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# Perspectives of bariatric surgery patients on the role of pre and post bariatric surgery counseling

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## ABSTRACT

This research study explores the perspectives of bariatric surgery patients about the role of pre and post bariatric surgery counseling. Their perspectives were gathered through semi-structured, qualitative interviews, which explored participants' experiences with counseling throughout the bariatric surgery procedure. This study also aimed to identify what barriers patients encountered when seeking counseling and what improvements could be made to the process. Major findings were that most participants felt unprepared for surgery, and that the pre-surgical psychosocial intakes were not useful in preparation. Many participants felt intakes could have been helpful if conducted differently. It was also identified that intake clinicians did not seem to have the knowledge to work with bariatric surgery patients. Another major finding was that despite research-driven guidelines for post-surgical support, participants' care teams seemed to speak very little about opportunities for ongoing support. Unfortunately, a surprising secondary finding was that when participants did attend those support groups they often found them to be confrontational and unsupportive. In some cases, this discomfort led participants to stop attending support groups. The finding suggests that bariatric surgery patients would value and potentially benefit from ongoing attention to counseling options, and from support groups facilitated by clinical social workers with experience in group dynamics.

# PERSPECTIVES OF BARIATRIC SURGERY PATIENTS ON THE ROLE OF PRE AND POST BARIATRIC SURGERY COUNSELING

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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# CHAPTER I

## Introduction

As obesity continues to be an important health concern in the United States with over one-third of Americans being categorized as obese (Ogden et al., 2012), a growing number of Americans are turning to bariatric surgery (BS) as the solution. BS is a medical procedure that is used as a weight loss intervention, and is generally conducted once a practitioner and patient deem that dieting and exercise will not be sufficient in bolstering weight loss. The increase in BS is not only connected with the increase in weight gain in America, but it has also become a more accepted intervention as this procedure has become more efficient and more insurance companies are covering the costs of the surgery (Owers et al., 2012).

At the same time, it is increasingly acknowledged that surgical intervention can only be a part of an overall weight loss plan, attending to psychological and social factors as well as the physical. There have been many studies that focus on the importance of counseling as an added support to this medical intervention and identify that individuals who attend counseling and support groups self-report greater success after surgery (Glinski et al., 2010). Although it has been identified that post-surgical support is an important part of weight loss and weight management after surgery, it has also been identified that up to 80% of BS patients do not attend post-surgical counseling (Magro et al., 2008). This statistic is alarming due to the fact that many BS patients continue to struggle with maladaptive eating behaviors after surgery and would benefit from support and psychoeducation around this topic (Bocchieri-Ricciardi et al., 2006).

What relevant research fails to identify is why patients are not attending post-surgical counseling and what barriers may be contributing to this lack of attendance.

This study explores patients' perspectives of pre and post-surgical counseling. This qualitative study used open-ended interview questions to gather the perspectives of BS patients on their experience of counseling pre and post-surgery. It will also work to understand in what capacity they received these services, their awareness retrospectively of other available resources, and how if at all they felt support services might be improved through enhanced social work attention to this issue. This study also sheds light on barriers participants face in receiving services. It will do so by exploring the perspectives of twelve BS patients who have completed the Roux-en-Y gastric bypass procedure and have both attended post-surgical counseling and have reached the weight maintenance stage after surgery.

These findings demonstrate the urgent need for greater attention by social workers to the psychosocial support needs of patients undergoing BS. This research was conducted in fulfillment of the author's thesis requirements of Smith College School for Social Work, Master of Social Work program. This study was submitted to and approved by Smith College's Human Subjects Review Board, see appendix (see appendix D).

Chapter II is a comprehensive literature review, focusing on multiple components of BS. This chapter is structured into multiple sections that provide pertinent information on each of these components of BS. The first segment explains BS and focuses on the importance of a multidisciplinary care team for all BS patients. The second segment explores premorbid behavioral health factors and dietary noncompliance. The third segment discusses the pre-surgical intake process and the importance of post-surgical counseling. The fourth section

reviews different types of treatments that are used in pre and post-surgical counseling. The final segment examines multiple sociocultural factors associated with BS.

Chapter III is the methodology section, which outlines this study's research process. This qualitative content analysis study was conducted through interviews with individuals who have completed BS. These twelve participants were recruited through an online BS support community. Since this online support site is a closed website for individuals who are preparing for BS or have completed the surgery, the researcher had to disclose the fact that he was had completed BS. This self-disclosure from the researcher not only assisted in building rapport, but led to more fruitful conversations and cross talk. All participants were asked open-ended questions that allowed them to explore their experiences with BS. This format was selected because open ended questions allow participants to explore their experiences without feeling confined to a particular topic, and allowed for the researcher to gather more information with added questions if deemed beneficial to the project. These responses were then analyzed and major themes were identified.

Chapter IV is the findings chapter which identified all major themes in participants' responses and discussed them through different sections. The first section is demographic data. The second section explores patients' experiences prior to enrollment in bariatric surgery. The third section discusses what structure of participants' treatment teams, and the types of counseling offered to patients. The fourth section examines patients' perspectives of their pre-surgical intake. The final section discussed patients' experience on multiple components of counseling and support post-surgery.

Chapter V is the discussion chapter which explores the most salient themes from these participants' interviews while comparing them to relevant literature, the study's strengths and

limitations, clinical implications for social workers, and recommendations for future research. One major theme from this research was that participants felt as though their pre-surgical intake clinician did not have the knowledge to work with the BS population. It also was identified that many participants believed this was due to the fact that most clinicians were not part of their care team which left them feeling alienated.

Another major finding was that participant didn't feel as though post-surgical counseling was discussed enough by their BS agencies, and identified that post-surgical support groups were not as supportive as they wanted them to be. Due to this fact participants stopped attending support groups and began seeking alternative forms of support. This chapter also discussed clinical implications for social workers. One major implication that was identified was the fact that participants felt as though their intake clinician was not knowledgeable with regard to BS. This is important for social workers because it identifies the fact that clinicians must either continue their clinical education when working with this particular population, or they must recognize where they are lacking and not accept the client. This standard, stated in section 1.04c of the Social Work Code of Ethics, is important in providing clients with appropriate care.

This study has been personally meaningful because of my own history of having completed BS. I became interested in exploring this topic when I began to realize that other BS patients did not have as much success with the surgery as I have had. Comparing stories, I began to understand that not all BS agencies followed the same protocols, which led to my curiosity about how counseling was presented to patients. I was also curious to understand if counseling was a key component of preparation for BS and what role social work as a field plays or could play in supporting patients throughout their treatment.

# CHAPTER II

## Literature Review

Bariatric surgical (BS) procedures are an increasingly common form of intervention for assisting obese patients in losing weight and creating a healthy lifestyle changes. According to Owers and colleagues (2012) BS has been increasing in popularity as a weight loss solution due to the fact that insurance companies are more willing to cover them, and because they have become safer and more efficient. This is the case because procedures have moved to less invasive methods such as laparoscopic surgery. Despite the fact that these procedures have become more accessible, routine, and common, so far there has been very little attention in the literature to how patients experience BS.

The purpose of this study is to explore patients' perspectives of pre and post-surgical counseling. This study will also work to understand in what capacity they received these services, or if they even were aware of these services. To do so this literature review will be broken down into multiple sections that explore the need to better understand patients' perspectives. These sections are the following: 1) the importance of having a multidisciplinary team approach to BS, 2) premorbid behavioral health factors that influence patients, 3) an understanding of the pre-surgical intake process and the importance of post-surgical counseling, 4) treatment modalities that have been used in conjunction with BS, and 5) sociocultural factors that influence patients access to BS and also influence their experiences of the procedure. By understanding these factors that play a role in patients' BS experiences, this will allow us to understand why patients' perspectives are a pivotal piece in the success of any procedure.

**Bariatric Surgery and a Multidisciplinary Approach**

BS is a medical procedure that is held in facilities across the country, and in most facilities teams of clinicians work together to provide patients with the support they need to successfully complete the surgery. This multidisciplinary team approach to care provides supports in monitoring patients' physiological and psychological health (Owers et al., 2012) and facilitates multiple prospective on patients care. These multidisciplinary teams must consist of medical doctors, clinical social workers or other mental health professionals, dieticians and specialized nurses.

Unfortunately, these experienced treatment teams don't always get fully utilized in real world application. The lack of case management creates a lack of support for BS patients, and results in lower BS results. Wood and Ogden (2012), argue that although bariatric surgery is a popular treatment for obesity, up to twenty percent of patients using this form of intervention are unable to achieve significant weight loss because they are not receiving post-surgical support from these multidisciplinary teams. This is a crucial reason for understanding BS patients' perspectives because it is important to know if they were offered post-operative counseling opportunities from their teams.

This article is very similar to the Greenberg and colleagues article (2005) which again highlights the importance of having multidisciplinary teams and other forms of post-surgical support. It was understood that patients who received post-surgical counseling support were more likely to self-report greater BS success. This can be attributed to post-surgical counseling and support groups which assisted patients in navigating their new healthy lifestyles. Glinski and colleagues (2001) discuss the importance of continued psychological services post-surgery by explaining the positive correlation between patients who have received group therapy post

bariatric surgery as opposed to those who have not. This article found that patients that seek group therapy post-surgery are able to lose a more significant amount of weight post-surgery and keep the weight off over time while identifying the importance of being continuously monitored by medical supervision post-surgery.

According to Inge and colleagues (2004), all BS patients should receive a strong recommendation to see a mental health professional, as a way to monitor post-surgical complications. These services include the medical component of routine post-surgical follow-ups, but also mental health counseling to monitor maladaptive behavioral patterns or psychiatric disorders that exist prior to surgery. This is an important part of BS success because clinical social workers or other clinicians are able to monitor any maladaptive eating behaviors such as emotional and binge eating while also providing clients with the coping skills they need to continue their healthy lifestyle change. For this reason it is necessary to know if patients are being offered these supports or are aware that they exist.

