and the roles of food are disrupted by the forced changes in eating which are created by surgery. The role of food as it was pre-surgery can no longer remain for the bariatric patient, which may create a dissonance between what they would like to use food for and what they are able to use food for. This may be particularly difficult for patients who Müller, Claes, Wilderjans &de Zwaan (2014) describe as displaying an 'emotionally dysregulated' temperament, i.e. more likely to be prone to impulsive eating behaviour and depressive symptoms. Dziurowicz-Kozlowska et al, (2006) say that for some people the rapid weight loss experienced following bariatric surgery may lead to a feeling of 'depersonalization' where the patient no longer feels fully themselves without excess weight. They go on to say that as food can no longer be used to divert attention away from stressful life experiences or act as a compensatory strategy (i.e. as a regulator or substitute for emotions), the challenge bariatric patients then face, is in understanding the mechanisms which drove this behaviour and how to compensate.

This has the potential to be extremely difficult and may have implications at a family systems level, for example when considered within Bisogni et al's (2002) conceptual model (Figure 5), it may be that the forced changes to the roles of food and eating not only have an impact on a patient's self identity, but their identity within the family system as well. Changes may therefore be viewed as undesirable or even threatening to the system around a patient and may lead to a lack of support for changes or even food being used to sabotage outcome (Dziurowicz-Kozlowska et al, 2006). Devine et al (1998) however suggest that changes may also have a positive connotation, whereby, when one family member has to avoid certain foods, it brings about a change in food trajectory for the entire household. The complexities within the roles of food in relationships following bariatric

surgery are however still relatively unclear. What are people's experiences of these types of changes? Are they perceived as positive? How do people navigate the potential social conflict evoked? These are questions which remain unanswered and warrant further investigation.

Overall Aims and Objectives

The aim of this study was therefore to explore participant experiences surrounding the roles of food and eating within interpersonal relationships, following bariatric surgery. While patients are typically well prepared for the physical effects of the surgery per se, they do not appear to be as well prepared for the longer term psychological/social outcomes or tensions that result from the physical changes. This study was therefore also interested in how people managed their experiences of food in relationships, with the view to providing some further insight into how to better prepare people for the consequences of bariatric surgery and to better understand peoples support needs post-operatively.

Research Questions

Consequently this study posed the following research questions:

1. What are people's experiences of the roles of food and eating, within the context of their interpersonal relationships, following bariatric surgery?

2. How do people manage these experiences?

CHAPTER TWO

Method

In this chapter the design of the present study will be outlined, along with a discussion of the issues considered around methodology. Following this, the selection of participants and sample size sections will precede the method of data collection and an outline of the associated ethical issues. A detailed description of the study's procedure will be presented. This chapter will end with a short description of the quality checks put in place prior to starting the study, in order to ensure validity, and a reflexive statement.

Design

A qualitative design was taken, comprising semi-structured interviews with seven participants that were recorded, transcribed verbatim and then analysed using an Interpretive Phenomenological Analysis (IPA).

Methodological Considerations

Rationale for using Interpretive Phenomenological Analysis (IPA)

Halling (2008, cited by Smith, Flowers & Larkin, 2009) writes that, "In everyday life each of us is something of a phenomenologist insofar as we genuinely listen to the stories that people tell us and insofar as we pay attention to and reflect on our own perceptions" (p.32). It follows that listening to the stories of those people who have experienced bariatric surgery and lived through the changes that result from this, would provide the most natural and accurate account of lived experience. That is, participants' experiences of food and eating since surgery and what role the meanings ascribed to these have played in their interpersonal relationships. These experiences and meanings can then be subject to the natural process of interpretation.

Smith & Osborn (2008) say that the aim of IPA is to explore in detail how participants make sense of their personal and social world through the meanings they make around certain experiences, events or states. They say that IPA is phenomenological in nature because it involves a: "detailed examination of the participant's life-world" (p.53), with a focus on the subjective perception of an experience rather than an objective statement or narrative account of what happened. This is achieved through researchers hearing a

participant's story, immersing themselves in the data, noticing emergent themes, and trying to make some sense of these using their existing psychological knowledge and skills. IPA has therefore been chosen for this research because of its focus on 'lived experience', however because IPA is a dynamic process with an active role for the researcher (Smith and Osborn, 2008), it does have some potential limitations with regard to researcher bias. Put simply this is because of two things, the double hermeneutic and insufficient reflexivity.

The double hermeneutic refers to the meanings a participant ascribes to their own experience, but also the meanings that the researcher ascribes to a participant's experience as part of a 'sense making' process. Schleiermacher, who wrote of 'hermeneutics' at the turn of the nineteenth century (i.e. the theory of interpretation), suggested that this interpretation could offer a different perspective to that of the individual. This may be used to develop a deeper understanding through comparing meanings to psychological theory and the larger data set (Smith, Flowers & Larkin, 2009). Heidegger wrote that this process cannot take place without the researcher interpreting what is heard in light of their own experiences and assumptions, or 'fore-conceptions'. Indeed right from the start, the questions asked and the way the research method is used places the researcher at the core of the research process along with all their associated fore-conceptions. Data must however still be analysed within the context of such fore-conceptions, which is possible so long as sufficient reflexivity is observed.

Reflexivity refers to the process whereby researchers reflect upon the sources of bias that exist within the research due to the knowledge, experience and beliefs of both themselves and the participant. This involves making an attempt to become as close as possible to the participant's personal world at an ideographic level whilst bearing in mind that one can never truly gain this 'insider perspective' in a complete or direct way. This depends upon, and is hindered by fore conceptions. These therefore hold the potential to interfere with the interpretive process. Making attempts to become aware of these however, goes some way to ensuring that the process is truly reflexive. That is concerned with allowing experiences to be recounted as they are, through close attendance to and engagement with the participant, as part of the 'hermeneutic circle'.

Alternative Approaches
Grounded Theory was considered as an alternative method to IPA for this study. Broadly speaking, Grounded Theory posits that analysis of the data will highlight 'categories of meaning' that can be developed into a theoretical framework from which to

base future hypotheses. As Grounded Theory has already been used to suggest that food and relationships both play a role in psychosocial outcome (Bocchieri et al, 2002b), a more interpretive method was considered preferable. Furthermore due to the complexity of interpersonal relationships and the elements which influence these, IPA was chosen over Grounded Theory so that a more in-depth understanding of an individual's experiences of food within the context of their relationships might be realised.

Discourse Analysis was another approach considered. Discourse analysis is interested in how language is used to construct resources which serve to facilitate interpersonal objectives in social interaction (Willig, 2008). This approach would therefore be useful for answering a question involving how participants adapt their discourses around food to manage relationships with family and friends following bariatric surgery. This study was interested in developing a detailed understanding of participant's experiences of food and relationships post surgery, rather than how language about food is used to influence relationships. Discourse Analysis was therefore thought to be inappropriate for addressing the aims of this study.

Thematic Analysis was also considered as a method of data analysis because of its flexibility, in the sense that it is less limited by any particular theoretical model. It has however been criticised as being: "a poorly demarcated and rarely acknowledged, yet widely used qualitative analytic method", (Braun & Clarke, 2006, p.77). Boyatzis (1998, cited by, Braun and Clarke, 2006) characterises Thematic Analysis as a tool used across different methods rather than as a method in its own right. Braun and Clarke (2006) maintain that Thematic Analysis is a method in its own right for: "analysing and reporting patterns (themes) within data" (p.79); however it was dismissed for the present research study because it lacks a focus on the phenomenology of experiences which was central to the aims of this study.

Participants & Recruitment

A local bariatric support group was identified and used for recruitment purposes. The group was open to individuals who had undergone bariatric surgery, as well as those who were considering it as an option. The focus of the meetings varied from month to month (as did attendance); however, members stayed in touch via email and social media websites. Guest speakers were invited to attend the group regularly and included surgeons, anaesthetists, dieticians, and psychologists. Some sessions were also run as open forums

where members could share their experiences of their route to surgery along with experiences of the operation, recovery and life after surgery.

I attended a number of meetings during the early phases of this research, initially with a psychologist known to the group, and later independently. The purpose of attending these meetings was to familiarise myself with the group and allow members to become familiar with me. Doing this allowed me to gain some useful service user input and we were able to make some sense of the relevance of the proposed research for that population.

Inclusion and Exclusion Criteria

All participants had to have undergone bariatric surgery at least 12 months prior to being interviewed for this study. This was to ensure that they had had sufficient time to recover physically from surgery, as well as to establish some relatively stable routines with regard to eating at the time of interview, e.g. changing from a completely soft diet once the initial healing had occurred. As the analysis that was used in the study (i.e. IPA), required a good understanding of the idiom and nuance in language, and as this is difficult to achieve through the use of interpreters, participants who were not fluent in English were excluded from the study.

Sample Size and Homogeneity

Small sample sizes are typical and indeed thought necessary in an IPA study, in order to establish a homogenous sample. Homogeneity refers to the inclusion of participants within the study for whom the specific phenomenon of interest will have a shared significance. For the present study, this refers to individuals who have undergone bariatric surgery and who are past the physical healing stage, so their focus will be on integrating changes to food into their daily lives and relationships. As a result the rich detail of the experience can be the focus of addressing specific research questions, rather than the data constituting a more descriptive account of generic stages of recovery/change following surgery. Homogeneity allows convergence and divergence within similar experiences to be examined in detail (Smith, Flowers & Larkin, 2009). As a result of this small sample, any claims made following analysis of the data are limited to the studied group; however Smith, Flowers and Larkin (2009) suggested that through theoretical generalisability, readers can evaluate the evidence in relation to their own professional experience and knowledge in the area. For a professional doctorate thesis, Smith, Flowers & Larkin (2009) suggest between 4 and 10 interviews as an appropriate dataset.

Participants consisted of a homogeneous sample of seven individuals (six women and one man), who had undergone some form of bariatric surgery and who were at least 12 months post-operative. A seventh female expressed an interest in participating initially, however she did not complete a consent form or make further contact regarding the study. An eighth female also expressed an interest, however did not fulfil the requirement to be 12 months post-operative and was thus excluded from the study.

Data Collection & Materials

Focus groups or dyad interviews involving bariatric service users, friends and family were considered as methods of gaining an understanding of how food and eating are experienced within the context of interpersonal relationships following surgery. However, as the goal of this study was to investigate an individual's subjective experience of food and eating within their family and peer relationships these ideas were dismissed. One reason for this was that interviewing a group or couple generates a collective narrative of experience rather than an individual and subjective one. Although this has the use of highlighting group process it tells little of the lived internal experiences which bariatric patients have around food and eating within their relationships. In addition to this, the development of focus groups or dyad interviews were thought to be outside the bounds of what was possible to achieve as part of a doctoral thesis; requiring more resources and time than was available. A further option for achieving the goals of this study could have been to use online bariatric group blogs or forums as a means of data collection, from a large and diverse sample. This would not however have provided the richness of data seen in more lengthy interviews with a smaller sample or allowed a detailed analysis of individual experiences.

Individual semi-structured interviews were therefore decided upon as the most appropriate approach to data collection. Semi-structured interviews equip the researcher with the flexibility to ask a range of open and closed questions aimed at gathering the data required to address the research aims in the subsequent analysis; whilst also allowing rich accounts of participant experiences to develop within the interview (Smith, Flowers & Larkin, 2009). A semi-structured interview schedule (Appendix VI) was developed from the following topic areas:

- Significant others in participants' lives.
- Experience of food choices, cooking and dining.
- Experience of socializing with food.

- Influence of food and eating on relationships.

- How such experiences compared to pre-surgery experiences.

- Experience of feelings about the above topics and any means of coping employed.

- Anything else participants wanted to add.

The interview schedule was piloted and refined with input from members of a qualitative research support group; the schedule was designed as a guide and it was anticipated that I would respond to and encourage the development of the stories that participants chose to share. Indeed, Smith, Flowers & Larkin (2009) say that because the participant is the 'experiential expert' on the topic, "they should be given much leeway in taking the interview to 'the thing itself'". As a result the exact questions and follow up questions varied somewhat between participants. When constructing the questions I tried to ensure they were free from my own fore-conceptions regarding theory and assumptions. I made conscious efforts to keep the schedule atheoretical in nature so that the participants were able to express their experiences as freely as possible within the research context. However, I needed to find a balance between participants talking primarily about food and relationships, and about all the other aspects of their post-surgery experience. In order to achieve this, participants were read a statement orienting them to the particular area of interest (see procedure below).

Ethical Approval

An application was made for NHS ethical approval as participants were recruited to the study through a support group which meets on NHS premises. Members of this group are also either past or current bariatric service users. A Proportionate Review Sub-Committee gave a favourable ethical opinion in a letter dated 22nd August 2013 (Appendix IV), with the only condition being to obtain NHS Research & Development (R&D) approval. This was granted in a letter dated 17th October 2013 (Appendix V).

Ethical Issues

Informed consent and withdrawal

Obtaining fully informed consent was addressed through the client information sheet (Appendix II) and consent form (Appendix III), which detailed the rationale and purpose of the study. Participants were given the opportunity to read this information and ask questions about it prior to giving consent. Participants were informed that they were free

to withdraw from the study at any time up until the point where their interviews had been transcribed. Prior to this, if a participant were to have withdrawn consent, any information held about them would have been destroyed. No participant asked to withdraw from the study.

Confidentiality and storage of data

In order to maintain confidentiality and protect the identities of the participants who took part in this study, pseudonyms were assigned to each participant. Furthermore, all data gathered as part of this research were anonymised, which involved reading through each transcript and removing or replacing any information pertaining to names, ages, locations, or employment. Quotes from individual participants were omitted from the study if any information within these appeared capable of revealing the identity of the participant.

All audio data gathered was stored securely on the Leeds University servers until the completion of the project, after which they were destroyed. Anonymised transcripts and consent forms will be stored securely in locked filing cabinets at the Leeds University Doctorate of Clinical Psychology Research Office for three years; in accordance with Leeds University policy.

Study Procedure

Following the initial service user involvement in the design phase of this study, an invitation for potential participants (Appendix I) was disseminated at a support group meeting by the group coordinators. They also posted it on the group's social media site and e-mailed it to group members. Contact details were included in the advert. Information sheets and consent forms were left for potential participants to take if they wished, and a return freepost envelope was included. Potential participants who didn't already have information sheets and consent forms from the support group meetings, were provided with these after they made contact via the details in the invitation letter. On receipt of completed consent forms, participants were contacted by email or telephone; any questions about the study were answered and interviews were arranged. These were predominantly at the participant's own home; however one participant requested to be seen at a local university site, and another in a hospital outpatient meeting room. Interviews took place between December 2013 and February 2014.

Interviews were audio-recorded by a digital voice recorder. Each interview started with the statement from the beginning of the information sheet. Although this statement may

have served to cue participants towards focusing on the topic of interest, thus becoming a potential source of social desirability bias, the benefit was that it orientated them to the very specific set of experiences which this study was designed to explore, rather than giving them free rein to discuss all aspects of their recovery:

"Food and eating can play a very important role in some people's relationships with the other adults in their lives (i.e partners, friends & relatives). Activities such as food shopping, cooking, and dining are activities that can be shared with family and friends. Bariatric (weight loss) surgery not only changes what and how much people eat; it can have an impact on their relationships with others because of the required changes to eating. I would like to talk to you about your own experiences of such things, and what has happened as a result".