The importance of receiving routine follow-ups by multidisciplinary teams is also heavily stressed in the study conducted by Magro and colleagues (2008). In this study which examined factors for BS failure, it was identified that among patients for whom surgery failed, 60% never underwent nutritional follow-up, and 80% never sought post-surgical counseling. These statistics were later examined and thought to be the reason why BS procedures were not as successful as once thought. One component of patients' experience that this study failed to fully explore was whether or not patients were aware of the importance of post-surgical counseling, whether the patients themselves would have believed post-surgical counseling to be a potentially useful resource, or if their multidisciplinary teams had urged them to attend routine follow-ups. Although not receiving post-surgical counseling or medical monitoring is not directly correlated

with surgical failure, it is important to consider premorbid psychological conditions that influence the success of BS.

**Premorbid Behavioral Health Factors and Dietary Noncompliance**

The inability to lose a significant amount of weight post-surgery is not only associated with failure to attend post-surgical counseling but it is also connected with premorbid behavioral health and postsurgical dietary noncompliance. Premorbid psychological factors include, but are not limited to emotional and binge eating, psychiatric disorders, and medical conditions that were existent prior to surgery. In an interesting pilot randomized control study, Weineland and colleagues (2011) found that most BS interventions do result in significant weight loss but up to thirty percent regain some weight within 24 months. What this study did not fully explore was the reason for this weight gain. It also did not take into consideration psychological factors that could have played a role in the weight gain such as anxiety or depression.

This two year mark is not only a key benchmark for weight gain, but also for suicide in patients who have undergone the surgery and are not pleased with their results or are struggling with their current weight gain (Tindle et al. 2010). The researchers consider this to be partly influenced by inconsistent treatment teams and waning interest in routine follow up, as well as premorbid psychological factors. Although this is the case, again in this study little attention is paid to why patients did not seek post-surgical counseling or whether they were offered information on post-surgical counseling options.

Tsushima and colleagues (2004) argue that it is extremely important to look at this form of surgery as not only an anti-obesity surgery but also a behavioral surgery which illustrated the fact that psychological support is just as important in the success of patients as medical support.

In taking into consideration important psychological factors that existed prior to surgery, a particularly impactful one is a patient's history of emotional eating. Emotional eating can be defined as eating during stressful or uncomfortable times with the intention of changing or masking those emotions through oral stimulation. In a survey conducted by Chesler (2012), information was gathered to support the idea that untreated emotional eating was a key risk factor for poor weight loss after surgery and a continuation of an old maladaptive coping skill. It was also speculated that by combining the BS procedure with treatment for emotional eating patients could optimize a positive surgical outcome. What was not discussed in the article was whether patients were aware of this problematic pattern prior to having BS.

Other psychological factors that can lead to the failure of BS are the psychological phenomenon of food grazing and loss of control related to eating or binge eating. According to Colles and colleagues (2008), grazing is when individuals continue to snack throughout the day, between meals, as a way to create an emotional stability. Binge eating is the phenomenon of an individual's inability to control their eating behaviors to the point where they are consuming excessive amounts of food which sometimes leads to nausea, vomiting, or physical pain. These uncontrollable episodes are usually linked to emotional disturbances where food is used as a maladaptive coping mechanism. What was not known was whether these patients ever sought post-surgical counseling for these behaviors, or if they were aware of the extent of their behaviors. The study did identify that individuals who presented with these behavioral patterns prior to surgery had poorer postsurgical weight loss.

As reported by Bocchieri-Ricciardi and colleagues (2006), individuals who struggled with binge eating or emotional eating who sought post-surgical counseling were more likely to self-identify greater success with their BS. What is important to know is whether these patients

who sought post-surgical counseling were aware of these behaviors prior to surgery, or whether they were advised to seek counseling post-surgery.

Other psychiatric disorders that are prevalent in the BS population are social phobias and avoidant personality disorder. For these patients, phobias and disorders may also make it difficult for them to attend postsurgical counseling groups which are pivotal to the success of their surgery (Lier et al., 2011). What is not known through this study was what other supports these patients were given. It was unclear if in a situation where these patients were uncomfortable with groups, if they were offered individual therapy options or other option such as online support communities. It was also observed that personality disorders played a large role in the success of BS because they begin in adolescence during key developmental milestones, and persist through adulthood (Herpertz et al., 2004). It was also identified that patients who had personality disorders continued to struggle with interpersonal relationships after their surgery, and this affected their ability to seek post-surgical counseling.

Although there was a disconnect between patients needing post- surgical counseling and their ability to receive it, this study illustrates the importance of having post-surgical counseling because a personality disorder is something that will impact the BS client throughout the rest of their lives and is something that needs to be explored in counseling. It is not known whether these patients were able to seek treatment after their procedures, and if they have found counseling to help them with their personality disorder and BS success.

Another psychiatric condition that impacts the success of weight loss is depressive disorder linked with general depression. It was identified that individuals who have depressive disorder due to their obesity showed signs of improvement post-surgery due to weight loss alone, but the surgery did not relieve all their symptoms (de Zwaan et al., 2011). This finding illustrated

the need for both post-surgical counseling and awareness that surgery isn't the complete solution for depression in obese individuals. Similarly it was found that even though depressive disorder symptoms improved, many clients later sought psychological treatment for their disorder because they continued to have high levels of depression. What is unclear is why BS patients sought treatment and what role their multidisciplinary team played in this decision. Sarwer and colleagues (2005) advocate in their article that clinicians who identify even minor depression in their patients before BS should especially recommend counseling services pre and post BS. These recommendations should include a form of mental health counseling such as group or individual therapy as part of the pre and post-surgical treatment plan.

Anxiety disorder was another psychiatric condition that was found to have negative implications on the success of BS. Kalarchian and colleagues (2007) discovered that anxiety disorders were the most prevalent disorders at the time of pre-surgical intake, and outnumbered other maladaptive eating behaviors such as binge or emotional eating. They also identified that patients who have anxiety disorders are less likely to have a functional health status and are less likely to succeed after surgery. This is important because these clients are in most need of post-surgical counseling, but are the least likely to receive it. What was not identified was why these patients did not seek treatment and if they had been aware of the implications of not receiving post-surgical counseling. One thing that is important to point out is that patients that have comorbid psychiatric disorders display more preoperative shame than patients without comorbid psychiatric disorders (Lier et al., 2012). This shame also often has implications on patients' ability to attend postsurgical support groups and counseling.

As the above studies indicate, there is a marked importance in providing patients with counseling post-surgery due to the fact that many individuals continue to have difficulty with

both preexisting psychological factors and tend to be dietary non-compliant post-surgery. Dietary noncompliance which is a main behavioral concern associated with bariatric surgery includes snacking throughout the day, binge eating, eating fatty foods, drinking soda and not attending support groups. Dietary noncompliance is an issue that bariatric surgery agencies take seriously because maintaining healthy eating behaviors post-surgery is the most important part of weight loss management (Elkins et al., 2005). This research also shows that in the first six to twelve months patients generally reported being dietary noncompliant. This is an important finding because it shows a possible lapse in the effectiveness of pre-surgical intakes, and continues to highlight the importance of post-surgical counseling. This study also illustrates why it is important to further understand the pre-surgical intake process and the need for more awareness around post-surgical counseling.

**Pre-Surgical Intake and the Importance of Post-Surgical Counseling**

Prior to patients being able to complete any bariatric surgery procedure, many programs require that individuals complete a pre-surgical intake. This pre-surgical intake is generally used as a tool to pre-screen clients out of the procedure by looking at any characteristics of psychiatric disorders or problematic eating behaviors. Patients who are screened out of the surgery are usually asked to seek additional counseling and are later reentered into the program once they have met agency standards. The majority of patients understand this risk prior to intake, so they omit information about themselves (LeMont et al., 2004). For this reason pre-operative intakes lack the ability to fully gather all important information due to the fact that patients are failing to disclose specific details.

It is unclear whether patients fail to disclose pertinent information intentional or unintentionally but what is identified is that some patients are completing the intake without

being screened out. What this means is that patients' fail to disclose important information such as problematic eating behaviors and history of depression so that they can have BS without having to go through the pre-surgical counseling protocol of their agency. By not disclosing these behaviors and symptoms, patients mask the underlying causes of their eating pathology, which makes dietary compliance and post-surgical lifestyle changes difficult to follow (Sarwer et al., 2004).

For this reason it is key to understand if patients actually recognize the importance of identifying their problematic eating behaviors, or the importance of post-surgical counseling. Kalarchian and colleagues (2007) identified that there is a high probability that patients did not disclose problems they feared may lead to the denial of surgery or prolonging of the pre-surgical process. Again what is not explored is whether or not patients understand the reason why prolonging the pre-surgical process is important to their post-surgical success. While pre-surgical screenings are unable to fully gather all preexisting patients' information due to either intentional or unintentional patient omissions, the issue is likely complicated by the fact that there is a lack or standardization in screening methods (Wolfe & Terry, 2006).

This lack of standardization protocols across BS programs is likely due to limited outcomes-based research. There may also be a lack of standardization because each patient presents in a different manner, and by having a strict standardized protocol, it may disqualify individuals from surgery even when there is a great sense of self-determination or motivation in their BS success. Having the understanding that there is limited research in the efficacy of preoperative intakes, it is vitally important that postsurgical counseling be a part of all patients' aftercare plans.

Not only can patients mask their underlying eating pathology, but certain patients attribute their previous failures in the realm of weight loss to a medical condition, when in reality it was later discovered that these patients used preexisting medical conditions as a way to externalize their maladaptive eating behaviors (Hwang et al., 2009). It was also identified that many patients seeking BS stated in their pre-surgical intake that they had supportive family and friends even though this was not the case. This is important because support from family and friends is an important part of BS success, and it is not clear if BS patients understood the importance of these peer supports.

For patients who lack supportive family and friends, it is even more important that they seek post-surgical counseling as a way to build supportive peers that help in boosting self-esteem. Due to the fact that pre-surgical intakes emphasis the importance of identifying problematic eating behaviors, psychiatric disorders and patients motivation to make lifestyle changes, the psychosocial portion of the intake is crucial in patient selection and the development of treatment plans. These pre-surgical assessments can take many forms but generally last approximately 60 to 90 minutes. These intakes assess psychological functioning, psychosocial status, dietary habits, identification of patient supports, and a Beck Depression Inventory (Wadden et al., 2001).