The interviews were then guided by the semi-structured interview schedule (Appendix VI) and lasted between 52-77 minutes. All participants were given the option of withdrawing from the study again and reminded that after interviews had been transcribed and the data were anonymous, it would no longer be possible to withdraw consent.

Transcription

Interviews were transcribed verbatim, including notes of all significant non-verbal utterances, pauses and hesitations (Smith, Flowers & Larkin, 2009). All interviews were transcribed by experienced transcribers sourced through Leeds University. All transcribers were asked to read and sign a confidentiality statement (Appendix VII). I listened to each recording with transcriptions in front of me several times, making necessary amendments and corrections as and when required. This process also allowed me to immerse myself in the data.

Data Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the transcripts generated from the semi structured interviews. In IPA, interviews are transcribed verbatim and the resulting transcripts analysed to identify emergent themes or patterns, which are then clustered together into 'sub-ordinate themes', and eventually into 'super-ordinate' themes, and 'master themes' following a group analysis of all transcripts (Biggerstaff & Thompson, 2008; Smith, Flowers & Larkin, 2009).

Smith, Flowers and Larkin (2009) provide detailed guidance on analysis in IPA and this was used as the basis for analysis in this study. The recommended steps include:

1. Reading and re-reading each transcript.
2. Initial noting down of anything of interest within the transcript (Appendix IX).
3. Developing emergent themes, i.e. looking for connections and patterns between exploratory notes (Appendix IX).
4. Searching for connections across the emergent themes, i.e. how do the themes fit together (Appendix X).
5. Moving to the next case, i.e. repeating the procedure for each transcript.
6. Looking for patterns across cases.

Following step four I wrote an initial pen portrait for the participant whose transcript I had just analysed. In choosing to write the pen portrait at that point, i.e. whilst immersed in the data, I was better placed to situate the participant's experiences within the wider context; incorporating the demographic information gathered and my impressions of the participant from reflecting throughout the analysis.

Validity and credibility

An important consideration for the researcher whilst using a qualitative methodology such as IPA, is to ensure quality pervades the whole process. Yardley (2000, cited by, Smith, Flowers & Larkin, 2009) offered four principles for assessing such quality in qualitative studies: sensitivity to context, commitment & rigour, transparency & coherence, and impact & importance. In order to provide the reader with some ability to judge the validity of the present research the following steps were taken from the outset:

- Situating participants in the wider context: Through the collection of brief demographic information and reflections on each participant's interview, pen portraits of each participant could be constructed to give the reader a context in which to place the analysis of data.
- Research methods training: I attended an external IPA training workshop in addition to the core training in qualitative research methods delivered as part of the Leeds Doctorate in Clinical Psychology. This allowed for a more in-depth consideration of IPA, broadening my knowledge and skill in using the approach for data generation and analysis.

- Research supervision: Regular meetings with research supervisors were used to discuss the progress of the research, including discussions around the process of analysis.

- Credibility checks: Meetings with both my research supervisor and peers (through attendance at a qualitative research support group) were used to specifically check coding of transcripts and emergent themes.

- Transparency: This was achieved through a clear description of data collection and analysis and through the inclusion of direct quotes from participant transcripts to support the themes identified during the course of analysis.

- Reflexivity: A reflective journal and the use of memos were used to construct reflexive statements and enhance personal reflexivity regarding possible fore-conceptions, whilst engaged in the process of data collection and analysis.

Reflexive Statement

I am a 28-year-old married man with no children. My wife and I cook and eat together on a daily basis; however she does the majority of food shopping. We also regularly share food with both my wife's family and my own, who all live within an hour's drive. Broadly speaking my wife and I also have joint friends with whom we socialise on a regular basis. This usually involves some degree of eating; be that in restaurants, cooking, or being cooked for. I therefore consider food to be an important aspect of my social world, and thus came to this research with an interest in finding out more about the implications of bariatric surgery in this area.

I come from a working-class family whose social mobility has now placed them within a middle-class setting. Whilst growing up, food was a valued commodity both for providing sustenance and energy for a father working in a manual role as a fitter; but also as a means of communicating and bonding as a family unit around the dinner table. My mother's (and grandmother's) provision of food was also a means of demonstrating love and affection for family members, whilst eating and enjoying the food reciprocated this. The norm was therefore large portions of rich, hearty and filling foods, inherited from a prior working-class generation of the family. The transition from large portions of traditional, filling foods did not however occur at the same rate as the family's transition into a middle-class setting; whereby my father found himself in a more sedentary management role. Therefore within my family, being overweight and subsequently using various forms of weight loss (mainly diet plans), was seen as a relatively normal occupation. Using such

strategies however disrupted the process of using food as a means of expressing love and affection as it meant different family members eating different foods. This appeared to lead to a 'yo-yo' dieting culture where a family member would lose weight, but then 'fall off the wagon', and move back in line with the rest of the family. Weight management difficulties therefore became part of the family dynamic during my childhood, with most members of the family falling into an 'overweight' BMI category at different points in time. The origin of my interest into the way food is used within relationships therefore comes from my early childhood experiences and family dynamics. The research questions and interviews however, will have been shaped not only by this prior interest, but also to some extent by the literature reviewed in the initial stages of this research.

My own experiences with food and weight management have mirrored my family's dynamic. I am for example aware that I use food for comfort and to manage anxiety; traits I recognise in my parents. Furthermore I recognise that I use food to share love, affection and togetherness; not only within my own family and friendship group, but also within my marriage and my wife's family. I have continued to struggle to manage weight as an adult; however, have had success through the use of exercise and diet plans (i.e. Weight Watchers). My BMI therefore fluctuates between being classed as 'healthy' and 'overweight'. It is at its most stable when my wife and I are engaged in diet plans together. I am therefore aware that whilst I share some of the experiences of struggling with weight management, I have been able to maintain weight within certain parameters. I was therefore mindful of exhibiting care when imposing my own interpretations on participant's experiences, as they may have had very different reasons for their own weight management difficulties. Nevertheless it is likely that my own experiences will have influenced my interpretation of the participant's experiences and thus the themes identified in this research.

In addition, I am currently in the 3rd year of a three-year doctoral training course which will lead to the qualification of Doctor of Clinical Psychology. This is my first research project using qualitative methodology. It became apparent early on, i.e. during the development of my research questions, that the language of qualitative and quantitative research is quite different. As such I had to remain mindful throughout this process of the influence that my past experiences of quantitative research would have on my adhering to the strict principles of an IPA study (i.e. a focus on the participant's subjective experience). In addition to this I am also a clinician within the NHS, with my area of interest being psychodynamic therapies. Intervention within psychodynamic therapies involves

interpretation as its mainstay. I am therefore aware that this tendency to interpretation will have had an impact in both the data collection phase of the research (i.e. in terms of my behaviour in the interview) and on the initial stages of the IPA analysis which requires a researcher to become immersed in the data prior to any interpretations being made.

CHAPTER THREE

Results

In order to situate the findings of this analysis within the wider context of participants' lives, I will first provide a pen portrait for each participant. I will then present the group analysis in the form of a thematic map (Figure 6) and indicate the frequency of each theme across participants (Table 1). Following this I will provide a detailed exploration of each theme in turn, with accompanying quotations from participants' transcripts. This chapter will end with a further reflexive statement in order to ensure transparency and quality.

Pen Portraits

The construction of these pen portraits was undertaken following the analysis of each participant's transcript. The information in each pen portrait comes from information offered by participants during the course of interview, brief demographic details gathered following interview and my own reflections throughout the interview process.

Angel.

Angel was a fifty-two-year-old female who reported having had a gastric bypass operation approximately 18 months prior to taking part in this study. Angel reported having lost six stone at the point of interview, with associated improvements in her pre-existing physical health conditions of arthritis and type II diabetes. Angel was married to her second husband whom she lived with and had a daughter from a previous relationship, who lived elsewhere in the country. She identified her husband and various friends as being the most important people with whom she shared food.

Angel appeared to have had a relatively positive experience of adapting to changes to food. Much of the interview with Angel focused on her friendship groups; she reported that most friends had understood and accepted the changes to food, after she educated them and allowed them to witness her being ill from something that 'didn't work'. One particular friend however, with whom she was close as a child, could not reportedly understand why Angel had had the surgery, saying that she herself could never have it because of all the food that would be wasted when ordering a meal out. Angel talked about being cautious with

what she ate in social settings, so that attention would not be drawn to her because of the pain she experienced. This meant eating noticeably smaller portions. To adapt, Angel talked about enjoying providing food for others at home saying she got a 'buzz' from this. In addition to friends, she also talked about her husband, saying that he had been very understanding throughout the whole process. She spoke fondly of how her husband found it rewarding to find foods that she could eat, even in the early stages after surgery. Despite the support offered by her husband, she said that in the early days he kept asking if she was okay when around other people. This served to highlight the fact that some foods made her sick which caused some upset to her daughter on one particular occasion. Not causing other people to be upset was something that Angel mentioned throughout the interview and it appeared that although she wanted people to understand the impact of her surgery on the foods she could eat, she did not want them to feel put out or upset when she couldn't eat something they had made for her.

Angel was extremely keen to talk to me about her experiences which meant that I found the interview an enjoyable experience. My perception of Angel was of somebody who loved life and was extremely pleased to have had the opportunity to improve it via bariatric surgery. It was evident that she had access to some extremely supportive relationships and that food was very much still a part of these. I noticed that Angel was somewhat anxious during the interview however, which on reflection I felt was to do with ensuring she gave an accurate and detailed account of her experiences so that others might be helped from her involvement in this study.

Alan.

Alan was a fifty-one-year-old male who reported having had a gastric bypass operation approximately 2 ½ years prior to taking part in this study. Alan reported having lost nine stone at the point of interview, with his diabetes being much improved and requiring minimal oral medication to be successfully managed. Alan had been married for over thirty years and had two children and two grandchildren. Alan reported that he lived with his wife and that his grandchildren also lived with them most of the time. He identified his wife and grandchildren as being the most important people with whom he shared food, along with his friends at the Freemasons.

Alan appeared to have had a relatively positive experience of adapting to changes to food, however described his route to surgery as a fairly traumatic one. He told me that prior to becoming obese he worked as a trainer in the army and reported having been very sporty

and physically fit. Upon leaving the army Alan reportedly continued to keep fit until an old knee injury flared up preventing him from doing this. He had to wait a long time for an operation on his knee, eventually opting to privately fund this through money obtained via the Freemasons. At the same time Alan said he was suffering profoundly from his diabetes and was being overmedicated with insulin. Alan said he began gaining weight rapidly which led to him being classified as obese. Doctors and family were reportedly extremely concerned for his future and Alan told me that he had become severely depressed. He spoke about being supported by his wife and GP to prepare for the surgery and that again the Freemasons came forward to pay for it. Alan seemed to have a strong sense of duty to stick to the rules regarding his new diet in order to honour the commitment the Freemasons had made in paying for his *"life-saving"* operation. Following surgery Alan's relationship with his wife appears to have been a key source of resilience that has helped him navigate his post-operative journey. Alan reported that since the operation his relationship with his wife had improved steadily, especially their sexual relationship. Maintaining relationships appeared to be of the utmost importance for Alan, which meant that whilst he did all he could to nudge his wife toward his modified diet *"for her own good"*; when she resisted this, he did not force the issue into open conflict. Instead he picked his battles and focused the majority of his attention on the positives, such as being able to regularly influence healthy eating through his own cooking.

My experience of Alan was that he had thoroughly embraced a healthy lifestyle following bariatric surgery and was extremely keen to tell his story. Although this made interviewing Alan interesting and enjoyable, it was also a challenge to keep him on task at times. He appeared extremely thankful and relieved that others had offered him encouragement and support throughout his journey, thus allowing him to adapt but remain part of social and family life. As such my sense is that Alan became involved with this study due to a strong desire, and possibly a perceived duty, to give something back and to aid others in taking similar steps.

Carrie.
Carrie was a fifty-nine-year-old female who reported having had a gastric bypass operation approximately 3 years ago. Carrie reported having lost thirteen stone at the point of interview and said that she was continuing to lose two–three pounds per week. Carrie spoke about being readmitted to hospital soon after surgery due to an ulcer that had been previously obscured by fat tissue. Other than this she reported no post-operative

complications and no other physical health issues. Carrie told me she was married when she had the surgery, however at the point of interview she was separated from her husband and in a new relationship of around a year. Carrie had three children, two of which lived close by along with her three grandchildren, whilst one lived elsewhere in the country. Carrie identified her local daughters and grandchildren as the most important people that she shared food with, eating with them weekly.

In addition she spoke about her new partner and her work colleagues, particularly in the context of having to prove to them the validity of her new eating style. Carrie was able to identify surgery, and the changes she had made as a result of it, as a source of personal pride and achievement. However, her journey to this assessment appeared to have been an emotionally challenging one. She spoke of her initial lack of understanding of what to expect from surgery with regard to food changes and appeared to have been unprepared for the impact of this on her emotional health and social relationships. She reported that she initially resisted the changes and felt as though her two daughters, who had been involved in all aspects of the surgery and post-operative life, were being cruel by making her stick to the new food regime. Whilst cognitively, she reported realising that their help was for her own good, she said her experience of this was persecutory initially, i.e. whilst her own understanding of the consequences of bariatric surgery was limited. Once Carrie was living the experience of post operative life however, and she slowly became more comfortable with what this meant for her eating, she reported becoming much more able to accept her daughter's help and began to negotiate eating experiences with them in order to ensure a sense of shared enjoyment. Once she had learned this, she also began to share her learning and teach others about making their own changes to food and eating, i.e. her grandchildren. The ability to be open and honest and teach people about how things were for her was reportedly a huge change from preoperative life and one she was increasingly proud of. Indeed Carrie was able to refine this and deliver it to her work colleagues in order to help them understand and accept her; although the process of doing this was lengthy and could be frustrating due to resistance and disbelief.

Carrie appeared to be extremely happy about being a part of the study and was extremely warm and welcoming. My experience of the interview was very positive. My sense of Carrie was of someone who had struggled to come to terms with the consequences of surgery after being psychologically underprepared for these pre-operatively. Prior to surgery, Carrie described herself as an extremely passive person and I wondered whether

she had avoided engaging psychologically in the preparatory processes of bariatric surgery; instead deferring to her daughters' judgements of what would be best for her. It therefore seemed that her personal journey post-surgery had been a difficult one, but that ultimately her daughters had acted as a source of great support for her, facilitating understanding and acceptance. On reflection I wondered whether Carrie's motivation for volunteering for this study was about sharing her discovery that it was all 'for her own good' so that others might be able to avoid some of the emotional consequence of being underprepared.

Alice.

Alice was a fifty-three-year-old female who reported having had a gastric bypass operation approximately 6 ½ years ago. Alice reported having lost a total of eleven stone at the point of interview, with significant improvements in her physical health. Before the surgery Alice had been in constant pain, which was the catalyst for seeking to lose weight. Alice was married and lived with her husband, identifying him as the most important person with whom she shared food. She also spoke about sharing food with her daughters.