The intensity of the pre-surgical intake is intended to make it difficult for individuals to mask their preexisting psychological disorders. Although pre-surgical intakes are meant to identify all these underlying factors, LeMont and colleagues (2004) stress the point of having patients take part in intensive psychological testing due to the fact that it is more difficult to mask problematic eating behaviors during psychological testing. This study also stressed the

importance of post-surgical counseling because some patients may not recognize the existence of maladaptive eating behaviors.

The emphasis on the effectiveness of pre-surgical mental health screening may at times obscure the potential value of counseling before and after the surgery, regardless of premorbid conditions. It is also interesting to me that there are limited resources and requirements in pre-surgical screenings that explore the sociocultural factors that impact BS patients. This topic will be discussed in a later section of this literature review. Although this lack of sociocultural exploration is not a vital portion of the intake, what could be a more useful approach to ensuring patients BS success post-surgery is to require all patients attend pre-surgical and post-surgical counseling as a mandatory element of treatment. There have been many studies conducted that have looked at different treatment modalities, and identified that they are beneficial in treating premorbid, comorbid and sociocultural factors that impact the success of BS.

**Treatments used in Pre and Post-Surgical Counseling**

There has been some recent attention to specific pre-and post-surgical mental health treatments in the field of BS that have been linked with greater BS success. These have included cognitive-behavioral therapy (CBT), Acceptance and Commitment Therapy (ACT), and mindfulness-based treatments. The modality that has been researched the most in the mental health treatment of BS patients has been CBT. CBT is an evidence-based practice that helps clients explore their past thought patterns, their emotional reactions to those thoughts and the behaviors that they express due to their emotions (Sheldon, 2011). This is all explored through the discussion of current issues, and through this exploration of past difficulties, patients are asked to dissect those past experiences and find new alternatives to their difficulties.

One CBT study by Ashton and colleagues (2009) looked at clients who were preparing for bariatric surgery and placed them in a four session CBT group. This study found that patients who participated in the group showed a reduction in their maladaptive eating behaviors. It also identified that most BS programs could benefit from this type of treatment because it allowed the patients the opportunity to better understand their maladaptive eating behaviors and work on reframing them prior to surgery. This is extremely important to the success of BS patients because if they had the opportunity to go into the procedure knowing there maladaptive behaviors, then it would assist them in staying dietary compliant.

A study held by Saunders (2001), also identified CBT as an important treatment modality for reducing binge eating in BS patients. Saunders stated that CBT was a useful treatment modality for helping BS patients uncover and explore their problematic eating behaviors while also gaining new coping skills that could be used to replace the problematic ones. Saunders also identified that support groups such as Overeaters Anonymous coupled with a treatment such as CBT was the most successful treatment and produced a positive therapeutic outcome in correlation with weight loss. Again what these studies did not identify was whether patients were aware of the importance of being in these treatment programs prior to surgery, or if their treatment teams had discussed these treatments as post-surgical options.

Another treatment modality that has been useful in treating BS patients prior to having BS is ACT. ACT is another evidence-based practice that explores patients behaviors through clinical analysis and according to Hayes and colleagues (2005), “The main purpose of ACT is to relieve human suffering through helping clients live a vital, valued life through helping clients live a vital, valued life” (p. 3). Weineland and colleagues (2012) found that in a pilot version of ACT, the treatment had a positive effect on BS patients with preexisting eating disorders. The

researchers developed a modified version of ACT geared towards patients who were overeaters, and the treatment was built on an internet based program. It was found that clients who participated in this treatment were able to better understand their negative thoughts and feelings. They also were able to identify and implement new behavioral changes that could take the place of their past problematic behaviors. This is important because in identifying and then changing these behaviors, patients were able to create a new lifestyle change prior to having BS. This lifestyle change assisted them in preparing for their dietary compliance post-surgery.

Another modality of therapy that has been identified as useful has been discussed by Leahey and colleagues (2008). It focuses on the importance of mindfulness therapy post-surgery and explores the idea that by practicing techniques such as mindfulness, patients are better prepared to limit their food intake. This is important because individuals who are not mindful of when they are full have the tendency to overeat, expand their stomach, or even in some cases rip their stomach. Also patients who are able to better notice what their body is feeling are better able to identify when they are full and have a better chance at combating previous patterns of binge eating as a way to self sooth.

Other research such as Hwang and colleagues (2009) have not only identified the importance of individual and group counseling modalities such as mindfulness post-surgery, but have discussed how new methods of finding post-surgical supports are becoming more readily available. This article stated that weight loss groups such as online support groups have also been found to be extremely important in the success of bariatric surgery clients. It was found that these new support groups have been useful because individuals taking part in these groups have more avenues to discuss difficulties they have face post-op, and this form of support is useful to individuals who don’t have local counseling programs or have psychiatric conditions that make it

difficult for them to attend counseling in person. As new research on pre and post-surgical counseling approaches is becoming very hopeful it is also important to identify that the research literature is just beginning to develop, and this developing literature has yet to integrate awareness of how sociocultural factors play a role in the success of BS.

These studies illustrated that practices such as CBT, ACT and mindfulness that are taught both pre and post-surgery have all been identified as practices that assist maladaptive eating behaviors and increase the likelihood of having patients stay dietary compliant post-surgery. These treatment modalities coupled with traditional methods of postsurgical counseling such as psychodynamically informed supportive counseling and group therapy continue to be successful tools in positive BS weight loss (Livhits et al., 2011).

**Sociocultural Factors Associated with BS**

When looking at any medical procedure and patients' ability to access these medical interventions, we must take a look at the ways sociocultural factors such as access to healthcare, ethnic differences, and environmental factors play a role in the success of BS patients. Buffington and colleagues (2006), identified many factors that affect the success rates for patients from different ethnic groups undergoing BS, for example African-American females were less likely to lose weight in comparison Caucasian females. This was explained by the fact that not only do African-American women biologically lose less body fat than Caucasian women through dieting but that culturally it is more acceptable for African-American women to be overweight. This is not the case in Caucasian women, where culturally thin women are attractive. This illustrates the fact that in this study Caucasian women identified their own body image issues as their motivation to lose the weight.

In a very similar study, Harvin and colleagues (2008), identified a significant difference in weight loss between races and attributed it to the fact that there is a discrepancy related to environmental factors that impacted their participants. They found that African-American and Hispanic women lost less weight than Caucasian women because they had limited access to a healthy diet. This was connected to the fact that the Caucasian women seeking treatment in their program mostly came from higher-income communities while the African-American and Hispanic women came from lower income communities. It was also identified that these clients had less access to post-surgical counseling because their insurance companies didn't support outpatient programs, or their communities didn't have the ability to financially provide these patients with these programs. One topic that this study did not explore was whether individuals going through BS were aware of the extent to which socioeconomic variables affected their success post BS or whether they in fact believe these factors did play a role in their success.

Alexander and colleagues (2008) identified that many of the clients attending BS programs on insurances such as Medicaid came into treatment with higher Body Mass Index's than private insurance patients because they were not able to medically meet criteria. This automatically placed clients in a position where they are primed for less success because they have to shed more weight. It is also important to know whether patients who had Medicare were told about post-surgical counseling, and whether their insurance would cover those services. It was also identified that 22% of morbidly obese individuals rely on Medicare, but only 7% of patients undergoing these operations have Medicare (Livingston and Ko, 2004). This seems to suggest BS is less accessible to patients with public insurances, and it also reveals that physicians and hospitals are less likely to serve Medicaid patients because the procedure for gaining payment reimbursement are often more difficult with Medicaid patients than with private

insurance patients (Martin et al., 2010). It was also identified that many agencies selected private insurance patients over patients with public insurance because studies have shown that low socioeconomic status and public insurance predict worse outcomes after BS. This is a major concern for BS patients because patients aren't being provided with access to counseling and they may not be aware of how important these post-surgical programs are to their BS success.

The lower BS success rate for patients from lower economic communities is also due to the fact that these patients live in communities where substance abuse is prevalent. This prevalence in substance abuse is closely linked to the failure of BS in certain patients and is also again linked with the inability of these patients to receive outpatient mental health support (Clark et al., 2003). In this population outpatient counseling is already a major concern, and not being able to access these services especially after BS is problematic to patients' post-surgical success. It is also important to understand that patients who are seeking treatment for their obesity who are coming from either impoverished neighborhoods or rural areas are disadvantaged because the availability of transportation to medical facilities is limited and this affects the availability of post-surgical support interventions (Livingston et al. 2007).

The final environmental factor that has played a role in patients' success post-surgery is their access to familial and friend support post-surgery (van Hout et al., 2006). Although support networks are assessed during pre-surgical intakes, some patients fabricate the strength of their close peer network. These peer networks are generally family, friends and close peer relations which are important because it was found that patients who return back to support groups that are envious or resentful of their weight loss after their surgeries, are less likely to have successful weight loss and weight loss maintenance. It was also shown that these patients do not attend post-surgical counseling because they are not being advised or motivated to attend by their peers.

These socioeconomic factors play a large role in the success of these clients, and illustrate the importance of both advocating for post-surgical counseling and understanding why there patients aren't seeking post-surgical counseling.

**Conclusion**

Bariatric surgery is a surgical procedure that has been pivotal in providing patients with an avenue to successfully lose weight and create a new healthy lifestyle. Although this is the case there are still many components of this procedure that are either lacking in depth or are limited in their effectiveness due to predisposed variables that are present before patients have the surgery.

Although there has been much research on the importance of preexisting psychological factors, behavioral patterns, and the effectiveness of pre and post-surgical counseling, one important component that hasn't been taking into consideration is the perspectives of BS patients. This is the most pivotal piece in regard to the success of BS because these patients are living the procedure and are the only ones who can tall clinicians why they have either found it successful or unsuccessful. Their perspectives could give us better insight into how to improve the procedure.

In taking into consideration the perspectives of BS patients, this study will explore what patients experience in their pre-surgical intake sessions and how that affects their decision in seeking counseling after surgery. This study will also work to identify what post-counseling resources are spoken about throughout preparation and which member of their multidisciplinary team provides this information. Another area that will be explored in this study is the overall experience patients have with post-surgical counseling and what barrier they may face in seeking those services. The final portion of this study will look at what improvements can be made to counseling post-surgery and what role patient believe counseling plays in their aftercare. In all,

these patient's perspectives on these key topics will illuminate the areas in which clinical social workers and other mental health professionals need to adapt and adjust current attention to topics that actually affect BS clients and their BS success.