Alice appeared to have had a difficult experience of adapting to changes to food following surgery. She did not regard her pre-operative eating to have been the main contributing factor for seeking surgery; rather she reported a family propensity for rapid weight gain that led to her entering into a cycle of pain, inactivity and then weight gain. Following surgery therefore, the requirement to modify her eating behaviour appeared to have been difficult to come to terms with, especially as it marked her as different to others and thus something other than *"normal"*. Alice spoke about adopting a strategy of keeping the required changes to food out of public knowledge in order that her anxiety around not being *"normal"* was hidden. This however had been a challenging endeavour, as her husband would tell people about the surgery in an attempt to help. Her daughter struggled to manage her emotions regarding Alice's new eating regime and subsequent rapid weight loss. This made feeling *"normal"* very difficult for Alice. She spoke of how embarrassed and angry she had felt, ultimately resulting in social withdrawal. The loss of social eating resulted in extreme stress on Alice's relationship with her husband, from whom she eventually separated for a period of time. She told me that the period of separation allowed her to take stock and realise that neither of them had been open and honest about their feelings surrounding the changes to food and eating. Alice recounted how, through communication and openness, they were able to work through this period of separation. Despite this, Alice was still struggling to do the same in social settings. She told me about

how she would avoid social eating situations, lie about her eating style, or use her family as allies to deflect attention away from her in social situations.

Alice appeared to have struggled with adapting to eating post operatively and this had been compounded by some quite challenging reactions from her close family. My sense was that although she was beginning to adapt, her anxiety of not being *"normal"* had lingered in other social settings; the ideas of openness and communication had not yet reached these arenas. As such, I was aware of a sense of internal conflict within Alice about sharing her experiences within the interview. In fact I was somewhat surprised once the interview had begun, that Alice had decided to volunteer to be a participant. This was because she often said that she did not like being questioned about food and eating; it was *"nobody else's business".* I wondered whether she consented because of the perceived safety of the research setting and my status as a researcher and clinician. Additionally, as had been the case for other participants, Alice spoke about a desire to help others who were considering opting for bariatric surgery. It was perhaps this which inspired her to take part. I was extremely grateful that she took this decision.

Tracey.

Tracey was a thirty-eight-year-old female who reported having had a gastric bypass operation approximately 2 ½ years prior to taking part in this study. Tracey reported having lost twelve stone nine pounds at the point of interview. Although Tracey had no physical health difficulties at the time, she reported having been ill post-operatively and having to go back into hospital to have her gallbladder removed. She also experienced nerve damage as a result of the gastric bypass operation and explained that she was off work for twelve weeks whilst she recovered physically from this. Tracey was in the process of separating from her husband at the point of interview, following the relationship breaking down post-surgery. Much of the interview therefore focused on the other important people in Tracey's life with whom she shared food, namely her mother and friends.

Tracey spoke about how difficult her separation from her husband was, especially given that they had decided upon and navigated the journey through surgery together, only for the relationship to break down because of the consequences of surgery. There appeared to be some anxiety around other people's capacity to understand and accept the changes she had to make, which likely stemmed from the loss of such a key relationship. Indeed, Tracey spoke about avoiding situations where she would have to eat with people who weren't aware of the changes. Tracey reported that sharing food with her mother was the most important of

her post-operative experiences as her mother had had a similar operation when Tracey was a child, but for different reasons. As a result she said that a shared understanding and acceptance was quick to form between mother and daughter which strengthened their relationship. Tracey's attachments to close others provided her with a safe base from which to build her confidence back up with regard to food and in turn allowed her to help others understand. Although eating for comfort was no longer possible for Tracey, she reported enjoying cooking for others because this allowed her to retain food as a source of comfort on some level. Additionally, retention of old food values appeared to help Tracey manage some of the internal conflicts she had around integrating her *"new normal"* into her social life.

Tracey appears to have had a mixed experience of surgery and its effects on food and eating. The breakdown of her marriage was an extremely challenging experience for Tracey and appears to have had some influence over her struggle to adapt to the necessary changes to food. On the other hand her strong relationships with her mother and friends, and their willingness to embrace the changes to food, appear to have allowed Tracey to retain food as a central part of her relationships with them. Her decision to have bariatric surgery was therefore not one she appeared to regret. Once again, Tracey seemed to take great pride in flying the flag for bariatric surgery with people who were interested to learn; this may have inspired her to volunteer for this study.

Polly.

Polly was a thirty-eight-year-old female who reported having had a gastric bypass operation approximately 13 months prior to taking part in this study. Polly reported having lost around eleven and half stone, however she also experienced some post-surgery complications requiring additional surgery in order that food was able to pass through her system without being overly restricted. She also told me that she had her gallbladder removed to prevent further complications from gallstones. Polly indicated that she worked in a management role and lived with her partner and son at the point of interview; she identified these as the most important people she shared food with. Additional important people in Polly's life were her auntie, cousins, niece, nephews and friends; with whom she also shared food.

Polly spoke about how her family and partner initially did not want her to have surgery, however accepted her decision after witnessing the growing physical health problems she was living with. Polly reported that she had experienced increasing pain in her knee joints, to the point where it interfered with her daily life. After taking the decision to

have surgery, Polly reported putting on quite a lot of weight in the lead up to the procedure; however since the operation she had maintained a relatively tight control over her food and eating. In order to manage both her own and others' emotions surrounding food changes, Polly spoke about using humour and encouraging others to do the same. This humour appears to have moderated the emotional exchanges within her relationships and allowed her to be transparent about her food needs, the physical consequences of eating and the emotional impact of the changes to food and eating. Consequently Polly appeared to have had a relatively positive post-operative experience, managing to retain food as a social connector and as a source of pleasure.

My experience of Polly was of someone who had thoroughly embraced the changes to food post-operatively and successfully integrated them into her social world. As a result she appeared to be enjoying life with the people closest to her. Polly was extremely keen to talk to me and appeared to have a good understanding of the nature of the data I was trying to elicit; as such the interview was concise and the shortest of the seven.

Mary.

Mary was a forty-nine-year-old female who reported having had a sleeve gastrectomy operation around three years prior to taking part in this study. Mary reported having lost ten and a half stone at the point of interview. Arthritis and pain in Mary's knees were the main drivers for seeking bariatric surgery. She explained that she initially wanted the gastric bypass, however due to problems with her bowels this was not possible and a gastric sleeve operation was instead performed. Since surgery Mary had had a further operation on her bowels to rectify the problems. Mary indicated that she was married, with adult children and a number of grandchildren of various ages. The most important people Mary ate with were her husband and her sisters-in-law, as they all shared family holidays together.

During the interview Mary spoke about how she had struggled to accept the loss of her old eating style after surgery. She stated that food was extremely important to her for moderating her mood state and its loss resulted in what she described as depression. She also reported becoming angry and resentful of others ability to enjoy food in her old eating style, conveying that this led to the loss of friendships and the deterioration in her marital relationship. Due to the strength of the marital relationship however, her husband was able to be frank and open about the need for change, which acted as a catalyst for just that. Nevertheless Mary highlighted some concerns regarding the possible destructive nature of

conflict within relationships, which led to her avoiding social eating to some extent. Mary spoke about deriving pleasure and comfort from cooking for others, preferring to do this than allow people to cook for her. Mary told me that she recognised her use of food in this way as excessive, buying and cooking far more food than necessary in order to give it to others.

During this interview I was aware that Mary might be called away to work, however this did not appear to distract her from the task in hand. She presented as friendly and enthusiastic, keen to be involved in this research, making the interview interesting and enjoyable. My sense was of a woman for whom food was of vital importance to both her physical and psychological survival. As such adapting to food changes post operatively had been personally challenging for her, as had integrating food socially.

<div align="center">Results of the Group Analysis</div>

The analysis highlighted three master themes:

1. Disruption to usual social eating
2. Food as a creator of conflict
3. Food as a connector

'Disruption to usual social eating' appeared to have a place in both 'Food as a creator of conflict' and 'Food as a connector'. The latter two master themes were situated at the ends of a continuum which appeared sensitive to the level of perceived disruption and the management of this. Figure 6 consists of a visual representation of the group analysis in the form of a thematic map. In the thematic map, master themes are coloured red, super-ordinate themes are green and sub-ordinate themes (that were considered particularly important), are blue:

Figure 6. Thematic map of master, super-ordinate, and sub-ordinate themes following a group analysis.
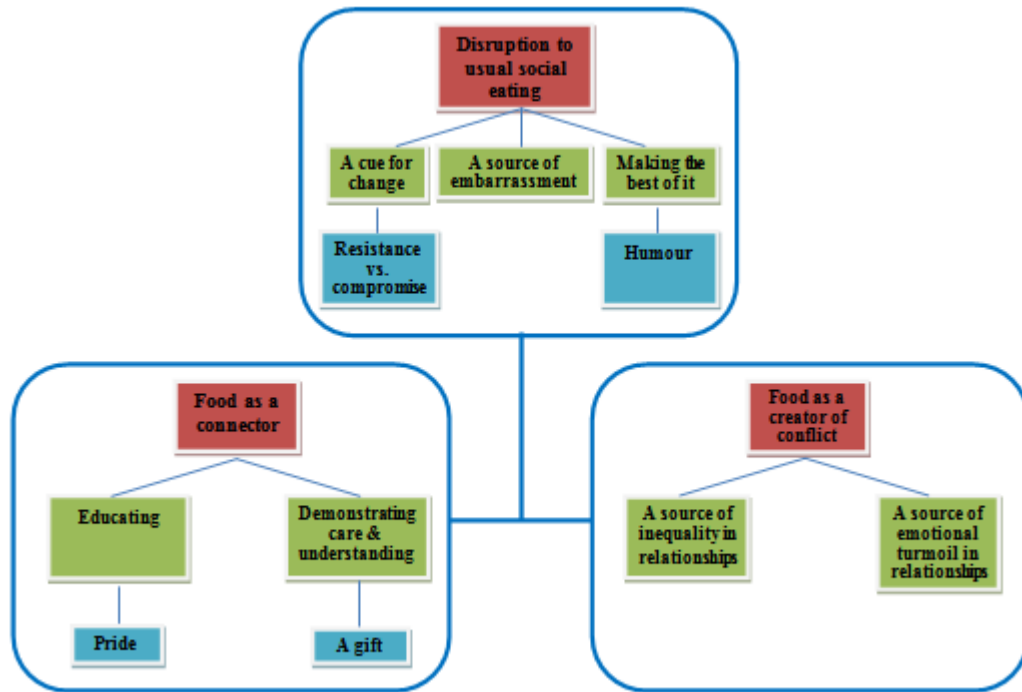
Participants spoke about a disruption to their usual social eating routines, typified by food becoming a source of embarrassment due to the physical consequences of being ill post surgery. Participants went on to talk about how this disruption acted as a cue for change with some embracing this and others resisting it. Either way there was a sense that participants tried to make the best of their new situation in a way that worked for them, often relying on humour to facilitate this. Depending on the participants' reactions to and the impact of such disruptions, food could become a source of conflict within relationships or could assume the role of social connector, to differing degrees. Participants spoke of how such disruptions led to food becoming a source of conflict within their relationships. This conflict was characterised by inequality within relationships and the emotional turmoil generated by such major changes within the food dynamic. Participants also however spoke about new ways of connecting with people through food, i.e. through educating others about the changes or by demonstrating/receiving care and understanding. Tools which seemed particularly important for connecting to others were showing pride in the changes and using food as a gift.

Table 1. Frequency of themes across participants

Master theme	Super-ordinate theme	(Important Sub-ordinate theme)	Angel	Alan	Carrie	Alice	Tracey	Polly	Mary
	A cue for change	(Resistance vs. Compromise)	x(*)	x(*)	x(*)	x(*)	x(*)	x(*)	x(*)
Disruption to usual social eating	A source of embarrassment	-	x	x		x	x	x	x
	Making the best of it	(Humour)	x (*)	x(*)	x(*)	x(*)	x(*)	x(*)	x(*)
Food as a connector	Educating	(Pride)	x(*)	x(*)	x(*)		x(*)		x
	Demonstrating care & understanding	(A gift)	x(*)	x(*)	x(*)	x	x(*)	x(*)	x(*)
Food as a creator of conflict	A source of inequality and relationships	-	x		x	x	x		
	A source of emotional turmoil in relationships	-	x	x	x	x	x	x	x

Table 1 illustrates the frequency of themes across all seven participants, which emphasizes the representativeness of participants' experiences in all master themes ('x' = presence of theme; '(*)' = presence of important sub-theme). I will now move on to discussing each master theme in turn, using direct quotations from participants' transcripts for illustration.

Disruption to usual social eating

The overarching master theme, as evident across all the data, was that of a disruption to participants' abilities to socialise using food/eating following bariatric surgery. This theme referred to the changes to food and eating that occurred as a result of surgery which meant the participants, who had undergone this procedure, could no longer eat certain types of food; eat to the same extent; nor at the same pace as the people around them:

"In, in the sense that … when we're sat down together… you don't always eat the same meals because em… sometimes the meal that she might want, it, it'll be something that I can't eat. Em and … if, if she wanted fish and chips

tonight, she could have fish and chips tonight and bring it home and I, I would get a tin of soup out and have a tin of soup." (Alan: Lines 148 – 52)

Participants experienced this as disrupting to their usual socialising, which appeared to be important in their lives for a number of reasons. For some, adapting to the way food could be used in socialising with others post-operatively proved challenging:

"I felt a bit socially alienated because I couldn't join in the fun, as soon as I ate a little bit of it, I'd had that much to drink, full, I just brought it all back up again." (Mary: Lines 75 – 6)

In a similar vein, others found the loss of typical ways of sharing food with others a frightening experience:

"Cos it was scary not eating with them as a family, as a unit and eating on my own." (Carrie: lines 432 – 3)

When considering the experiences of all seven participants, the master theme could be split into three super-ordinate themes: 'A source of embarrassment', 'A cue for change' and 'Making the best of it'. The ways in which participants experienced these three super-ordinate themes, appeared to have links with the extent to which food was experienced as a connector or source of conflict within their relationships. For example, disruption leading to social connection can be illustrated by the following extract from Angel's transcript:

"we used to go out drinking and then we'd go for a curry, erm and I don't tend to do that anymore, but that's not a bad thing. I have them here, I'll put a buffet on which means I can nibble at things so I feel like I'm doing exactly what they are doing" (Angel: Lines 16-19)

Whilst disruption leading to social conflict can be illustrated by the following extract from Polly's transcript where she is talking about sharing a meal with her husband who was eating too fast and threatening to finish the food before Polly had had her fill:

"Erm... I suppose it made me... I don't know really. It made me a little bit cross that he'd forgot that… I, that that's how it, that's how it is for the rest of my life. That's how I have to eat. And I think sometimes he forgets himself." (Polly: Lines 96 – 98)

So disruptions to the usual ways food and eating were practised by participants, had an impact on the way their relationships with other people were experienced and managed. This is illustrated by the following three super-ordinate themes.