# CHAPTER III

## Methodology

The purpose of this study is to identify and analyze the perspectives of bariatric surgery (BS) patients on the role of pre and post BS counseling. This study used a qualitative modality of research through patient interviews. In having a qualitative modality, the research questions will allow for a deeper understanding of the perceptions of BS patients who have reached their self-determined weight loss goal and are now in the weight maintenance stage of BS. These interviews have identified patients' experience with the pre-surgical assessment procedure and also their experience with post-surgical counseling. It has also identified which types of post-surgical counseling they received, and what their perspectives are on these types of treatments.

This research is a qualitative content analysis study. As defined by Elo and Kyngas (2008), "Content analysis is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action". Although this study used this qualitative method of analysis as a means to gain a better understanding of the perspective of BS patients, this study is different from previous research due to the fact that the majority of past research has focused solely on the medical success of patients neglecting perspectives of pre and post-surgical counseling. This study was approved by the Smith College Human Subjects Review Board (see appendix D).

This study was conducted through interviews with patients. They were asked open-ended questions, using an interview tool (see Appendix B) for a semi-structured interview model. By asking open-ended questions about their retrospective experiences, patients were able to discuss their experiences with pre and post-surgical counseling and how it affected their overall BS experience. This flexibility within the research modality also allowed for a deeper understanding of BS patients' experience through different types of post-surgical counseling. Rubin and Babbie (2012) describe the strengths of qualitative research as creating an interviewing container where the researcher can gather a better understanding of patients experience by asking open-ended questions without minimizing the uniqueness of individual life experiences and unanticipated factors. It is also important to identify that in qualitative research, the researcher has the ability to explore the specifics of a participant's experience through probes that again lead to a deeper understanding of their perspectives.

### *Sample*

This qualitative study was conducted using the nonprobability sampling procedure of convenience sampling. Convenience sampling is the method of selecting participants that are readily available as opposed to randomly selecting them from a pool of possible participants (Rubin and Babbie, 2012). This method was used due to the fact that I reached out to an online BS community where the participant pool were comprised of individuals who were interested in participating in the study.

Participants were selected once they had met certain inclusionary criteria. Recruitment information and inclusionary criteria for participants were posted onto the websites (see appendix A), and are as follows: 1) Participants will have had to have completed the Roux-en-Y gastric bypass procedure. 2) Participants will have reached their self-determined weight loss goal

and have begun the weight maintenance portion of BS. 3) Participants will have completed the pre-operative intake process through a BS agency. 4) Participants will have attended post-surgical counseling, which is identified as individual therapy, group therapy, or a BS support group. 5) Participants will be able to hold a Skype interview after they have been selected as a study participant.

In working with this method of sampling, biases arose in the process. These biases included the understanding that these participants had the ability to use online resources. This, in itself, is problematic, because there are populations of individuals that have had bariatric surgery and lack the resources to use online support communities. Although this created a more narrow population, I believe that reaching out to individuals who are part of the online community was more productive simply for the fact that these individuals already show a sense of comfort with sharing their BS experience.

I also made every effort to interview individuals of different races, ages, genders, and ethnicities which would have created a more culturally competent study without marginalizing certain populations. However, this proved challenging and all participants in the study self-identified as White/Caucasian. I believe that this sample was homogenous due to the fact that the majority of individuals who seek BS are Caucasian females. Although this is case, this study benefited from the fact that there was great diversity with regard to geographic placement. This is later explored in the demographic portion of the findings chapter

### *Ethics and Safeguards*

These interviews were conducted via Skype. The researcher hosted the interview from a private, quiet space while the participant was asked to do the same. Holding the interview in a private and quiet space insured participant confidentiality. Each participant was asked for their

consent to be both interviews and audio recorded (see appendix C). These files are securely saved on the researchers' computer hard drive which is password protected. All paper consents are stored in a secure filing cabinet separate from other study materials.

Once the Skype calls were audio recorded, they were saved onto a password protected hard drive to ensure participant confidentiality. Once saved, the conversations were transcribed, coded and stripped of any identifying information, and again, saved onto a password protected hard drive. The information collected during these interviews will be securely stored for three years in accordance with Federal Guidelines, after which they will be destroyed.

During the interview process, participants were informed of the study's purpose, the nature of their participation, and the benefits or risks of participating in this study. Participants were reminded that their participation was completely voluntary and that they had the right to stop or withdraw from the study at any point during the interview. Participants were also informed that they had the ability to withdraw from the study after the interview had taken place as long as it was before April 1, 2013. They were told that if they chose to withdraw at any point from the study, their information would have been removed from the study and promptly destroyed. However, no participants requested to be removed from the study, and all their information was used in this thesis. Participants were informed of the confidentiality agreement which ensured that all of their responses were safely disguised in accordance with Federal Guidelines.

Participants were provided with an informed consent form which outlined their participation in this study. This consent form was delivered to them via mail prior to the interview. The consent was accompanied with a return envelope which had paid postage. This consent also identify the fact that they were not going to receive any form of direct compensation

for their participation, and that although they may not directly benefit from the study, their responses provided important insight into the perspectives of BS patients and their experience with BS counseling. By gathering a better understanding of BS patients' experiences with pre and post-surgical counseling, this information may help reshape the process of BS, and improve the experience for future patients.

### *Data Collection*

Data collection was conducted through online Skype interviews with BS patients. These semi-structured interviews were approximately 45 minutes long and consisted of open-ended questions tailored to their experience during pre and post-surgical counseling. In addition, participants were asked to discuss aspects of their BS experience such as psychosocial factors, past medical health factors, mental health barriers, and past history of mental health counseling that influenced their BS experience.

Participants were also asked demographic information which allowed for a deeper understanding of their BS experience. Demographic information included; race, ethnicity, gender, age, and current living area. This information was used as a way to code all data and allowed for a more comprehensive understanding of the patient's experience.

### *Data Analysis*

Data coding was manually completed by the researcher. The coded data was then thematically analyzed through the computer software, MAXQDA, which was also saved onto a password protected hard drive. By using this software, I was able to categorize all responses into subcategories, and was able to identify thematic patterns such as themes or phrases that emerge in the interviews.

# CHAPTER IV

## Findings

The purpose of this study is to identify the perspectives of bariatric surgery patients regarding their experiences with counseling options and support groups both prior to and post bariatric surgery. This study also sought to identify barriers to seeking counseling support, and particular components of pre and post-surgical counseling that patients found beneficial.

This section contains findings from twelve interviews that were conducted with bariatric surgery patients from across the United States. Interview questions were designed to gain a deeper understanding into the perspectives of these patients on their experiences with pre and post-surgical counseling options. All interviews began with demographic information: their age, gender, race/ethnicity, state and city/town of residence, what type of agency conducted their surgery, and how many years they have been post-op. The second portion of the interview focused on their experience with counseling and mental health support throughout their lives. This includes their experiences prior to enrolling in their bariatric surgery program, throughout their preparation for the surgery, and after having the procedure. The final portion of the interview concentrated on what barriers or limitations participants may have faced with regard to receiving counseling as well as a section where participants suggest improvements for the counseling process.

The data collected through these interviews has been organized into relevant themes and will be explored through the following sections:

1. Demographics of participants
2. Patients' experiences prior to enrollment in bariatric surgery
    a. Rationale for surgery
    b. Types of pre-surgical counseling attended
    c. Experiences with counseling prior to surgery
    d. Self-identified traumas
    e. Maladaptive eating behaviors
3. Team of providers and counseling options offered
    a. Composition of their treatment team
    b. Which team members identified counseling options
    c. How often were counseling options discussed and what types of counseling options were discussed
4. Patient perspectives of their pre-surgical intake session
    a. Jumping through hoops: Patients' experience with their pre-surgical intakes
    b. Involvement of the intake clinician within the bariatric surgery agency
    c. Patients' feelings of the intake clinicians ability to complete the intake
    d. Content of the intake session
    e. Patients perspectives on how the intake prepared them for bariatric surgery
5. Counseling and support post-surgery
    a. Types of mental health supports sought post-surgery
    b. Experience with post-surgical counseling and support
    c. Post-surgical support group facilitators
    d. Benefits of having post-surgical counseling and support

e. Experience with online support groups

f. Barriers to seeking formal support groups

g. Patients identified potential for improvements to post-surgery supports

**Demographics of Participants**

This study is based on the interviews of twelve participants with regard to their counseling experiences throughout their bariatric surgery process. These participants ranged in age from 26 to 62 years old. Out of these twelve participants, ten identified as female and two identified as male and all participants identified as either White or Caucasian. The participants in this study came from many different states in the U.S. which included Massachusetts, New York, Pennsylvania, Ohio, Iowa, Colorado, New Hampshire, Minnesota and Washington. When asked to identify the current town or city they lived in, six participants identified as living in a town, four participants identified as living in a city and two participants identified as living in a suburb. All participants were asked to identify the kind of agency where they had their surgery. Ten participants identified having their surgery at a large hospital while two identified having their surgery at a smaller community based agency. Their post-surgery time ranged from one to ten years.

**Patients' Experiences Prior to Enrollment in Bariatric Surgery**

**Rational for Surgery.** A major finding from this study is that most participants seemed to want to share their rationales for having bariatric surgery. This question was not included in the research interview guide, but many participants began the interview with disclosing this information (n=11). In examining this finding it is unclear why participants shared their rational for having the surgery but in looking at their following responses I believe that it was a way for patients to build report in the interview. I believe this to be the case due to the fact that prior to

the interview I had disclosed the fact that I had completed bariatric surgery. For many of the participants, they disclosed multiple reasons for having the surgery and were very open about expressing their reasoning.

Out of these eleven participants, seven individuals spoke about how their main driving force was their obesity but others pointed to other factors. Four participants identified that they decided to have bariatric surgery after failing at multiple dieting attempts also known as "Yo-Yo dieting." For these four participants when asked to identify what was meant by "Yo-Yo dieting," each participant spoke of switching between multiple diets that would be affective in the beginning but would then stop working and would result in weight gain. These participants stated that generally the program would be initially affective but they were unable to stay motivated and connected to the programs. This was different from participants who deciding to have the surgery solely due to obesity because these participants spoke about the concept of failure and how the inability to lose weight was another failure in their life experience.

This concept of failures in weight loss and inability to control one's own weight was an important trend because the majority of participants spoke about how bariatric surgery was their final attempt at gaining control of their weight after multiple failed attempts at other alternatives. One participant stated, "Well I wanted to have the surgery because I had always been a yo-yo dieter and I was getting tired of struggled with my weight". This concept of struggling to control weight gain was an important precursor to surgery for most individuals and the concept of multiple failed attempts at dieting was associated with this struggle.

Two participants spoke about medical issues that led them to surgery and identified that they had the surgery as a way to control those medical issues. The final participant spoke about how she felt as though she needed to have the procedure because she was tired of "watching life

fly by while I was trapped within my weight." This participant's fear of not being able to accomplish the daily tasks she found enjoyable acted as the catalyst for her final decision to have BS.

**Types of Pre-Surgical Counseling Attended.** Five participants reported they had never sought any prior mental health support before enrolling in their bariatric programs. Out of the remaining participants, four individuals identified having sought treatment within an individual therapy modality, two identified having been involved with different group-based therapy programs, and one participant identified being enrolled in multiple treatment modalities that included individual therapy, group therapy, and hospitalization. For the participants that had been involved in pre-surgical counseling, most identified that their experiences with these counseling sessions had little influence over their experience with counseling during and post-surgery.

**Self-Identified Traumas.** One important theme that arose in these sessions when discussing counseling prior to enrollment in bariatric surgery programs was the concept of trauma. Out of this pool of participants half the group identified as having lived through a traumatic event which was a reason why they had gained most of their weight. These traumas included being a child of an abusive household, being diagnosed with cancer, but the most commonly identified trauma was the loss of a close support such as a parent (n=4). One participant stated, "I lost my mom on an operating table when I was younger and I turned to food for comfort." This participant's experience of using food as a coping tool was a trend that was identified in many participants. Another participant also identified with the pain felt by losing a parent:

> I gained the weight a few years ago and I think that it was from stress and also the fact that my father got cancer. I think that at that point in my mind, I recognized that food was comforting and when my dad died I think that I just lost control and things just spiraled out of control.

This participant also identified the fact that once she had gained the weight after her father's passing, her peers and family members shamed her for her weight by often telling her that she was "out of control" and "needed to lose weight because she looked terrible in her clothing. Once subjected to this shaming, she would have feelings of hopelessness associated with both her appearance and her ability to control her maladaptive eating. She also experienced this inability to lose weight through dieting as traumatic because she felt helpless in her weight loss. She also felt as though her close supports were either punitive or unresponsive in helping her. This concept of trauma will be further examined through the trauma theory of "victim-victimizer-bystander" in the discussion chapter of this thesis. A third participant stated that after the loss of her mother, she began to put on weight which only increased when she became involved with a partner who was emotionally abusive:

> I think that with the stress of losing my mom I don't think that I was taking care of myself as much as I should have been and when I finally did remarry, that marriage turned into an abusive relationship. He was incredibly emotionally abusive towards my weight and what ended up happening was that I began to put on more weight. He would often tell me that I wasn't attractive. So when I finally ended it with him I decided that it was time to do something about it.

This experience also confirms the theme that trauma dynamics played into this participant's rationale for having the surgery. Although six participants associated their weight gain in part

with traumatic experience, two of them had never sought counseling or mental health support prior to considering the surgery.

Of the four participants who did seek counseling first, all identified that mental health support has been helpful in improving their symptoms of depression and anxiety but all stated that it did not assist them in losing weight. What may be important to recognize here is that all of the patients who identified related trauma histories seemed to implicitly see the surgery as a treatment for the trauma, and a way to interrupt the persistent trauma dynamics. Although this was not vocalized in the interviews, these participants thought that having the surgery would "solve their problems" and "make them feel better." This is important to identify because for these participants, BS was the only intervention they believed would be beneficial in stabilizing their mood and increasing their self-esteem.

**Maladaptive Eating Behaviors.** Another major theme that was explored during the discussion of experiences with pre-surgical counseling was that nine participants identified having maladaptive eating behaviors prior to surgery that persisted in post-surgery. These maladaptive eating behaviors included emotional eating, stress eating, boredom eating and binge eating. One participant stated "You know I found myself always eating to feel better and after the surgery that ability to cope by eating wasn't there anymore." As a result that participant would eat until he became physically ill and would then purge his food. Another participant stated, "When I was in my second marriage I made it through the struggle by stress eating… after I had the surgery I found myself wanting to eat when I was stressed but I didn't get the same release from eating". This participant discussed how she would continue to eat in stressful situations until the discomfort became so great that she would be forced to stop eating.

This concept of maladaptive eating behaviors was also amplified by the responses of four of the participants who identified their eating behaviors not only as maladaptive but used the terminology of living with an active addiction. In thinking of their maladaptive eating behaviors as an addiction, one participant stated:

> I realized that I was an emotional eater, so instead of having a drinking or drugging addiction I acquired a food addiction. To be honest with you I know exactly what foods are my weak spot. Sometimes I am craving chocolate and other times I am a bread and bagel person. Those are my substances of choice and I find myself using them to cope with my problems.

In identifying that she had an addiction, she was later able to work through her cravings and was able to find alternative ways to cope with stress. Another participant spoke about how he enrolled himself in a 28-day residential weight loss program after recognizing that he had been struggling with his own addiction to food. In this program he was able to identify his maladaptive eating patterns and establish healthy coping skills. He later used these skills post-surgery and found them to be extremely beneficial in not “abusing food”.

A third participant spoke about their experience of recognizing that they had a food addiction once they had completed their surgery and had been enrolled in post-counseling:

> I found out that my eating came from my fears and anxieties, so it was good that I was able to go to post-surgical counseling. I could then pursue my addiction with a more clear mind when I was not in the throes of my addiction.

This participant stated that she was only able to identify her “active addiction” once she had enrolled in post-surgical counseling and was unaware that her eating patterns were maladaptive until that point.

Many participants reported that normal weight loss regiments and programs did not help them to lose weight because of seemingly intractable emotional eating behaviors. These individuals also discussed the fact that they would experience symptoms that can be connected with active addiction, such as a craving to use. One participant also spoke about their "addictive voice". When asked to elaborate, he stated that his addictive voice was the voice in his mind that sounded like his own and continuously told him to eat even though he knew that it wasn't going to make his stress and anxiety any better.

**Team of Providers and Counseling Options Offered**

**Composition of their Treatment Team.** Participants were asked to identify what their multidisciplinary team of providers looked like in their bariatric agency. All responses to this question included the following members as a part of this multidisciplinary team: a surgeon, a dietician, a nurse practitioner, and an office staff member such a secretary or receptionist. One theme that was identified during this discussion was the fact that only three participants identified a mental health clinician as a member of their multidisciplinary team. When asked to elaborate why they did not include the mental health clinician in there description of their team, most members stated that their bariatric surgery program did not have a mental health clinician on staff. This finding played a major role into these participants' experience with the pre-surgical intake which will be explored in more detail in the section entitled perspectives of the pre-surgical intake session.

**Which Team Members Identified Counseling Options.** After identifying the members of their bariatric treatment team, participants were asked to identify which members of their team spoke about counseling options for pre and post-surgery. One theme that was prevalent in these responses was the fact that many participants did not remember who had spoken to them about

counseling options (n=9). This is an important finding because as the literature review describes, post-surgical counseling has been found to be an important part of post-surgical success. Only three participants were able to identify which members of their team spoke about counseling options and all. Those participants identified that their nutritionist was the individual who spoke the most about post-counseling support groups. One participant stated, “The dietitian runs the support groups after surgery and she did mention the support groups a few times”, while another participant said “Well the program would have a gal that would talk to us about the support groups after surgery. She was the dietitian and she would often ask us to go to the meeting for support after surgery”. For these participants, if it wasn’t for the dietician advocating for post-surgical counseling, then they would have never been informed on what options were available.

Another participant identified that her surgeon, nurse and on staff psychologist would discuss counseling options for both pre and post-surgery and the final participant spoke about how the secretary on staff was the person who advocated for her to go to the support groups after surgery, “Ya it was as though every time I went to pay my co-payment the secretary would remind me how important it was to go to the support meetings”. This participant took the secretary’s advice and found that support groups were an important part of her success post-surgery.

Only one participant identified that their intake clinician spoke to them about counseling options both pre and post-surgery. This was the same participant who described her bariatric program as being extremely connected and thorough in advocating for mental health supports. She also found that having an “open door” policy to counseling was something that assisted her in being successful post-surgery. In identifying this, she stated that if she didn’t have this option of support than she doesn’t know if her surgery would have been as successful.

**How Often Were Counseling Options Discussed and What Types of Counseling Options Were Discussed.** Another important theme that was identified came for the questions "How often did your treatment team speak to you about counseling options after surgery?" and "What types of counseling services were discussed?" Most participants in the study identified that counseling options were not often discussed (n=9). Out of those nine participants, seven identified that they believed that counseling options were not discussed often enough and this is an area in which their program could have improved. One participant stated, "Well in thinking back to my time in the program, I really don't think that they brought it up and if they did it was occasionally," while another stated "I don't think that it was adequately brought up, and now that I think about it I can't remember if it was discussed." Both of these participants discussed how the only reason they knew about post-counseling support group was through peer interactions.

Another participant stressed the fact that counseling options were not discussed at all by the staff at the agency and that the only reason that she knew about those options was because it had been included in her bariatric programs weight loss packet. She stated that her introductory packet included a segment in it that outlines the support group schedule. This segment stated that support group would be held on the third Wednesday of every month. Except for this description, she stated that little was discussed around support groups.

Only three participants believed that counseling and support options were discussed often by their teams. One participant stated,

> Our program always stressed the point that we could go to different counseling options after we had the surgery. The therapist said that I could always email her and that she would have an open door to me going in for extra support. She also stated that going to the support groups was also extremely important to life after surgery.