A source of embarrassment. This super-ordinate theme typified participants' experiences of disruption to food and eating within their relationships post operatively. It refers to the more difficult aspects of the participants' experiences of consuming food in a social setting and their bodies' potential responses to doing this. One of the major sources of embarrassment for participants was being physically ill in the company of others following the consumption of food:

"I'd have just been mortified, I mean people would've understood, there wasn't, there wasn't one person at the [event]*, at the* [event] *that didn't know that I'd had surgery and they may not have known all the ins and outs but most people were aware that you know, sometimes I can get, it can upset me can food, but it was just like, I just didn't want it, I just wanted to thoroughly enjoy the day, which I did, and not have to run to the loo and be ill, you know"* (Angel: lines 353 – 8)

A further source of embarrassment for some participants was that food marked them as something other than 'normal' when eating in a more social setting; for example Alice spoke about other people questioning her about her new eating style:

"I would find it rather embarrassing because I don't want to answer them sort of questions, I've got past that stage now, I don't need it again. I am so past that stage. They all know me as I am now, and if they start asking questions [sigh] I don't know what - apart from saying I don't eat a lot - what other reasons would I give?" (Alice: Lines 473 – 76)

"everything else about me is normal, so to speak, and I tend to try and keep it that way" (Alice: Lines 594 – 5)

Feeling embarrassed about deviating from 'the norm' was also evident when Tracey talked about going into restaurants and only being able to order/eat a starter portion as a main course:

"It, it, you just feel, well I don't, how do I feel when I'm in there? You just, I guess stupid because you don't want to draw attention to yourself while you're there and the very last thing that I want to do is explain to some random person that I don't know, I've had to go through all this and I can't come in to your restaurant and eat normal food." (Tracey: Lines 191 – 95)

The threat of food as a source of embarrassment therefore seemed to nudge participants toward a tendency to conceal their post-operative experiences of food and eating from the people around them, albeit to different degrees.

A cue for change. This super-ordinate theme captured participants' experiences of food and eating as a signal for some form of change within interpersonal relationships. The realisation that food required change in relationships created unexpected internal conflict in participants as they often had to facilitate change through complete openness, despite having to cope with the personal physical effects of food and eating post-surgery:

"it was erm a bit of a pain to begin with, realising that I was gonna have to placate everybody and make sure they realised it wasn't them" (Angel: Lines 227 – 9)

Whether change occurred smoothly or was more difficult for participants was dependent upon the nature of communication within their relationships. Some participants were able to recognise the value of openness in managing the relational changes cued by food:

"just makes it easier for him to understand what I'm going through. Telling him how I felt … you know… I remember… just feeling so low and I don't know why I felt so low at the beginning. Em… you know but he were always there and I don't know if he always understood. You know I don't think it's, it hasn't

changed me as a person at all. A lot of people say it changes you and it breaks relationships. It, it hasn't. It hasn't changed our relationship at all. I don't think, well I don't think it has anyway. Em… but yes I think about being open and honest with each other." (Polly: Lines 488 – 94)

In doing so, disruption to typical social eating, although challenging for most, was experienced as a process; being different to others facilitated the working through of changes in order to move back in line, to some extent, with family and peers:

"It's fine now, I'm honestly over that now and I'm over, I'm over going out really as well, I've just got used to being socially, I don't not socialise but I try put myself into different social situations where I do different things socially than I used to do, whereas at one time I wouldn't have minded going to the pub and then going out for a meal and, but I just don't do that now, but I'm ok to do that because I'm happier with who I am as a person than I was when I were fat, so I'm…I'm quite happy with that now." (Mary: Lines 89 – 95)

This process of working through and modifying typical food-based social activities was however not an easy experience for some. Indeed, Alice struggled appearing different to others regarding food; navigating the disruption to typical socialising had been a real battle for her:

"It wasn't until after the surgery that I basically, we stopped going out, because there was no point, we weren't going out to eat, I didn't drink, what was the point of going out? So we got ourselves into a bit of a rut where for four years, a whole four years, we never went out on a weekend at all, we never went on holiday, we never went out." (Alice: Lines 376 – 80)

For some participants then there was a reluctance to communicate openly about the changes to food, which made them much harder to implement. In the following extract Mary was talking about how she ignored the cues food was giving her in favour of retaining a typical social eating style:

"I felt a bit like a bulimic really, I were eating it because they were all 'ooh have you tried this, have you tried this?' so I were having a taste and then going and be sick to get rid of it" (Mary: Lines 665 – 7)

So disruption to social eating had the effect of being a cue within relationships, for change to occur. An important sub-theme within this super-ordinate theme was 'resistance vs. compromise' which could be seen throughout the data. The balance between resistance and compromise, was reflected in the nature of communication between participants and their significant others. In those participants for whom resistance appeared to dominate, communication and therefore change was more difficult. However for participants who were able to strike a balance between resistance and compromise within communication, the change process was facilitated:

"I think he was surprised that I'd told him not to ask (laughs) how I was and I think I did say something like 'that doesn't mean to say you can't ask me ever, just not in this situation', erm and he just hadn't thought about it, he hadn't thought about how it made me feel then having, and how it made them feel, he just hadn't put that together, I mean no, he was ok with it then" (Angel: Lines 307 – 11)

Making the best of it. This super-ordinate theme captured participant's experiences of managing the disruption to usual social eating within interpersonal relationships. To a certain extent this theme acted as a bridge; allowing some acceptance of the changes to occur, despite food acting as a source of embarrassment in relationships. One way in which this was possible for some participants, was for them to focus on the benefits afforded others by their changes to food and eating post operatively. The most striking use of a focus on the benefits could be seen within Alan's interview:

"when they're eating it as well you're thinking "oh well at least they're eating healthy food instead of… burgers or meat or whatever" and stuff like that so I suppose, yes, it gives you some satisfaction knowing that they're turned a bit healthier by you … so they're inadvertently asking for this sort of food and they then eat it" (Alan: Lines 319 – 22)

By far the most important aspect of this subtheme however, was participants' ability to maximise the effectiveness of their interpersonal communication through the use of humour. Humour was present across all seven participants as a way of tempering the difficult emotional responses to food and eating which occurred within their relationships following bariatric surgery. Using humour appeared to provide a vehicle for safely discussing and experiencing what would otherwise have been extremely anxiety provoking and possibly destructive changes within social eating settings. This theme was highlighted by Tracy in the following extracts:

> *"It's never gonna be the easiest thing in the world but yeah, it, I think joking about it puts them more at ease that 'ah I'm not worried about it so don't you be'"* (Tracy: Lines 527 – 9)

> *"I think once you've got the joking thing then if it happens again it's a case of I think they then kind of joke with it, it's like 'oh that again?'"* (Tracy: Lines 545 – 6)

In summary, participants experienced a disruption to their usual social eating following bariatric surgery. This was typified by a sense of embarrassment regarding the required changes to food, which prompted participants to concealment. The disruption also however acted as a cue for change which, in spite of embarrassment, facilitated some level of working through the changes socially. This working through however required a balance to be struck between resistance and compromise in relationships, which made the process of change easier or harder depending on the balance struck. One way participants managed this disruption to social eating was to make the best of it by focusing on the positives and using humour as a vehicle for communication. Participants' experiences which made up the master theme 'disruption' and the ways in which they managed these, influenced the extent to which food acted as a connector or a creator of conflict in relationships.

Food as a creator of conflict

The second of the three master themes identified was food as a creator of conflict. Food as a creator of conflict was a theme that captured participants' experiences of food being a source of disharmony within their relationships with other people; in other words food served to create social conflict. This conflict was evident in participants' stories about their experiences of not only coming to terms with the radical shift in food and eating

behaviours themselves, but also in living alongside family, friends and relatives who inevitably had to make their own changes. Conflict or relational disharmony was therefore, for some, part of the process of change within relationships, ultimately leading to stronger connections, acceptance and understanding. For others however conflict was much more punitive and put incredible pressure on the continued existence of their relationships. Anxiety, guilt and anger all characterised participants' experiences of this master theme. As can be seen in Table 1, all participants appeared to display some elements of food as a creator of conflict within social relationships, even those who had broadly positive experiences after surgery. This reflected the sense in which connection and conflict exist at two ends of a continuum.

Two super-ordinate themes 'A source of emotional turmoil in relationships' & 'A source of inequality in relationships' were identified as making up the overarching master theme of food as a creator of conflict.

A source of emotional turmoil in relationships. This super-ordinate theme captured participants' experiences of how the changes to food and eating generated strong emotional reactions within their interpersonal relationships. This was characterised by feelings such as anger, guilt and anxiety. These strong emotional reactions could be a source of conflict within relationships when food and eating were viewed as a burden, or when people were unprepared for these changes psychologically.

The two main feelings which appeared to be linked to food being a burden, and thus creating conflict, were guilt and anxiety. Carrie highlighted this sense of guilt in the following extract:

"I felt as though I had let them down again, because I'm on my own and they're eating there and she probably feels as though she's erm, I don't know what the word is... teasing me cos they're eating and I'm not and it's making me feel uncomfortable. But I said it doesn't make me feel uncomfortable cos I've had summat to eat, before I come here." (Carrie: Lines 435 – 9)

In addition to guilt, Polly also highlighted the anxiety aspect of food being a burden:

"So we got something to share… and he forgets, cos he eats really fast. I can't eat fast anymore. And he forgets. And I'm thinking (laughs) "I'm sat there and he's stuffing it down." And I'm thinking "Oh there's going to be none left for me then." (Laughs) because I have to eat really slowly. And I had to say something to him" (Polly: Lines 52 – 5)

Being unprepared for the changes to food and eating following surgery was also a source of emotional turmoil within relationships, characterised by the feelings of anger and anxiety. Anger and conflict are often synonymous with one another, so it is unsurprising that feelings of anger related to food played a role in social conflict following bariatric surgery. Anger was indeed found to be evident within a conflict between Alice and her husband, whereby he would answer for her if others questioned Alice's new eating style. Ultimately this was down to being unprepared for social eating situations:

"it wasn't until we split up that I started opening up and talking to him and telling him what the problem was. I just found I couldn't, I didn't want to talk to him, he should know, basically. I just thought he should know what I'm going through. He's there with me all the time. But obviously he didn't and we never communicated. So, it just took something drastic to get us to talk." (Alice: Lines 76 – 81)

Indeed, for some participants, the experience of conflict as a result of unpreparedness was a real source of threat to the relationship:

"we nearly did split up because he couldn't understand how I felt, and he didn't understand, I was missing food so much, it were like being an addict and being withdrawn, he just couldn't get over how it changed me" (Mary: Lines 259 – 62)

More common however, were participants' experiences of unpreparedness leading to some anxiety within relationships. This appeared to be a potential source of conflict for some:

"I felt quite resentful actually, for a time, because I like my meals hot, er, but I did it for her because I didn't want her upset." (Alice: Lines 347 – 8)

For others, the resultant disharmony within the relationship often appeared to be part of the process of working through to social connection. This was illustrated in Tracey's interview:

> *"I instantly started dumping, so I was being violently sick, the room was spinning, the usual dumping syndrome things, and she just, I think she was shocked and quite, obviously never seen it happen before, was quite worried"* (Tracey: Lines 57 – 9)

> *"I'm never allowed chocolate again if I'm with her, she'll make sure that I don't do it."* (Tracey: Lines 44 – 5)

So although there was evidence of conflict in all participants' experiences, this was not necessarily a negative; indeed for most it led to strengthened connections. Perhaps the difficulty lies not in the conflict itself, but in how an individual and their close others manage this conflict. Managed well, conflict can be a facilitator of change and can strengthen relationships; managed poorly it can be a source of real inequality and relationship breakdown.

A source of inequality in relationships. This super-ordinate theme captured participants' experiences of food being used within relationships to engender inequality. That is to say, food not only marked people as different due to the disruption to usual eating, but was used by others to emphasise this difference in a punitive way. One way in which this occurred was through perceived oppression, which some found a frightening experience:

> *"It was very scary, it was cos we thought we were being victimised, you know, eating pureed food instead of us going back to us normal thing."* (Carrie: Lines 365 – 7)

For others, this sense of feeling less than equal within their relationship generated an angry response. For example, Alice spoke about her husband using her food and eating as a discussion point with others which made her incredibly angry:

"It just felt as though he was trying to take over me, and trying to explain things to people on my behalf, and just take over from me, as though I wasn't there, you know, just something to be discussed. I don't think he did it on purpose, but it really used to wind me up." (Alice: Lines 60 – 3)

Participants also spoke about how food became a source of conflict within their relationships if a culture of criticism and rejection existed within these relationships. For example, whilst Angel's post surgery experience of food in relationships was largely positive, she did speak about one particular friend who found it difficult to accept the stark differences between the two women with regard to food and eating. Her experience of this friend was that she was critical and rejecting of Angel's 'new normal':

"I didn't even eat half of it, and she went 'I could never have your op' and she's a big lass, she went 'I could never have your op', she says erm 'the waste of money, all that food there' and actually made me feel (laughs) really awful" (Angel: Lines 443 – 6)

Participants' experience of being criticised and rejected was therefore incredibly difficult emotionally and made the disruptions to food and eating much more challenging for participants to navigate:

"I felt degraded and I felt as though nobody believes what I'm doing. Erm and how can I show it by just showing 'em the portions?" (Carrie: Lines 695 – 6)

For some participants, the resulting inequality and conflict associated with criticism and rejection within relationships, ultimately led to relationship breakdown. The following extract highlights just how difficult the experience, of a partner rejecting the changes to food and eating after surgery, was:

"Er that was…that was a massive, massive hit, that was a…that (sighs) I don't even think you can describe, you've gone, you've gone from the very, very beginning of going to see the doctor and you've gone through every single appointment all the way through together, you've gone down to surgery, you've walked down to the theatre, you've gone through everything and you've got to

the point in your life that you've both been talking about from having this surgery, and then he just goes 'I don't like you the way you are anymore' and leaves, it's the (pause), that kind of makes you think 'well what have I done it all for?' what have I done it all for?" (Tracey: Lines 676 – 83)

Despite Tracey's experience of marital breakdown, most participants did manage to navigate the process of 'working through' conflict in their closest relationships, to form some level of understanding and acceptance within these.

Food as a connector

This theme captured participants' experiences of food being used as a means of becoming closer to the people around them; in other words food assumed the role of connecting people socially. The connection was evident in participants' stories of their family and friends gathering around them, showing support, and embracing the changes to food and eating that were required following surgery. Gratitude, love, and a sense of being understood all characterised participants' experiences, as did the ability to display affection toward others using food.

The master theme comprised two super-ordinate themes 'Educating' and 'Demonstrating care & understanding'.

Educating. This super-ordinate theme captured participants' experiences of not only educating individuals about the required changes to food and eating, but also of generating some form of empathy or emotional understanding through sharing the consequences of such a radical change to eating. Tracey highlighted the importance of education clearly when talking about her mother witnessing dumping syndrome:

"I don't think anybody can realise just how certain foods can cause certain things to happen, which was enlightening for her I think more than anything." (Tracey: Lines 48 – 50)

This witnessing was of vital importance for the ability to use food as a source of connection in relationships. Without the understanding this offered, sharing the journey of change proved more difficult, i.e. a potential source of conflict.