This participant spoke about how the ability to seek mental health support when needed was a tool that she found beneficial and was important in her success post-surgery.

Out of these three participants, one identified that she felt as though the discussion of support groups was done in a way that was punitive and shaming. She stated that her bariatric surgery program stated that, “Since she was so obese and incapable of controlling here eating, she should attend support groups or she would fail.” Therefore, she went into support groups with a negative attitude that was at first a barrier to her ability to fully invest in those groups. It is also important to point out that the three participants who identified having been spoken to about counseling options were the same three participants who identified that a mental health professional was a part of their multidisciplinary team.

When participants were asked what types of counseling options were offered to them after surgery, all participants stated that support groups were offered to them, while only two individuals were offered individual therapy as another counseling modality after surgery. One participants stated, “I was told that I could always walk in for individual counseling through my program and that I could also go to the support groups.” This availability of counseling was beneficial in the participant’s efforts to shed her maladaptive eating behaviors post-surgery.

This lack in discussing mental health treatment and support options was reflected on by many of the participants in this study. Another important theme was the fact that the majority of participants had to rely on peers to find support group meetings and those participants felt as though their team did not do a good job of explaining where those support groups were held (n=7). For many participants if it wasn’t for that peer support in identifying options, they stated that they would have never attended post-counseling support.

**Patient Perspectives of their Pre-Surgical Intake Session**

**Jumping Through Hoops: Patients' Experience with Their Pre-Surgical Intakes.**

When exploring patients experiences with regard to their pre-surgical intake session, there were many themes that emerged from participants' answers. The first major theme came from the question "Tell me about your experience with the pre-surgical intake." The majority of the participants were dissatisfied with the intake session (n=9) and most of them left the session feeling frustrated with the time they spent at the intake session (n=5).

One interesting themes that emerged was the fact that many of the participants felt as though the intake session was just another step to get through and identified that it was a waste of time (n=6). Out of those six individuals, five participants used the terminology "jumping through hoops" when explaining the process that they went through. One participant was very avid in explaining her discontent leaving the session and stated:

> Oh yeah, I really resented the fact that I needed to waste my time having this intake. It was outrageous to be wasting that entire time sitting in that room having someone create a psychological profile of me while not even asking questions about my real experience. He had no clue who I was and he had no way to tell if I should be worthy of having the surgery. I was so pissed off but I knew that I had to do it and it was all red tape and jumping through hoops.

This participant identified that this sentiment was one that she carried through the rest of her procedure and stated that she even contemplated not completing the procedure post-intake. She later further explained that she felt angry because she didn't feel understood by the clinician and she felt as though he was asking her "stupid" questions. Another participant shared similar frustrations with regard to "jumping through hoops" by stating:

> Honestly, I found going there and sitting there with the other patients that were waiting there to see him (the clinician) while I was filling out all that paperwork was a little odd and I wasn't totally comfortable doing it. It was one of those hoops that you had to jump through so I did it and got it over with. It was a waste of time though.

This participant went on to identify that the intake itself "lacked the feeling of personal connection" and for that reason as well it seemed to be another mandated obstacle to complete prior to surgery.

Another patient spoke about her experience with the intake session and discussed how she too was uncomfortable with the process of doing the intake session:

> To be really honest with you the whole thing (the pre-surgical intake session) really bothered me but you know I went with the flow because I knew that I had to get it done and I also knew that I didn't have a choice. You know if you didn't do the whole process then you couldn't have the surgery.

This participant also identified the theme of "going through the motions" and stated that it stemmed from the fact that she felt as though the process lasted too long and also didn't feel personal. For two other participants, they left the intake session feeling frustrated, belittled and ashamed, but again for the majority of the participants it was the fact that they felt as though it was a waste of time.

Out of the remaining participants, two had neither negative or positive things to say about the intake and the only participant that found the intake beneficial was the same participant who had been offered multiple counseling supports through her agency. She stated, "I think that it was good! I'm glad that it was there. I think that if I didn't have it before the surgery then I don't think that the surgery would have worked as well." This participant also identified that she had

built a good relationship with the intake clinician through multiple sessions, and she was someone who was an integral part of the agency's multidisciplinary team.

**Involvement of the Intake Clinician within the Bariatric Surgery Agency.** One major theme that arose in the discussion of participants' pre-surgical intake was the realization that the majority of participants did not identify the intake clinician as someone from their multidisciplinary team. When asked to elaborate, it was found that the majority of participants had completed their intakes through providers that were not part of their bariatric surgery agency (n=9). When asked how they found those clinicians, each participant had found them in different fashions.

One participant spoke about how she had to find a clinician that was referred to patients if they didn't have their own individual therapists. She stated that her hospital provided her with a packet of materials that included a referral list for intake clinicians. These clinicians were known in their community as individuals who would generally accept and pass bariatric patients more quickly. This participant believed that her intake clinician was not versed in the field of bariatric surgery and for that reason didn't complete a proper assessment. She also identified that she became frustrated with the fact that her bariatric surgery agency didn't have an intake clinician on staff.

Another participant spoke about a similar experience with regard to finding a therapist to conduct the intake,

> The office gave me a list of psychologists in the area and I had to make the decision on which one to go to. I picked the one that was closest to my house. I ended up realizing that all the people on the list weren't really affiliated with the doctor's office.

This participant greatest frustration stemmed from the fact that this intake clinician wasn't someone who was connected to the bariatric surgery program and for that fact they didn't "do a good intake that really connected with the surgery." This sentiment later continued when he began to attend support groups, and felt that the clinician was also not prepared to facilitate the sessions.

In all of the interviews each participant who stated that they had completed the intake with a clinician that was not associated with their office also expressed their frustrations with the process and how much of "a waste" the session had been. The other three participants spoke about how their intake clinician was an integral part of the treatment team and they found this to be less stressful then having to find their own clinician. Out of those three participants, one described how having this clinician as part of their team was important to them and showed how "smoothly" the agency operated:

> The psychologist was connected to the agency I was at and they worked very closely with the other members of the team. They were very well connected to all the programs and worked with other programs as well. In fact they would always put out a newsletter that showed what was going on and what supports were in the area.

This agencies ability to provide consistency in all portions of the bariatric surgery process was important to this participant and was one that many participants wish they could have had.

This discovery that the majority of the mental health clinicians who worked with the participants were not closely affiliated with the care team is an important point, particularly because patients themselves experienced the clinicians as outsiders, which they believed contributed to their feelings of discomfort and lack of engagement. The sense that the intake clinicians were outsiders may also have been compounded by the sense that they were not

knowledgeable about the surgery or about the life experiences and symptoms so common to patients.

**Patients' Feelings of the Intake Clinicians Ability to Complete the Intake.** After beginning to identify that fact that many of the intake clinicians' were not part of the bariatric surgery agency, the next theme that began to be explored was the fact that the majority of participants did not believe that their intake clinician was well versed or knowledgeable about working with patients who were preparing for bariatric surgery (n=8). One participant discussed how she felt as though the clinician was completing the session without any knowledge of the surgery and solely wanted to make money from the intake:

> I don't think that he (the clinician) was trained in working with people who were going to get the surgery. All he had to do was make a decision on that person and decide if they were ready in the head to have it. Again I don't think that he was ready and able to work with people who were going to have bypass. It seemed as though he just wanted to rush through it and make his money.

This participant's frustration around feeling rushed was one that was mirrored by other patients and as this participant stated it led to their sense that the intake was a waste of time.

Another participant shared a similar experience to feeling as though the clinician completing the intake was not knowledgeable in the field and was not prepared to work with patients who were going in for gastric bypass:

> So it was very difficult finding someone that was going to complete the intake because of my insurance and the program that I was in. I finally found someone and when I met with him I realized that from the moment I walked in this guy had no idea of what he was doing. It seemed as though someone had handed him a paper with a bunch of questions

> and then told him if she (the patient) answers them in a certain way then she is a candidate for the surgery.

This identified that the clinician's inability to properly complete the session was a major hurdle in her comfort with the surgical process, and after the surgery this patient contemplated not finishing the procedure.

The sentiment that the intake clinician was not versed in working with bariatric surgery patients continued to carry throughout the rest of the participants who had negative intake experiences. Although this was a recurring theme, one participant's experience with her pre-surgical intake encompassed this sentiment the most. Through her experience she believed that the clinician had no knowledge of the field and she identified the experience as being traumatic:

> When I walked into that session and that woman began to ask me questions about my life I began to realize that this was going to be the worst experience of my life. She started by talking to me about how she had my surgeon in her pocket and she kept asking me personal questions about him. After a while when I didn't answer those questions she began to get angry so she began to ask me about my father who passed away. The questions that she was asking me were so inappropriate that when I left there I was in tears and I felt so belittled and defeated. She (the clinician) ended up calling my surgeon and told him that she thought that I shouldn't get the bypass because I could do the weight loss on my own and if I should get something it should be the band because then I would have to work harder. She had no right to do that and she also had no idea what she was talking about in regard to the difference between all the surgeries.

In our interview, this participant could vividly recall her frustration and anger with her clinician's unprofessional behavior and lack of knowledge about bariatric surgery. This

frustration was so great that she eventually contacted the head surgeon of the hospital to discuss her experience. After her complaint the agency reorganized their bariatric team and terminated that outside clinician from their referral list.

In this portion of the interview process, the underlying feeling between these participants who were discussing their frustration with the sessions was that if the clinician was not part of the team then it seemed unlikely that clinicians would have adequate understanding of their experiences. They also identified that this lack in knowledge would led to the thoughts that the intake clinician wouldn't understand how the surgery would affect them, and this was alarming to most participants. Participants also generally expressed the belief that if the clinician was not a part of the agency, gastric bypass was not likely a specialty for the clinician.

**Content of the Intake Session.** The next major theme that was identified through these interviews came from the question "What were some of the questions that they asked you in your pre-surgical intake?" This was a very enlightening question because there was a great inconsistency between all of the participants' responses with regard to the content of the session/sessions. Out of all the participants, four spoke about how they felt as though they went through intensive psychological testing that was both exhausting and had nothing to do with their life experiences. One participant spoke about her overwhelming session where she spent hours completing psychological testing to then sit with the clinician where they spent little time discussing the results:

> First we had an hour session where we sat and he asked me all these questions from this book and then asked a few about feeling prepared for the surgery. He also asked me about having supports in my life but when I started to explain he cut me off. After that I took a psychological exam where they kept asking you the same question over and over

> and over again. After that I took a quiz on my satisfaction with life. There was also a medical portion about my current medical issues. Then after that was all done he skimmed over the results and he said that everything looked good and I was good to go.

This participant's experience of being subjected to an intensive psychological exam was something that frustrated her due to the fact that the results were not explored. It is also important to identify that later in her interview she spoke about how an improvement to the intake session could be reorganizing it in a way that didn't seem like "a multiple choice exam" and rather create a space where the patient could talk about her concerns.

This experience of having intensive psychological testing that led to no fruitful discussion was mirrored by another participant who stated:

> I had to do what the doctor called a mini-mental, whatever that is. All I have to say is that it was like 200 questions. Basically what happened was that he gave me the questionnaire, sent me off to his lobby and had me fill it out while other people were waiting to see him. After I was done I had to leave it with the receptionist and then he called me to talk about the results. While I was sitting in the lobby doing that mini-mental I felt so ashamed and I was embarrassed to be completing a psychological exam in front of all those people. In the end it was a waste of time because when we spoke about the results he said all was well and I was ready for the surgery.

This participants feeling of having to complete an incredibly long psychological exam was not only difficult for her because she felt that it was a waste of time but she was also "forced" to complete it in a space that was not private. For her not being able to complete this assessment is a space that felt safe and private left her feeling embarrassed and ashamed and negatively impacted her experience with bariatric surgery.

Although this sentiment is one that is very important to how these participants looked at their overall experience with the pre-surgical intake, it was not the same sentiment that other patients experienced. Five participants spoke about how they felt as though the intake session was extremely short or rushed and that they didn't accomplish anything in the session. One participant stated,

> The intake session was extremely short. To me it just felt like, are you kidding me? All I could think about was how ridiculous this session was and how the materials covered in it had nothing to do with my actual surgery or experience before the program.

This participant's major frustration was that she felt as though the intake session was not sufficient enough to prepare her "mentally" for the surgery. This was the same sentiment shared by another participant who spoke about similar feelings of being rushed:

> All they did was basically asked a few questions, and then it was over. It was done faster than it took to start the session. I thought that they were going to ask questions about your life and how you had gotten so fat but in the end the questions that they asked didn't really have any importance.

This participant's experience not only identified the fact that the intake session felt short but it is important to identify that another theme that was identified throughout this participants evaluation of the intake was that he felt as though the clinician wasn't invested in building rapport in their clinical relationship. This feeling of lack of rapport was only amplified by the sense of urgency in completing the intake.

Two of the final three participants spoke about how they felt as though the intake session was extremely informative and was very personal while still being respectful and understanding. Again, these two participants were individuals who had identified these clinicians as part of their

multidisciplinary team. This is an incredible theme because it continues to strengthen the concept that for those participants, consistency and collaboration within the multidisciplinary team was important in preparing for the surgery.

The final participant spoke about her horrific intake where she felt attacked and belittled. It also demonstrates the fact that her experience with the pre-surgical intake alienated her overall experience with counseling and it also impacted her relationship with her surgeon days before the operation:

> When I was at the intake she (the clinician) talked to me about how hot my surgeon was and how she knew what I had in my back pocket that would help me be successful with the surgery (the participant had struggled with bulimia as a youth). It was just so condescending and I wish that I never had to go through that process. I have to say that is was the worst experience of my life.

After exploring this experience with her intake clinician we then discussed how this session affected her experience with bariatric surgery as a whole. Her response was that in completing this "horrific" intake, she not only became uncomfortable in her relationship with her surgeon days prior to having the surgery, but she also became "off put" to the idea of seeking mental health counseling in the future. She further went on to say,

> To be honest with you looking back I think that I could have used other counseling like one-on-ones or something but I didn't want to because I was scared. Because of that I only went to support groups because this person I met in the program asked me to go with her. The only reason I agreed was because I knew that I could leave if the atmosphere ever became uncomfortable.

This is a very powerful experience because it identifies the fact that one intake session with a clinician who wasn't receptive to the patients' needs defined this participant's future possibility of seeking mental health support.

When all of these experiences are compiled together, they all shared a similar underlying theme that must be explored. This is the theme that there is no standardized protocol for pre-surgical intakes. In not having a standardized protocol, it makes it difficult if not impossible to have consistency and standards of care within programs or within the intake assessment process itself. This is a problematic finding because without this consistency it not only opens the door for clinician biases, but as participants in this study identified, it left them feeling vulnerable and alienated to the thought of seeking treatment in the future.

**Patients Perspectives on how the Intake prepared them for Bariatric Surgery.** The final theme that emerged from discussions regarding participants' experiences with the pre-surgical intake came from the question "How do you believe that pre-surgical psychological intake process prepared you for life after surgery?" When participants were asked to answer this question, the majority of participants stated that the intake session was not useful and did not prepare them for life after surgery (n=8). One participant stated,

> It had nothing to do with anything and it also prepared me in no way for life after surgery. Truthfully I think that it was a waste of time and I could have been just as successful if I didn't have the intake. I also think it is important to point out that since it was such a terrible experience, that didn't really help.

This participant identified that having an intake session where she felt unprepared was stressful because she was unsure about her "preparedness" for surgery. She also went on to identify that the intake session could have been more beneficial if she had been "taught something" with

regard to “life after surgery”. In exploring this theme, her wish was to have had education around coping strategies and maladaptive eating behaviors.

Another participant shared a similar experience with her feelings of leaving the intake session unprepared by stating: “It didn’t prepare me at all for surgery and like I said before it was just another hoop to jump through. I did the intake then washed it out of my mind.” This is a frightening comment on this participant’s experience with her pre-surgical intake because she was able to “wash out” a process that studies show is one of the most important milestones in preparing for surgery.

Within this theme as well it is important to state that out of the final four participants that felt prepared by the pre-surgical intake, three of those individual had identified that their intake clinicians were an integrate part of the intake session. In this finding it is also important to identify that these three patients felt prepared for the surgery but as stated in the segment above on how patients found it to be beneficial, only one participant found it to be beneficial. This is an interesting finding because the patients who felt prepared but did not find it beneficial identified that they felt prepared because it felt to them like it was completing an exam and they had passed it. This moves the patients experience of the intake from being an interpersonal session where problematic areas can be addressed prior to surgery to one of “having to pass” the intake. One of those participants described this sensation of completing a test by stating:

> To go through that session and pass the test, it showed me that I was prepared to do it and that I wasn’t crazy. Losing the weight before the surgery helped boost my self-esteem and having this intake made me feel like I was mentally prepared for the surgery. It also reminded me that once I had surgery I was going to feel better and that things would get better.

This participant's experience as feeling as though she had passed a test was a great success and bolstered her confidence in her ability to succeed post-surgery. This experience closely resembled the experiences of the other two participants that felt prepared by their intake session. They too felt as though "passing" the intake was a way to designate that mentally they were prepared for the surgery.

The final participant who also felt prepared by the intake session attributed this to the fact that he had been through multiple weight loss programs, such as a 28-day residential program that he was able to recall while sitting in the session, "I think that I felt prepared by the intake session because it was similar to what I had gone through before in that 28-day program". This participant identified that being able to discuss with the clinician the coping strategies he had learned from the 28-day program was a way for him to reassure himself that he was prepared for surgery.

**Counseling and Support Post-Surgery**

**Types of Mental Health Supports Sought Post-Surgery.** The majority of participants reported that agency-run support groups were their sole source of post-surgical counseling support (n=8), while two participants identified that they both sought support groups and individual therapy. One participant who identified only attending support groups stated, "After I had the surgery I began to attend the monthly support groups. I found that they were a good part of trying to stay on track." This participant went on to describe the fact that if it wasn't for a support group then she wouldn't have been as successful post-surgery.

The final two participants identified that they had never attended "formal" mental health supports after their surgeries, but stated that they enrolled in and became connected with an online support community as their means of mental health support. When asked why they did not

attend formal supports they defined many obstacles to receiving services that will be explored later in this findings section. In identifying these obstacles, these participants later stated that if these obstacles did not exists, then they would have been open to attending post-counseling support.

**Experience with Post-Surgical Counseling and Support.** When participants were asked to discuss their overall experiences with post-surgical counseling, the majority of participants categorized their overall experience as being positive (n=7). They attributed this positivity to the relationships that they built in these programs, and one participant stated,

> Attending the support groups after surgery helped me immensely. I have gotten a lot out of attending them and overall I have found people in these groups to be so helpful. It was nice to see other people going through the same struggles and to be able to have a place where we would discuss the situations that were causing the issues. These groups also helped me get connected with people in my area which was something that I never expected

This participant identified that support groups were a venue for her to connect with peers who were going through similar obstacles and her support group acted as a safe container for her to explore what struggles she was facing in her life with regard to bariatric surgery.

Another participant shared a similar experience of feeling as though support groups were helpful to her even though originally she was not enthusiastic about attending them:

> To be honest with you I never thought that I would be a support group type of person but after going to them I found them to be really helpful and informative. These support groups also helped me stay connected with people in my area. I ended up really loving these support groups and couldn't see myself not going to them.

This participant's experience of feeling supported in this group setting was extremely important to her views on counseling due to the fact that she was the participant who had attended her pre-surgical intake and had left the session feeling "belittled and demeaned". At a time where she had been "shamed" by her intake clinician, she was later able to find a supportive network where she could feel safe to explore her life experience and barriers after surgery. Although these participants found post-surgery support groups positive and helpful others did not.

Out of the seven participants who found post-counseling support groups to be positive, three of those participants spoke about how those groups eventually turned negative, and if combined with the participants who felt as though support sessions after surgery were negative from the beginning, that would make a total of eight participants who identified post-surgical groups as having negative components to them. One participant shared that she had initially enjoyed attending a group, but that it quickly devolved into "being catty and judgmental to other people in the group." This is important to this participant because she later stated that she had hoped that she could have continued to attend these support groups to help her navigate transitions in her life. After the groups began to become "catty" she stopped attending those support groups and had to find an alternative to in-person support groups. This alternative became an online support community.