"She understands that I...I...she was there, she knows I can't tolerate it erm now, she didn't realise how bad it was for me and how much pain I were in and how much, but she was there when I was being sick in a carrier bag" (Mary: Lines 441 – 3)

Being able to show others the reality of physical illness in relation to eating inappropriately, appeared to facilitate some form of understanding which conversational-based education could not convey. This was not a comfortable experience however, as it tended to occur at times when participants felt embarrassed about their physical responses to food. Until learning was achieved however, connecting through food was extremely difficult for participants; the disruptions to usual socialising caused by food, being more likely to create conflict than connection. For example, when people pressed Carrie to eat more she reportedly responded:

"if you're prepared to pick up the sick" (Carrie: Lines 188 – 9)

In this case however Carrie was able to use food as a means of helping others to understand its effects after surgery, which led to understanding and acceptance:

"I did it one day on purpose I overfilled myself and I was sick and they saw me in a different light. Because when I was being sick it wasn't food, it was phlegm and it was erm liquid coming out and I, I went pale and I just passed out. And they were a bit shocked. I said "well that is what it's like for me if I overfeed" so they said "right okay then right then that's fair enough". You know and now when they see me with a portion they don't question anything." (Carrie: Lines 189 – 94)

A key aspect of participants being able to educate others was for them to have felt a sense of pride in the changes they had made surrounding food and eating. Angel spoke about using different herbs and spices in order to retain a level of interest in food which aided in maintaining her relationship with her husband. She appeared proud of her efforts:

"I like talking about it, I suppose it's showing off (laughs) isn't it, like just say how I handled it and [Husband] *enjoyed finding stuff that we could eat together, that he liked as well, not just for me"* (Angel: Lines 592 – 4)

Tracey also highlighted a sense of pride in being able to educate and thus connect to others through food:

"you do actually feel as though you've achieved something because you've changed somebody's mind, you've slightly changed somebody's mind, they're looking at something in a completely different way" (Tracey: Lines 649 – 51)

Demonstrating care & understanding. This second super-ordinate theme captured the experiences of care and understanding required, in addition to education, for food to assume the role of social connector. A noteworthy tool for the retention of food as a way of caring for others in this way was to use it as a gift:

"Because food's always a comfort isn't it, foods something that you sort of give to people as a gift really and I'm getting to do that, they're all coming to see me and I get to make sure that they go home satisfied really." (Tracey: Lines 563 – 5)

"I enjoy cooking and I think when you're in love with someone and they appreciate what you're cooking, it's something you want to do" (Angel: Lines 618 – 9)

By accepting food from participants, family and peers displayed care and understanding of the changes that had to be made and thus showed support for those changes. For example Polly spoke about going out for a work meal and giving most of her food away to a friend who accepted without question:

"I just said "[Name] do you" I said "do you want this?" I said "cos that, you know me, I'm a light weight. I won't be able to eat my dinner if I eat this" and he went "yes, pass us it here." And it were just, yes, just like that." (Polly: Lines 541 – 43)

Although gifting food served to connect people through the demonstration of care and understanding this was not always a comfortable experience. Indeed Polly also worried about the possible negative implications of gifting food:

> *"I turn into a bit of a feeder. I know that. With him, not with my son, because I don't want him to be overweight and he is overweight."* (Polly: Lines 344 – 5)

Broadly speaking then this theme reflected participants' experiences of how disruption, regarding food in relationships, was navigated in a positive and connecting way. Central to this, was the idea of equality in relationships, which involved the acceptance and embracing of difference. Alice and her husband reportedly found this difficult initially, which put strain on their relationship, until her husband demonstrated acceptance of the differences and ensured she felt like an equal member in food-based activities:

> *"Started going out with my husband because he said "well just don't eat what you don't eat," "don't worry about it, we need to be going out and eating more often" because we used to enjoy it."* (Alice: Lines 23 – 5)

Embracing difference encompassed not only the acceptance of the changes to food and eating, but an active and involved integration of these into family and peer systems:

> *"She asks me what I like and what I don't like and then we have what we all like together."* (Carrie: Lines 398 – 9)

By embracing changes to food and eating, food was retained as a connector within family and peer systems and served to strengthen connections between people:

> *"It makes me feel … it makes me feel em… happy. It makes me feel that they're me, they're my best friends you know. Em and, and they understand, they understand it and they don't make an issue of it. They just get on with it and do it."* (Polly: lines 735 – 7)

One specific way in which food and eating changes were embraced within participants' social settings, was through creating a new shared style of eating. For many participants buffet style eating appeared to fulfil this requirement, whereas for others a pick and share style was preferable. Common to both of these styles of eating however was the use of food as a vehicle for connecting with others, rather than it being a focus in its own right. Because of this, 'difference' faded into the background in favour of communication and enjoyment of the social event. To illustrate, Tracy spoke about attending a tapas night:

"Friendly eating's nice because you can still have everything that you want but you can have it in tiny, tiny portions and really, moderation, and everybody sort of wants to share what you've got and that were…that were a really nice meal." (Tracey: Lines 434 – 6)

A further example of demonstrating care and understanding was through participants' experiences of food acting as a rallying point; family and peers became allies against uneducated individuals or acted as the voice of reason where food consumption was concerned. Angel illustrated the latter when reflecting upon her husband becoming an ally at times when she was at risk of allowing food to tempt her:

"I am more eat to live than live to eat, and the fact that he handles me when I'm going off the rails a little bit, erm it just means I don't have these flash points of 'I'm gonna get in the car and I'm gonna go out and buy myself a take away" (Angel: Lines 711 – 3)

In terms of allies against the uneducated, Polly highlighted the need for these within social environments where the required changes participants had to make, were not catered for:

"I'll laugh at my friends. Bless them. They're so supportive. I used to get these little mini bottles of diet lemonade and put them in everybody's bag when I used to go out. And (laughs) I used to say "I'm really sorry." And it looks like, you know, I says, I used to have to go to the toilet and pour this lemonade in my wine. Cos I thought well if they see you doing it at the bar you get thrown out. Because it looks like you're bringing your own drink in. But it, there were a reason why I was doing it" (Polly: Lines 715 – 21)

For some participants the care and understanding generated following the disruption to usual social eating, only served as a partial connector and indeed contributed to a level of conflict within social eating settings. For example, Alice spoke about how her daughters had become allies in social settings involving food by clustering around her, thus protecting her from experiencing the anxiety associated with people questioning the differences in eating:

> *"They just sit around me and protect me, try and keep people away. They don't need to but that's what they do. They'll sit around me ...* [INTERVIEWER: How does that feel?] *...comforting really, yeah quite comforting because I know that if they're around me and they're eating, other people are less likely to bother me. Whereas if I'm sat there on my own they'll come up, "aren't you having owt? As soon as somebody comes up to me and says that, the girls or other members of me family will all come and sit with me. Which is good, it's nice. It is nice to feel protected. But like I say, any other social events, I really tend not to let myself get into those situations."* (Alice: Lines 535 – 43)

In doing this Alice's anxieties were kept at bay and food was seen as something which connected her to her allies. This dynamic however limited connections through food to close others.

To summarise; the different ways that food and eating were used, to connect socially, had an impact on participants' perceptions of the extent to which typical socialising was disrupted by post-surgery changes. Similar to the role of food becoming a source of conflict, using food as a connector could limit the adaptation to social eating after surgery. Typically though, developing and retaining food as a way of connecting with others, be that through education or by navigating the conflict it causes, ensured that participants were able to adapt to the disruptions to usual socialising.

Reflexive Statement

As the hermeneutic circle is a key aspect of an IPA study, is only fitting that I now reflect upon some of the known fore-conceptions which will undoubtedly have had an influence over the themes I generated during the analysis phase and the way in which I chose to present the above results.

The first point of note is that when I was analysing each transcript I was acutely aware that my interest in psychodynamic ways of working would be influencing my coding of the data. I was therefore particularly anxious in the initial stages of coding that I did not become too analytical prior to obtaining a detailed understanding of the participants' lived experience. In order to compensate for this, I made use of research supervision sessions early on in the process where my supervisor and I reviewed my initial coding. Whilst reflecting on the analysis of my fifth transcript however, I noticed that in my attempt to remain true to the participant's experience, I had over-compensated and was actually not being analytic enough when identifying emergent themes (Appendix VIII). By omitting all of my analytic self from the process, I appeared to have inadvertently moved away from the principles of IPA in a different way, which was just as limiting.

The second point of note came from a level of uncertainty around my initial group analysis. The problem with my initial group analysis was that it told the story of a participant's journey through recovery from bariatric surgery (Appendix XI). Although interesting and true to the narratives provided by the seven participants, much of what I found had already been reported elsewhere. When considering this in supervision I realised that my anxiety around remaining close to participants' lived experience, had again shutdown the analytical part of myself. Along with the strong desire for participants to tell me their full stories, this left me with an analysis that had become removed from my initial interests and research questions which specifically focused on food in relationships.

In becoming aware of these fore conceptions I was however able to modify my analysis and bring it back in line with the principles of IPA and my initial interests in food within relationships following bariatric surgery.

CHAPTER FOUR

Discussion

In this chapter the main research findings will be summarised and linked to the extant literature and psychological theory. A number of different theories have been drawn upon (and a great many not) which reflects the aforementioned atheoretical approach. In order for the research to remain as free from fore-conceptions as possible I have not specified one particular theory throughout. Rather, I offer a number of ways to understand the findings of this research and trust that in doing so, a wide range of clinicians may draw on their own knowledge base to facilitate theoretical generalisability. This means that the following discussion will not focus in detail on developing one particular theoretical perspective. The findings are considered in relation to the study's two research questions which were:

1. What are people's experiences of the roles of food and eating, within the context of their interpersonal relationships, following bariatric surgery?

2. How do people manage these experiences?

Following this the clinical implications of the research will be discussed, alongside some possible recommendations and areas for future research. Prior to concluding I will also explore the strengths and limitations of this study and present a final reflexive statement.

Disruption to usual social eating

The overarching experience for the participants of this study was that typical food-based socialising routines were disrupted by the conspicuous changes surrounding food and eating. This built upon Bocchieri, Meana & Fisher (2002b)'s grounded theory model which suggested that surgery created a dichotomy between a patient's old and new lives. Whilst they found positive changes, but also tensions in a number of areas (including food and relationships), the patients' lived experiences of these were not elaborated on, due to the nature of the grounded theory approach employed (Wimpenny, 2000) As such a specific focus on lived experience was the starting point for the present research and focusing in on

one area of Bocchieri et al's (2002b) model allowed for an in depth analysis to be carried out using an interpretative phenomenological approach. The master theme in the present study, i.e. disruption to usual social eating, was therefore developed from participants' accounts of their specific lived experience surrounding food and eating within relationships. This allowed an insight into how the roles of food had changed for participants' following surgery, how they had experienced these changes socially and managed the consequences.

One aspect of their experience of disruption was that food became a source of embarrassment for participants due to the physical consequences of eating the wrong foods, or even the right foods too fast or too freely. When considering the literature surrounding obesity and weight management, the concept of embarrassment is evident, however in the bariatric surgery literature this is not a concept that is well represented. In a qualitative study Tod & Lacey (2004) explored the factors that influenced individual's motivation to access weight loss services. One of the themes they identified as an important 'trigger to action', was indeed 'embarrassment and humiliation', involving a crippling self-consciousness. The focus of this however, was more about others' judgements surrounding an individual's physical appearance, rather than food specifically facilitating embarrassment. Nevertheless embarrassment around food and eating situations was present and reported in the study; thus it could be suggested that escape from embarrassment may play a factor in an individual's decision to seek a weight loss intervention. If people approach surgery believing that sources of embarrassment in a social eating setting will be alleviated post surgery, then the realisation that food itself may assume this role has the potential to be extremely disappointing or distressing. Indeed for some participants in the present study, embarrassment around food was extremely limiting to their experiences of social eating and navigating change, largely due to a tendency toward concealment.

It would appear then that following surgery the participants of this study had to be more conscious of the food they consumed whilst at social events, i.e. food acted as a cue for change. A number of participants spoke about the learning curve involved in social eating following surgery, where in the early stages they would eat to the point of physical illness largely because of being distracted or influenced by the people around them (i.e. resistant to change). The possible effects of the obesogenic environment (Fox & Hillsden, 2007), on an individual's ability to adapt to food changes post surgery, are thus highlighted. This links into the literature on social facilitation such as the findings of Redd & de Castro (1992), who found that people tended to eat more in group situations than when alone. It

may also tie in with the literature around identity, in that Bisogni et al (2002) suggested that individuals' management of eating situations and expression through food, was a key aspect of constructing and maintaining identities relating to 'reference groups or social categories'. In other words food is a major source of 'typical socialising' and thus a source of group identity (Lupton, 1996). The identity descriptors used by Bisogni et al (2002) revolved around a sense of normality, i.e. how different individuals are when compared to others. The concern surrounding loss of normality was evident within the current study, with some participants apparently struggling to construct new social identities with regard to food following bariatric surgery; whilst others fully embraced and integrated the changes into what they described as a 'new normal'. This reflects the difference in navigation of the three processes thought to be involved with conceptualising eating related identities, i.e. development and revision of identities, evaluation and monitoring of identities, and enactment of identities (Bisogni et al, 2002). Individuals who expect surgery to create normality for them within relationships, i.e. achieving a 'normal weight' when compared to peers, may again be left struggling to accept the reality of having to settle for 'relative' normality with regard to food itself. For example, the realisation that eating can't be the same as it was pre-operatively and that food is likely to facilitate some degree of standing out from peers. This may mirror some of the feelings associated with why participants sought surgery in the first place, i.e. embarrassment, and could account for the resistance to change observed in some.

One of the ways in which participants appeared to manage the disruptions to usual social eating was to 'make the best of it'. For some this involved viewing the changes to food and eating as of benefit to everyone, not just themselves. For others it involved a level of dissociation from the challenging emotions elicited, which led to a level of social concealment. Both of these allowed participants the psychological distance required to enter into a change process, wherein the most noteworthy tool for facilitating change was humour. Samson & Gross (2012) investigated humour as a tool for emotional regulation after their review of the literature surrounding this proved inconclusive. They reported that some studies suggested benefits, others no effects, while some even claimed detrimental effects. In order to shed some light on this, Samson & Gross (2012) examined the consequences of both negative (mean-spirited) and positive (good-natured) humour. They found that positive humour may indeed be an effective tool for emotional regulation, however, they also suggested that negative humour may: "create an emotional distance from the negative event without being able to look on the bright side of the negative event". This would account for

participants in the current study being able to use humour within relationships as a tool for managing disruption to social eating and forming connections. It would also account for some participants' experiences of struggling to 'make the best of it' within their relationships due to critical others hindering the adaptation process, e.g. Tracey's husband employed sarcasm: *"he'd see what I'd portioned out and it was a case of 'being ambitious again are we?'"* (Tracey: Lines 408–9).

Food as a creator of conflict

Food appeared to become a source of conflict when participants, or the social systems around them, struggled to accept or adapt to the disruption to social eating. Participants who were overwhelmed by embarrassment for example, had a tendency to conceal aspects of the changes. Taken to the extreme this resulted in frustration, anger and resentment within the family system and conflict ensued. When family members resisted the required changes to eating, this was characterised by a breakdown of communication and conflict. The disruption to social eating therefore appeared to influence equality within relationships; in other words it created inequality or affected the homoeostasis of family and peer systems. For example, some participants spoke about partners and friends being completely unable to understand the changes to food and eating, leading to conflict and inequality within the relationship. Indeed for some participants this led to relationship breakdown. This appears consistent with the ideas reported by Lupton (1996), who said that food acts as a binding agent within families and is based on reciprocity regarding the giving and receiving of food. She argued that any break within this social convention has the potential to be viewed highly negatively by others and referred to Charles & Kerr's (1998) findings that rejection of food was hurtful and provoking of anger and resentment.

One possible explanation for this negative reaction within the relationships can be taken from compassion focused therapy where three affect regulation systems are proposed (Gilbert, 2009). It is possible that the first of these systems, i.e. 'content, safe, connect', is disrupted by bariatric surgery, in that food can no longer be used to bolster it. This system is the only one of the three which is, as Gilbert describes, 'affiliative focussed', i.e. it is has a social function. Indeed Depue & Morrone-Strupinsky (2005, cited by Gilbert, 2009) suggest, "the contentment system has been significantly developed with the evolution of attachment behaviour" (p.202) and Gilbert (2009) says that caring behaviour stimulates the soothing

and safeness system. When food is the crux of attachment/caring behaviour, it is clear that bariatric surgery has the potential to upset the relational dynamics dependent upon this system. The two remaining systems, left to regulate affect, are the threat system and the drive system. While the drive system may account for the process of working through and making the best of the changes, the threat system may reflect the anger, anxiety and guilt characterising the super-ordinate theme of food as a source of emotional turmoil in relationships. This also links in with the idea that food acts as a source of emotional regulation (Canetti, Bachar & Berry, 2002). When considering Hilde Bruch's (1955) idea that feeding can become 'overcharged with emotional significance' (p.73) and the only meaningful emotional narrative within family relationships, it is understandable that the removal of this through bariatric surgery would result in conflict, due to having no 'container' for the emotional aspects of relationships.

Food as a connector

Food also appeared to act as a social connector. This was the case when participants were able to tolerate the embarrassment within relationships and be open and honest about the changes they had to make. As previously stated, humour played a key role in participants' abilities to be open and honest, by managing some of the associated anxiety. When it was possible for participants to navigate disruption to eating in this way, food could act as a connector through being educative and through being demonstrative of shared care and understanding.

A large part of participants' use of food as an educator involved allowing others to witness the consequences of the changes to food first-hand, rather than concealing them. Masuda, Boone & Timko (2011) found a link between self-concealment and disordered eating symptoms. They suggested that high levels of self-concealment were linked to poorer psychological flexibility, which in turn was indicative of disordered eating symptoms. So it would appear important for individuals who have undergone bariatric surgery to remain open and honest about food and eating in order that the required adaptation can be made physically, psychologically and socially. Indeed for the participants in this study, being proud of the changes to food and eating and thus open and honest about them, led to acceptance, understanding and social connection.

One specific factor which may have had influence over care and understanding within relationships was the nature of attachments within participants' family and peer groups. Anderson and Whitaker (2011) argued that attachment is the 'best behavioural marker' (p.235) of having developed emotional regulation and that those with insecure attachments may be more likely to struggle with obesity. Indeed Sockalingama,Wnuka, Strimasa, Hawaa & Okrainec (2011) found that avoidant attachment styles in bariatric surgery candidates were linked with increased depressive symptoms and poorer quality of life. As Bruch (1955) argued, if a precedent is established within families whereby food is the only meaningful emotional narrative, then a foundation is laid for future unhelpful eating behaviours. If this is the case then more secure attachment relationships may aid bariatric patients in their ability to give and receive care/understanding due to the existence of elements other than just food, as means of emotional regulation. This is consistent with Van Hout, Verschure & van Heck (2005) who argue that those in solid marriages found it easier to weather the changes that occurred after surgery, whereas those in dysfunctional marriages struggled to do so. Garip & Yardley (2011) also emphasised the importance of support from peers in creating a positive and encouraging environment for weight management efforts.

Despite requiring more than just food as a means of emotional regulation within relationships, it is important that food be retained in some form within relationships because as Lupton (1996) attests, sharing food is a vital part of relationships in all societies. One way in which this was achieved for the majority of participants was in the use of food as a gift. As Cheal (1988, cited by Lupton, 1996) points out, individuals often use food to display love, friendship and gratitude to family and friends; this appeared especially evident and important for participants in this study due to the radical changes to food, which family and friends had to tolerate. Indeed as Lupton suggested, food can act as a binding agent, so finding a way to retain this in a modified form is important for re-establishing homoeostasis within the family or peer setting.

Clinical implications, recommendations and areas for future research

Although bariatric surgery candidates are usually prepared for the changes they must undertake with regard to their diet (Noble, 2012), it appeared that not all the participants in this study were prepared for the emotional and social impact of having to eat very differently from the people around them; nor for dealing with the potentially

embarrassing consequences. Indeed bariatric surgery acted as a cue for change within relationships. Part of this involved a level of communication about the changes in order to facilitate acceptance and support throughout the process. Some relationships embraced this, using compromise to integrate new and old eating styles, whereas other relationships were more resistant to this and thus found change more challenging. These findings therefore emphasise the Foresight report's assertion that reshaping the wider environment in which people live is a key challenge faced by society if any interest in healthy living can become an achievable widespread goal (Butland et al, 2007). As surgery is one of a number of treatments for obesity, which span a biopsychsocial approach, perhaps this also highlights the fact that more needs to change at a socio-cultural level to facilitate the success of less extreme forms of treatment. For some individuals however, surgery remains the last resort. For these people a move away from the primarily 'medical' focus of bariatric surgery toward a 'reshaping' of the patient's environment after surgery at a socio-cultural level, may aid successful weight maintenance following bariatric surgery.

The first issue this raises is that part of any psychological assessment prior to surgery may benefit from being systemic in nature and involve close family and friends. This could specifically look at the nature and strength of relationships of those seeking to undergo bariatric surgery and investigate the system's preparedness for change to food and eating. It could provide some indication of attachment and communication styles within the relationships and give an idea about whether an individual's socio-cultural context is amenable to the changes. If, from such an assessment, it was considered likely that conflict might ensue post operatively, families and peer groups could be signposted to additional support pre-emptively. Such an approach to assessment could also provide an opportunity to educate the systems around a bariatric patient in order to maximise the tools involved in strengthening connections such as humour, openness, being proud of the changes and using food as a gift.

The second issue is how to provide this additional support to family and peer groups, both in helping to prepare them for the changes bariatric surgery elicits and in managing these post-operatively to ensure connection through food is retained. Meana and Ricciardi (2008, cited by Noble, 2012) developed a preparatory programme for this purpose. It involved preparing patients for the emotional and relational consequences of bariatric surgery through educating them, identifying the potential issues and involving significant others in discussions around these. The program emphasised emotional processing and

relationships amongst other things; which appeared to correspond to the issues of most import highlighted by this study. Noble (2012) reported that the program had yet to be evaluated, however this thesis suggests that such a program might be useful for the long term recovery process. Indeed Noble (2012) supports this assertion, finding that bariatric patients required preparation for helping them to tolerate and adapt to the consequences of surgery rather than preparation to help inform decision-making. Furthermore Magdaleno, Chaim, Pareja & Turato (2011) have recommended that partners be involved in the preparation for bariatric surgery in order that post surgery conflict does not jeopardise the positive changes weight loss can generate.

One suggestion for how to implement this would be to make better use of the existing bariatric support groups, which are well established throughout the country. As the group format is already established for this population, further 'linked groups' could be developed around the main service user led group; that could itself be responsible for signposting. These 'linked groups' might include a psychotherapy group for individuals who require more psychological support and a dietician or occupational therapy led experiential group giving patients and significant others education and experience of exploring post-surgery food. Furthermore, additional skills-based groups could also be run around Mindfulness Based Cognitive Therapy, such as a variant of the MB-EAT programme developed by Jean Kristeller, in order to help maximise skills for emotional regulation once food is disrupted in this role by surgery. The core of MB-EAT lies in cultivating inner and outer wisdom regarding food, through mindful meditation, nutritional information, exercise, and stress management. Inner wisdom involves heightening ones awareness of and response to physical, emotional and cognitive aspects of food choice, eating and self-acceptance. Outer wisdom involves learning to make 'wise' choices in the face of the wider socio-cultural landscape (Kristeller & Epel, 2014).

Developing the existing service-user-led bariatric support groups in this way, could be viewed as creating a 'bariatric support community' involving a variety of multidisciplinary, group-based interventions, with service users at the core. These should include a patient's wider socio-cultural context and focus on food/eating changes, in order to maximise the benefits of bariatric surgery. Within the current financial climate the development of more cost effective group based interventions may be the logical direction of travel for this client group. Perhaps an appropriate place to begin would be to try introducing a mindfulness element into the existing bariatric support groups through

offering an initial MB-EAT type programme. This could be piloted and followed up with periodic top-up sessions over a period of time, with group coordinators facilitating mindfulness practises in between. This could then be evaluated and refined as appropriate.

As the present research focussed on the lived experience of participants themselves, it would also be important to undertake further research looking into the experiences of close family and friends. This would allow a greater understanding to form through the amalgamation of information from a variety of sources and would thus better facilitate the development of a 'bariatric support community'.

Strengths and limitations

This study was an original piece of research which has contributed to the understanding of an important area linked to bariatric surgery that was not fully understood within the literature; namely the role of food in relationships post-surgery. The results of this study are also clinically relevant in that they provide an idea of the possible omissions in preparation for surgery that have been previously overlooked and allow for suggestions on how best to support individuals and their close others through the process in the future.

The strength of this study lies in the rigour with which it was undertaken. As the sample was homogenous, generalizability across the seven participants was possible within the study and theoretical generalizability is thought to be possible when considering the phenomena in a clinical bariatric context. This was largely due to the development of the semi-structured interview (Appendix VI) and the enthusiasm of the participants for developing the literature base in this area. The semi-structured interviews were designed and conducted in such a way that allowed for rich and detailed accounts to be gathered from participants, as evident from the amount of data elicited. This in turn constituted the necessary data for a detailed and complete interpretive phenomenological analysis. As indicated in chapter two, a number of steps were taken to ensure the quality and validity of this research. Evidence of these can be found throughout the thesis and in the appendices. Regular supervision and keeping a research journal (Appendix VIII) allowed for a reflexive and robust analysis. As both reflexive statements and direct quotes from the data have been documented throughout the study, transparency has also been achieved as far as was possible.

As with any piece of research, there were some limitations to this study. First of all no specific measures of anxiety and depression were used in this study to capture the emotional state of the participants. This meant that in order to situate participants within the wider context of their lives and comment on how their emotional wellbeing had impacted upon food and relationships, I had to rely upon my experience and abilities as a clinician. A possible improvement, therefore, would have been to include some standardised measures to better inform the pen portraits and the interpretation of the data. A second limitation lies with the semi-structured interviews. As the interview schedule was pre-conceived, some areas of experience may have been prioritized over others and thus the data generated influenced in some way. This was balanced to some degree however, because of the flexibility semi-structured interviews allow in deviating from the existing questions. As Smith, Flowers & Larkin (2009) say, participants were allowed to take the interview to "the thing itself". In saying that, a researcher can also never control for the material a participant chooses offer or the way this is done; the effect of this on the current analysis remains unknown. Another potential limitation to an IPA study lies with how far a researcher's fore-conceptions influence the whole research process. As I took steps to become aware of my own fore-conceptions through the process of reflexivity, this was controlled to some degree. However one can never truly be aware of all one's fore-conceptions, of fully account for the influence of them within a study. The results and findings of this thesis are therefore presented with this in mind.

Reflexive statement

My experience of conducting this research has been both enjoyable but also challenging. Getting to grips with the methodology is one aspect of this, but more so was managing the shift in my understanding of this area. I have been acutely aware of a shift in my knowledge and understanding surrounding obesity in general and more specifically surrounding bariatric surgery. I was asked to present on this thesis within my clinical placement because issues surrounding bariatric surgery and obesity are becoming more common within this adult secondary-care psychological service. One particularly interesting observation I made while doing this was that even within this specialist field, assumptions and biases informed and polarized people's opinions surrounding the topic. Even psychologists appeared to struggle to manage the dominant, negative, cultural narratives.

This mirrors my experience of friends' reactions, which if anything, were more extreme in their negative opinions about individuals seeking bariatric surgery. The plethora of mainstream 'entertainment' devoted to the voyeuristic depiction of bariatric patients' experiences and the drive for the 'perfect' thin body, seems to be reflected in the narratives that I have encountered throughout this process. Knowing what I know, I feel saddened by such a negative outlook and hope that this research may go some way to shifting this narrative at least within the profession of psychology, which should be the most amenable group to this change. Encouragingly the psychologists within my clinical placement were interested, insightful and open to being challenged on their assumptions in this area. I have thus developed a strong empathy and respect for individuals seeking surgery for weight loss and find myself taking a somewhat zealous stance when talking about it with others. I am unclear when this stance first formed, having only become conscious of it near the end of writing this thesis. Its effect on the analysis therefore remains unknown; however, I hope that it ensured a rigorous and thorough analysis of the data generated, so that the findings might contribute to advancing the knowledge base of this developing area.

Conclusion

The date an individual undergoes bariatric surgery is often described by people as a re-birth. Bariatric surgery can be a powerful and life changing event; however, merely focusing on the positive physical effects of such procedures, may be to risk overlooking the associated psychosocial tensions. The present study focused on two areas of tension identified in previous research, i.e. food and relationships, with a specific interest in lived experience. The main findings of this study were that individuals who undergo bariatric surgery are faced with a disruption to their established socialising routines involving food/eating. They are often unprepared for the consequences of this, with embarrassment at being physically ill and being forced to make changes to food and eating, being commonly reported. Depending on how an individual experiences this disruption, food can become a source of conflict within their relationships or a way to re-connect with others. Conflict and connection exist on a continuum which reflects an ability to work through disruption, even if it is characterised by conflict. That said, conflict can be challenging and even destructive within relationships if managed poorly. The results suggested that more needs to be done in the preparation and aftercare of patients to include their close others, so that supportive

relationships can thrive and bolster recovery through adaptation to food and eating. There are programmes in existence which would be a good starting point for local services to begin from and further research should explore their feasibility and efficacy for UK bariatric services. One way of modifying services would be to create a 'bariatric support community', structured around existing support groups, which could incorporate multidisciplinary support, but retain service users and their close others at the core of the process.

This research provides a unique and valuable insight into the experiences of individuals who have undergone bariatric surgery. Previous research by Bocchieri, Meana & Fisher (2002b) constituted a descriptive account of the generic stages of recovery and some of the changes that may occur following surgery. The current study narrowed this focus down to a specific psychosocial issue, namely individuals' experiences of food and its place in relationships following the radical changes to the ways in which food can be used. Consequently the main finding of this study was that individuals do more than just learn to adapt to the often difficult physical effects of weight loss and the different body shape/ image they develop, they also actively adapt the very (food) foundations on which relationships are built.

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APPENDICES

Appendix I. Recruitment Letter

Programme in Clinical Psychology,
Leeds Institute of Health Sciences,
Charles Thackrah Building,
101 Clarendon road,
Leeds,
LS2 9LJ.

xx/xx/2013

Dear Support Group Member,

RE: Project- Food and Relationships after Bariatric Surgery

I am completing a piece of research at the University of Leeds, as part of the Doctorate in Clinical Psychology programme, which asks individuals who have undergone bariatric surgery to explore their experiences of the roles of food and eating within relationships after surgery. As part of this research I am looking to interview between 6 – 10 people who have undergone bariatric surgery 12+ months ago.

You are therefore being invited to take part in this research. If you do think that you might like to be involved, please be assured that I will try not to inconvenience you in any way. The amount of time that I will be asking from you will be kept to a minimum and I will endeavour to be flexible in any arrangements that I make with you.

It is important that you understand what the research will involve and why it is being done before you decide if you want to participate. These details are provided on a separate information sheet which will tell you why I am asking for help with this project, what you will be asked to do, how long it will take, and what will be done with the results. If you are interested in finding out more about taking part in this study please contact me via the details below and I will send you an information sheet in the post:

E-mail: umsdh@leeds.ac.uk
Telephone: 0113 343 0829 (Please leave a message and I will reply as soon as possible)

Best wishes,

Stephen Hoole
Psychologist in Clinical Training

Under the supervision of:
Dr Sylvie Collins & Prof Andrew Hill

Appendix II. Participant Information Sheet

Food and relationships post bariatric surgery: Participant Information Sheet

Food and eating can play a very important role in some people's relationships with the other adults in their lives (i.e. partners, friends & relatives). Activities such as food shopping, cooking, and dining are activities that can be shared with family and friends. Bariatric (weight loss) surgery not only changes what and how much people eat; it can have an impact on their relationships with others because of the required changes to eating. I would like to talk to you about your own experiences of such things, and what has happened as a result.

As such this is an invitation to take part in the above research project, however before you decide whether or not you would like to participate there are a number of things to consider in order that you are fully informed of what the study entails.

What is the purpose of the study?

The aim of this study is to interview individual participants who have undergone bariatric (weight loss) surgery in order to gain an understanding of some of the ways food is used within their interpersonal relationships after surgery. This will help to develop some understanding of how best to prepare both individuals who are looking to undergo surgery, and the significant people in their lives, for the changes that follow with regard to food and relationships.

Do I have to take part?

It is entirely your own decision as to whether you take part in this study or not. Please feel free to retain this information sheet and discuss it with other people if you wish. If your decision requires any further information then my contact details can be found at the bottom of the page and I will be more than happy to provide this where possible. Should you decide that you do wish to take part in the study then you will be asked to read and sign a consent form indicating that you are willing to proceed. You are free to withdraw from the study at any time up to the point where the interview has been transcribed into written format and all identifiable information removed. Following this it will not be possible to withdraw consent. During the interview you are at liberty to refuse to answer any question without explanation. At no point will any decision you make with regard to this study, affect the health care you receive.

What will the study require me to do?

Participants will be asked to take part in an individual research interview which is expected to last for between 60–90 minutes. This will be arranged at a time and location which best suits you; ideally either at home or at St Luke's Hospital, Bradford (alternative locations may be possible). The interview will consist of some questions that will explore your experience of relationships and the role food plays within these. These interviews will be recorded using digital audio-recording equipment and transcribed into a written format which can then be analysed.

Who is involved in the study?

My name is Stephen Hoole; I am a Psychologist in Clinical Training at the University of Leeds and will be the primary researcher for this study. As such I will be the person who you meet with to do the research interview. As this study forms part of an academic qualification there are also two research supervisors involved in the study, Dr Sylvie Collins and Professor Andrew Hill both from the University of Leeds and contactable via the details below.

What are the pro's and con's of taking part?

Some potential benefits of being involved in the study are that the resulting thesis may lead to academic publications which could inform future clinical practise and services within the field of bariatric (weight loss) surgery, e.g. preparation / aftercare.

It is also possible however that some participants could find the experience of discussing food, their relationships, or aspects of their surgery / recovery distressing. In this case it is important that you are aware that the interview can be stopped at any point, and the option of withdrawing from the study completely is available to you. If any further support is required I am available to talk to you during the interview and can direct you on to the most appropriate service, be that psychology, your GP, A&E, etc.

The study does require a small time commitment for the interview (60-90 minutes) and may involve travelling to and from the location of the interview, e.g. St Luke's Hospital. Travel expenses can be reimbursed if travelling by train or bus, upon presentation of a valid ticket; as can car parking costs. It is expected that the majority of interviews will however be conducted by the primary researcher visiting the participants home, if participants are able to accommodate this. As such, no financial costs would be incurred by participants in these instances.

What if there is a problem or I have concerns about the research?

If you are concerned about any aspect of the research then please contact me directly using the details below and I will do my utmost to address these. Alternatively, if you remain unhappy or feel unable to speak to me regarding your concerns, Dr Sylvie Collins and Professor Andrew Hill are also available to contact via the details below.

Will the information that I provide be kept confidential and secure?

Any information provided by participants would be kept confidential and secure at all times. This includes all digital recordings being stored on encrypted storage equipment, as per university policy, and destroyed once transcribed. All identifiable information, including master transcripts of recordings, will be stored in locked cabinets and destroyed after 3 years. Anonymised transcripts will be used for analysis and extracts used within the main body of the report. Identifiable information will be removed or altered and pseudonyms will be assigned to each participant to ensure anonymity. Participants will be given the option of choosing their own pseudonyms.

A notable exception to the above confidentiality statement is that if a participant were to disclose something which gave rise to concerns about harm to themselves or others,

then I would be obligated to pass this information onto the relevant people external to the study. Ideally and whenever possible, this would be discussed with the participant beforehand and information passed on with their consent, however as significant risk issues supersede confidentiality in these cases, this protocol is not always possible. In addition to this I am also bound by the same rules as the general public to report any disclosures pertaining to crime, to the police.

What happens at the end of the study?

The results of the study will be written up as an academic doctoral thesis which forms part of the Doctorate in Clinical Psychology qualification at the University of Leeds. Aspects of the thesis may shared with professionals for service development purposes and may also be written up for peer review and publication in academic journals and / or presented as posters at academic conferences. The findings of this research will be summarized and a copy of this offered to all participants.

Contact details.

If you have any further questions regarding the study which will help you to decide whether or not to participate, please don't hesitate to contact me using the following details:

> **Stephen Hoole**
> **Psychologist in Clinical Training**
> Institute of Health Sciences
> University of Leeds
> Charles Thackrah Building
> 101 Clarendon Road
> Leeds
> LS2 9LJ.
> E-mail: umsdh@leeds.ac.uk
> Telephone: 0113 343 0829

 N.B. Dr Sylvie Collins and Prof Andrew Hill can also be contacted via the above Leeds University address and telephone number; however their email addresses are as follows:

> **Dr Sylvie Collins** –   s.c.collins@leeds.ac.uk
> **Prof Andrew Hill** –   a.j.hill@leeds.ac.uk

If, having read the information above and having had the opportunity to speak to the researcher, you would like to participate in this study; please read and sign the following consent form and return it in the freepost envelope provided.

Appendix III. Participant Consent Form

Title of Research: Food and relationships after bariatric surgery

	Please initial
Primary Researcher: Stephen Hoole	
I have read the information sheet associated with this study.	
I have been offered the chance to ask questions about the study and am satisfied that I now have enough information to make an informed decision about participation.	
I understand that participation is completely voluntary and therefore I am under no obligation to take part in this study.	
I understand that I can withdraw at any point without explanation and without negative consequences.	
I understand that I have the right to refuse to answer any question without explanation and stop the interview at any point.	
I understand that any decisions I make with regard to this research project will not affect the healthcare I receive.	
I give my consent to be interviewed as part of this research project.	
I give my consent for an audio recording of this interview to be made and transcribed.	
I am aware that my personal details will be kept confidential and that any reports written will be fully anonymised.	
I give consent for extracts of my interview to be used in the write up of this study and any subsequent publications that result from this.	
I give my consent for the results of this study to be presented at the bariatric support group.	

Signed: ....

Print name: ....

Date: ....

Contact details:

Address...................................
....
....
....
....
....
...................................Tel.......
....

Appendix IV. Ethical Approval Letter

NHS
Health Research Authority

NRES Committee London - Queen Square
HRA Head Office
Skipton House
80 London Road
London
SE1 6LH

Telephone: 02079722584

22 August 2013

Mr Stephen Hoole

Dear Mr Hoole

Study title:	**A qualitative study into the roles of food within relationships after bariatric surgery.**
REC reference:	13/LO/1242
Protocol number:	N/A
IRAS project ID:	127146

The Proportionate Review Sub-committee of the NRES Committee London - Queen Square reviewed the above application on 06 August 2013.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Audrey Adams.

Ethical opinion

- We would suggest that the researchers reconsider the exclusion of participants not fully fluent in English but this is not a specific requirement.

- We would suggest that the patient information sheet should say that the patient can withdraw without giving a reason (although this is mentioned on the consent form) and the pros and cons section needs to be clear that there is no direct benefit to the patient.

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research 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).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

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

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.

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).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Evidence of insurance or indemnity		21 September 2012
Interview Schedules/Topic Guides	1.0	06 July 2013
Investigator CV	Stephen Hoole	
Letter of invitation to participant	1	06 July 2013
Other: CV: Sylvie Chantal Collins		

Other: CV: Andrew John Hill		
Other: Transfer Recommendation Form		
Other: Research Interview Safety Protocol (Home Visit	1	06 July 2013
Other: Leeds University Transcriber Statement		
Other: Research Panel Constitution	1.0	24 July 2013
Other: Information letter about the Trainee Clinical Psychology Research	1.0	24 July 2013
Other: DClinPsychol Policy on Safeguarding Sensitive Data	1.0	10 December 2010
Participant Consent Form	1	06 July 2013
Participant Information Sheet	1	06 July 2013
Protocol	1	06 July 2013
REC application	127146/481150/1/964	24 July 2013

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

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

Reporting requirements

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

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

13/LO/1242	Please quote this number on all correspondence

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

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

Yours sincerely

Dr Yogi Amin
Chair
(pp.Thomas McQuillan)

Email: nrescommittee.london-queensquare@nhs.net

Enclosures:	List of names and professions of members who took part in the review

Copy to:	Clare Skinner, University of Leeds
	Ms Jane Dennison, Bradford Teaching Hospitals NHS Foundation Trust

NRES Committee London - Queen Square

Attendance at PRS Sub-Committee of the REC meeting on 06 August 2013

Committee Members:

Name	Profession	Present	Notes
Mr Francis Curtiss	Accountant	Yes	
Mr Ciaran Scott Hill	Neurosurgery Speciality Registrar	Yes	
Mrs Claire Reynolds	Radiotherapy Radiographer	Yes	

Also in attendance:

Name	Position (or reason for attending)
Ms Laura Hewitt	Assistant Co-ordinator

Appendix V. Research and Development Approval

Bradford Teaching Hospitals NHS
NHS Foundation Trust

Enquiries on this matter should be made to:

The Research Management & Support Office
The Bradford Institute for Health Research (BIHR)
Bradford Royal Infirmary
Email: BradfordResearch.Applications@bthft.nhs.uk
Fax: 01274 38(2640)

Research Support & Governance Manager
Mrs Jane Dennison
Email: jane.dennison@bthft.nhs.uk
Tel: 01274 382575 (Direct)

Director of Research/BIHR
Professor John Wright
Email: john.wright@bthft.nhs.uk
Tel: 01274 364279 (Direct)

17th October 2013

Dr Sylvie Collins
Bradford Teaching Hospitals Foundation NHS Trust
St. Luke's Hospital
Little Horton Lane
Bradford
BD5 0NA

Dear Dr Collins,

NHS Permission Letter for Research at Bradford Teaching Hospitals NHS Foundation Trust

Re: A qualitative study into the roles of food within relationships after bariatric surgery.
Sponsor: University of Leeds
REC Ref No: 13/LO/1242
R&D Ref No: 1606
CSP Reference: N/A

Following submission of your Site-Specific Information form and supporting documentation seeking permission to conduct the above study at Bradford Teaching Hospitals NHS Foundation Trust (the "Foundation Trust"), I am pleased to inform you that your application has successfully completed an internal review process appropriate for this type of study and has satisfied our research governance checks. A project record has been created on the Foundation Trust's research database. You may commence research activities at the Foundation Trust in the locations specified in your Site-Specific Information (SSI) form subject to the terms of this letter. The effective date of NHS permission for research is the date of this letter and this is the earliest commencement date for research activities at the Foundation Trust. This letter supersedes all previous letters you have received from us with regard to permission to proceed with this research at Bradford Teaching Hospitals NHS Foundation Trust.

NHS permission for the above research has been granted on the basis described in the application forms, protocol and supporting documentation. The documents reviewed were:

INVESTORS IN PEOPLE   POSITIVE ABOUT DISABLED PEOPLE   BRADFORD CITY OF FILM a UNESCO creative city   **Better Medicine, Better Health**

Reviewed Documents –

Document	Version	Date of document
SSI form	127146/498010/6/731/196392/280522	29/08/2013
NHS R&D form	127146/497977/14/773	04/07/2013
Protocol	1.0.	06th July 2013
Participant Information Sheet:	Version 1.0.	06th July 2013
Participant Consent Form:	Version 1.0.	06th July 2013
Ethics Favourable Opinion Letter		22nd August 2013

The site for which NHS permission for research is given is -

Bradford Teaching Hospitals NHS Foundation Trust

The terms referred to are:

1. You are the Principal Investigator or Local Collaborator for this Study and you are responsible for the conduct of this Study at this site.

2. NHS Indemnity applies to this Study with respect to negligent harm. However, NHS Indemnity does not provide compensation in the event of non-negligent harm.

3. *This Study is a non-CTIMP (ie, **not** a clinical trial that involves an investigational medicinal product) and you may commence recruitment on receipt of this letter if you are ready to start.*

4. Ongoing permission is subject to you adhering to the Trust's standard conditions of NHS Permission for research (attached).

5. You comply with the R&D Office's Oversight Plan as detailed below.

The approach taken for each Study shall be proportionate to the risks associated with the Study and the level of monitoring and support being undertaken by the Sponsor. The R&D Office's Oversight Plan for this study is as follows –

1 Study Tracking
Please provide the R&D Office with –
   a. Completed initial project status enquiry report sent to you directly from the R&D Office following the NHS Permission Letter.
   b. Completed Principal Investigator (PI) Annual Progress Report available from the Downloads section of the Bradford Institute for Health Research website at www.bradfordresearch.nhs.uk due every year for the life of the Study on the anniversary of the date of this letter.
   c. Completed PI end of study declaration report (as defined in the protocol) (together with final recruitment figures for the Foundation Trust) available from the Downloads section of the Bradford Institute for Health Research website at www.bradfordresearch.nhs.uk

    d. Copy of amendment documentation and a copy of the REC and MHRA (if applicable) approval letters prior to implementing the changes at the Foundation Trust.

2 Issue Management –
    a. Managing External Agreements.
    b. Managing Internal Agreements.
    c. Managing Study Processes.
    d. Managing Research Passports

If an issue arises during the Study, please ensure you have a process in place to escalate this and seek support from the R&D Office.

3 Audit -
The R&D Office performs a risk assessment prior to issuing this letter which provides the Foundation Trust with a risk-based approach to audit activities. The R&D Office undertakes to audit at least 10% of its research projects each year. Priority will be given to studies with the higher risk scores, clinical trials involving an investigational medicinal product(s) (CTIMPs), NIHR portfolio studies, and studies sponsored by the Foundation Trust. Some low risk studies may not be subject to scheduled audit at all. You will be informed by the R&D Office if a scheduled audit of this research study is planned in plenty of time (ie, at least six weeks' notice).

The R&D Office always has the option to conduct specific oversight activities at any time as the result of any exceptional activity / events identified during the Study and failure to comply with these terms may lead to suspension or termination of NHS Permission for research.

Please inform the R&D Office immediately should you have any concerns about patient safety or wellbeing with regard to research at the Foundation Trust.

If you have any queries during the conduct of your research, please do not hesitate to contact the Research Governance Manager using the contact details provided at the top of this letter. May I take this opportunity to wish you well with your research Study.

Please help us to improve our service by completing the feedback form emailed previously to you and returning it to the R&D Office as soon as possible.

Yours sincerely

PROFESSOR JOHN WRIGHT
Director of Research/BIHR

Encs

cc CI/Sponsor/study co-ordinator

Appendix VI. Interview Schedule

- *Opening Statement-*

"Food and eating can play a very important role in some people's relationships with the other adults in their lives (i.e partners, friends & relatives). Activities such as food shopping, cooking, and dining are activities that can be shared with family and friends. Bariatric (weight loss) surgery not only changes what and how much people eat; it can have an impact on their relationships with others because of the required changes to eating. I would like to talk to you about your own experiences of such things and what has happened as a result"

- *Context Question-*

1. **Can you please tell me who the most important people are that you most frequently share experiences of food and eating with at the moment?**
   - Family, friends, colleagues?
   - Who's the most important?
   - What relationship are they to you?
   - What do they mean to you?
   - How does this compare to before surgery?

- *Main Interview questions-*

2. **Please can you tell me about a recent shared experience of food with someone significant in your life?**
   - How did the experience make you feel?
   - What did that mean for you to share that experience?
   - What sense did you make of that?
   - What did that mean for your relationship?
   - How does this compare to before surgery?
   - Do you have another example?

3. **What do you think X think(s) about how food and eating are for you now?**
   - How do you feel about that?
   - What is that like for you?
   - What did that mean for your relationship?
   - What about X_2, what do you think they think?

4. **Please can you tell me about a recent time when eating with others in a more social setting has gone well?**
   - Who was involved?
   - What happened?
   - Why did you think it had gone well?
   - What sense did you make of that?
   - How did you feel?
   - What impact has that had on you / your relationships?

5. **Please can you tell me about a recent time when eating with others in a more social setting has been more challenging for you?**
   - Who was involved?
   - What happened?
   - Why do you think it felt challenging?
   - What sense did you make of that?
   - How did you feel?
   - What impact has that had on you / your relationships?

6. **What are your current thoughts around planning for future social events involving food?**
   - i.e. Christmas, birthdays, parties etc.
   - How do you feel about that?
   - How will you manage it?
   - How is that different to before surgery?

7. **How do you think the experiences we've been talking about would be, if you hadn't had surgery?**
   - What would the pros and cons have been?
   - What would that have meant for your relationships?
   - How do you feel about that?

8. **Is there anything else you would like to tell me that we haven't already covered?**

Appendix VII. Confidentiality Statement for Transcribers

Confidentiality Statement for Transcribers

Ethics Committee, School of Psychology, Leeds University

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Ethics Committee of the D.Clin.Psychol course requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

1) I understand that the material I am transcribing is confidential.

2) The material transcribed will be discussed with no-one.

3) The identity of research participants will not be divulged.

Transcription procedure

4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.

5) I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.

6) All materials relating to transcription will be returned to the researcher.

Signed..**Date**........................

Print name..

Researcher..

Project title...

Appendix VIII. Excerpt from Reflective Journal

25/04/14 – PS analysis

26/04/14 PS – Analysis

20/04/14 PS analysis

26/04/14 PS – Analysis

21/08/14 PS – analysis
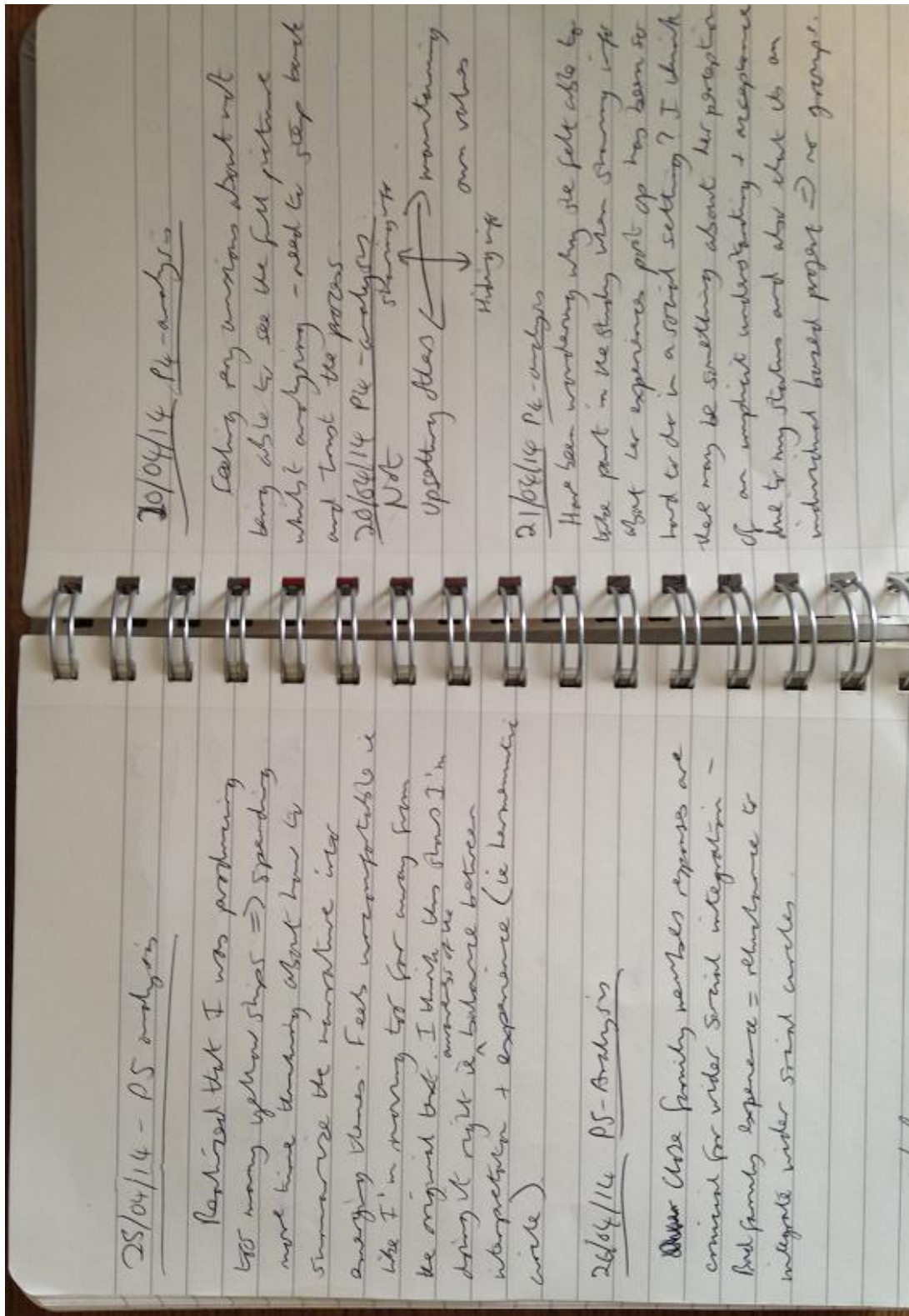
Appendix IX. Coded Interview Extract

560	[PARTICIPANT]: I get to feed somebody, that...I absolutely love doing stuff like that,	*Loves feeding others.*
561	erm it...	
562	[INTERVIEWER]: Why do you think that is?	
563	[PARTICIPANT]: Because foods always a comfort isn't it, foods something that you	*Food is a comfort.*
564	sort of give to people as a gift really and I'm getting to do that, they're all coming to see	*Food is a gift* *Cooking allows her to get comfort from social interaction +*
565	me and I get to make sure that they go home satisfied really.	*satisfaction from giving food as a gift.*
566	[INTERVIEWER]: And why do you think that? Why do you think you do that?	
567	[PARTICIPANT]: Cause I'm a feeder, I've always, I've grown up round food, I've	*Food always been important part of life growing up.*
568	always had, foods always been a massive comfort to me and I feel that that makes other	*Food is a comfort, makes others feel comfortable*
569	people feel comfortable, so by me making them welcome in my home and wanting to	*so it way of connecting socially*
570	feed them, then I hope that that makes them feel comfortable.	
571	[INTERVIEWER]: And what does it mean to you that you're able to do that?	

Cooking for others provides a vehicle to social connection which in turn provides a source of comfort. Of comfort
- Relaxation vehicle s comfort
Food is

47

572   [PARTICIPANT]: Oh yeah, it's, yeah I like doing it, I absolutely love doing it, it's, it's

573   brilliant, yeah.

574   [INTERVIEWER]: So how, how will you manage the situation then tomorrow?

575   [PARTICIPANT]: I'll just pick at things that I know that I can have, and the nice thing

576   is, because it's the girlies and they know the situation and they know everything, they

577   won't force me to try do anything that, if you go somewhere with people that don't know

578   you it's like 'here, have a biscuit' 'here, have a bar of chocolate, and this' and it's stuff

579   that I know that I can't have but they don't, whereas the girlies know that I can't have

580   certain things so they just leave me to do my little bit and they'll just get on with it

581   themselves.

582   [INTERVIEWER]: So you said when you go places where you don't know people and

583   they offer you things that you know you can't eat, how does that feel when that happens?

Handwritten margin notes:

Gets real pleasure from cooking for others.

Tracey will have the freedom to eat what she likes because her friends all know + understand her cooking requirements. Strangers tend to force food on her which she turns down + work but her friends know all the ins + outs.

Social inclusion + acceptance + the perception of the positive normality.

48

584 [PARTICIPANT]: It can be quite embarrassing sometimes I think, well not

585 embarrassing, you just feel ungrateful erm but you know, you go to somewhere 'ooh can,

586 you know, would you like a cake or would you like this?' or you know if you go out for

587 a coffee somewhere 'can I get you a biscuit?' and they don't understand that you can't

588 eat sweet anymore and you have to kind of go, it…I went…like I say we've been to

589 [Place] and it was my birthday while I were away, and what they did because it was my

590 birthday, they baked me a cake and put it on the bed, and the cleaner came in and he's

591 like 'happy birthday, happy birthday' and I had to go see the reps because there was only

592 me and mum and I just thought there's this massive cake, it's filled with chocolate, I'm

593 sure that somebody would appreciate this and you then have to go to somebody and say

594 'I don't mean to be ungrateful but I really don't want it to go to waste, can I give it to

595 somebody else so that they can eat it because I, I can't?' and then it, then you get into the

596 why, the wherefores and all that sort of thing but…

597 [INTERVIEWER]: And how does that feel?

49

(handwritten margin notes, right side)

Eating with strangers can be embarrassing.

Feel ungrateful refusing food people offer

They don't understand about the eating changes
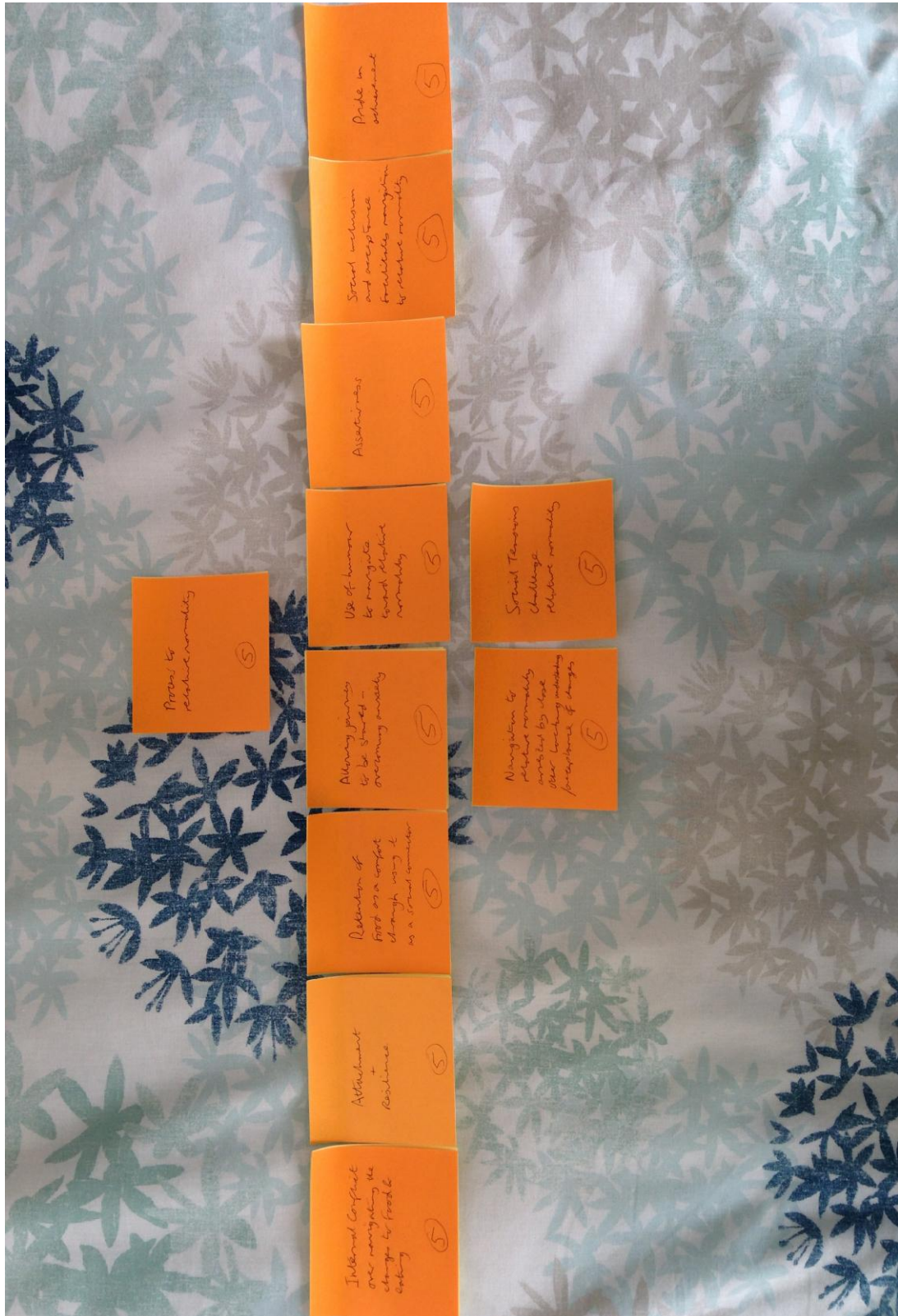
Had a cake baked for her when on holiday

Had to work/sort it out — she could give it away because felt ungrateful she couldn't eat it

Then had to explain why she couldn't eat it

(handwritten margin notes, left side)

Social Trauma

People who aren't aware of the situation can upset someone

Appendix X. Individual Participant Analysis

Appendix XI. Initial Group Analysis