Another participant shared a similar story about a shift in the group support and stated that he eventually stopped going to formal support groups because of the shift in group dynamic:

> Going to support groups was great because it helped me integrate into the real world and be a part of what was going on, it wasn't just classroom stuff. We would help each other out a lot and it was phenomenal because it was really a supportive family. The only issue was that it disintegrated over the years and I stopped going to the groups because I

> couldn't deal with the personalities in the group. These were the people that ruined group support for me.

This participant stated that the change in the group atmosphere became so "toxic" that he eventually discontinued going to the meetings. One final participant explained that her negative experience with post-surgical counseling led her to turn instead to online communities:

> Well from the time I started group support the groups began to get confrontational. This made it really difficult for me because I wasn't losing weight as fast as the other people in the group. At that point other people in the group would call me out and ask what I was eating and what I was doing wrong. It was really shaming and degrading to be in that group to have to be called out like that in front of so many people.

This participant quickly stopped attending formal support groups after her third session due to her discomfort with the group. She later stated that she wished she had been able to find another in-person support group because she needed the additional support.

These experiences again identified that theme that most individuals found support groups to be useful after surgery but many of them found that the atmosphere in the group began to become more negative and eventually they stopped attending groups. From participants experiences, it seemed as though negativity in the group tended to be from members who had been out of surgery for some time and were as one participant stated "the veterans" of the surgery. This is important to identify because these participants who were non-supportive in groups should have been the individuals that were most helpful in assisting new participants.

**Post-Surgical Support Group Facilitators.** As participants began to discuss their experiences with post-counseling support groups a theme arose on the topic of who was facilitating these sessions. When asked to identify who facilitated their support group eight

participants identified that the facilitator was the nutritionist associated with their agency. For one participant she expressed her frustration with having the nutritionist as the group facilitator and attributed her discontent with support groups to this fact:

> You know at first going to the support groups were fine but after a while I couldn't go anymore. We would show up once a week and would spend an hour with the nutritionist talking about what we had been eating and how our recovery was going. I just couldn't stand it because I couldn't talk about food anymore.

This participant later went on to say that she wished that the group could have been more focused on what she was going through emotionally and less about the diet portion.

Out of the five participants that identified post-surgical counseling as being negative, four of those participant identified that their group facilitator was their agencies nutritionist. For three more participants in this study, they identified that their support groups were split between two separate facilitators and they identified those individuals as the nutritionist and a mental health professional. Out of these three participants, two identified post-surgical support groups to be helpful and continue to go to them on a regular basis. One participant stated,

> Our groups are run split between two people. One time a month you have the nutritionist come in and you talk about what is going on diet wise and the other time it is the psychologist and he asks the group how everything has been going on…. You know it is just nice to have that split because it's good to get both sides.

This participant was able to identify that having the split in facilitators was something that was beneficial for her and she continues to attend meetings regularly.

The final participant spoke about how her support sessions are facilitated by a different individual every session. She stated, "One time it will be the nutritionist, another it's a guest

speaker. It's always changing which is nice." For this participant having the different facilitators is a way for her to be able to get different information from each session and she expressed that she "never stops learning" from these groups. In identifying this finding it is interesting to see that the majority of individuals that found support groups to hold negative qualities, the majority of them were facilitated by the nutritionist, which may be an individual who is not trained in facilitating groups and identifying group dynamics.

**Benefits of Having Post-Surgical Counseling and Support.** Although most participants in the study identified that at times the support groups they attended began to take on a negative aspects such as judgmental group members, most were able to identify how beneficial they believed the support groups had been (n=9). Out of those participants, four participants identified that support groups helped them to feel supported in all aspects of life, three participants identified that support groups helped them feel understood, and two participants identified that these support groups helped them keep their weight loss goals in line. In looking at the participants who spoke about how support groups made them feel understood in times when they felt misunderstood, one participant stated:

> I think that going to these support groups helped me feel understood at times where I wasn't feeling understood. I think that the people that have never had the surgery find it really hard to relate to the person who had it and eventually they begin to treat us differently. Being in these support groups just helped me connect with people and I felt like I could reflect my experiences in other peoples' stories.

This participant was able to identify that having support groups assisted her in connecting with peers who were experiencing the same struggles as she was. Another participant shared something similar in stating:

> The major place that I felt obstacles in being supported was from my family and coworkers. It seems as though they couldn't really understand what I was going through and it wasn't until I got connected with the support groups that I began to feel connected and understood by others.

Again this participant's decision to connect with a support group was a way for her to feel connected to others in a time that she felt misunderstood. These experiences illustrated the fact that individuals found that support groups were beneficial to their overall weight loss support but also they assisted in creating an environment that allowed them to connect with peer supports.

**Experience with Online Support Groups.** Due to the fact that a part of the recruitment process involved finding participants on an online bariatric surgery community I believed that it would be beneficial to identify why patients reached out to this venue for support rather than the "formal" support group held through their bariatric surgery agency. When asked to identify why they used this online support community as a means of support a few themes emerged.

One major theme was that a number of patients identified that having an online support community assisted them in gaining quick responses for the issues that they were facing (n=9). Instead of waiting for their in-person support group they were able to get quick responses from peers. One participant stated,

> You know if I was struggling with some issues related to my surgery or I was just going through a tough time in general I always know that I can reach out to the members of the online community to help. It doesn't matter if it is two in the morning or three in the afternoon. The moment I have an issue I know who I can ask.

This participant's ability to find support "24-7" was her defining reason to connect with online support communities. Another participant stated:

> I have been lucky to be a part of this online forum because it has been helpful in making me feel better and has provided me with the ability to get help from others really quickly. If I didn't have that added support I don't think that this surgery would have been so successful.

By having online supports participants felt as though they had more avenues to explore their issues and were able to do so from a space that felt safe and comfortable to them. This option of support was an added help to their overall experience. Participants also stated that online support group generally tended to be more supportive than in-person groups for multiple reasons. The first was that all participants in these communities were sharing information from all aspects of their lives. This included dietary concerns and also mental health related struggles.

Another important aspect of why these groups were "more supportive" was due to the fact that some participants identified that if there was a member of the forum that was being negative or judgmental, as part of the forums rules of use, their post would be deleted, they would be warned by the sites webmaster, and then if the behavior continues they would be removed from the site permanently. This created a safe space for these participants to share their experiences.

**Barriers to Seeking Formal Support Groups.** One of the final segments of the interview focused on identifying barriers for patients seeking "formal" support groups. First, most patients did not feel as though there were enough support groups in their area (n=5). One participant spoke about this challenge by stating,

> You know one of the issues was that when I looked for support groups in my area it didn't seem as though there were many. I even looked for support groups in other towns and cities near me but I couldn't find anything. All I could find was support groups for

> Overeaters Anonymous, and to tell you the truth I wanted a group that was specific to my procedure.

This participant's feelings of having limited groups in the participants area of residence was one that was mirrored by many individuals but a number of participants also identified that even though there were support groups in driving distance, the trip itself was a barrier to receiving the support (n=6). One participant stated,

> Well the biggest obstacle was that I have to travel to the support groups that my agency provides. Those support groups are over one hour away and I hate having to get in the car to drive all the way there just to do the group for an hour. If the groups were more local then I would have attended them more often. At this point I just go if I think that it is something that I really need.

This participant's experience of having to travel a far distance to take part in a group that only lasted an hour was a barrier that stopped him from continuing to attend support groups.

The next theme that arose with regard to barriers to attending support groups was the fact that most participants spoke about how there was a limited number of support groups that their agency provided (n=6). Although this finding was similar to the fact that many participants identified limited support groups, this point seemed potentially more important to the participants because participants didn't feel as though their programs were providing them with the bariatric support groups they needed. One participant stated, "The issues that I found was that my program only had support groups one night a month. I just think that at that point in time, one group a month wasn't enough for me." This participant identified how support groups in his area were so infrequent, that they were not enough to meet his support needs. Another participant spoke similarly but also identified that there were times where she forgot about the meeting or

there was a conflict, then she would have to wait for another month to attend. She also stated that when she would miss the monthly meeting she would begin to get anxious and frustrated because she felt as though she needed additional support.

Many participants also felt as though the hours that groups were being held didn't fit into their schedule and was the biggest barrier to support (n=7). One participant stated,

> I guess the biggest issue I had with support groups was that they weren't convenient to my schedule. The general population works from 9 to 5 or 8-4 and as someone who works afternoons into evening those meetings didn't fit my schedule. I think that if they also offered daytime meetings and support groups then I would have been able to go. I think that this would also help out all the people that worked nights.

This participant spoke about how she was unable to find meetings that fit into her schedule and she would generally feel unsupported in her recovery. Another participant spoke about how she also felt as though support groups needed to be scheduled at different times:

> The support group that I went to was really great but I think that they needed to expand because people loved that group but at times wouldn't be able to make it. My issue was that if there was a support group that took place right after I got out of work then it would have been more convenient than having to wait until 7pm to go to the meeting. It's just that the times didn't work into my schedule.

This participant's struggle to find a meeting that could fit into his busy work schedule was his largest barrier and eventually led to his termination of attending the meetings.

**Patients Identified Potential for Improvements to Post-Surgery Supports.** The final segment of this interview identified participants' ideas for improving counseling and support options. For the majority of participants, they focused their responses on post-surgical counseling

improvements (n=10). The first theme that was identified was that participants believed that the structure of the post-surgical counseling support groups needed to change (n=8). When asked to elaborate, most participants stated that they had wished that the post-counseling support groups were less structured around the medical portion of bariatric surgery and more focused on the mental health portion of surgery (n=5). They wished that they had more of a space to speak about their maladaptive eating, cravings and emotional stressors that were arising in their lives. One participant shared her thoughts about this shift if structure by stating:

> I think that the support groups focus too much on how surgery is going and how everyone is feeling and also if we are losing weight how that is going. I found that the groups tended to be superficial and it would have been great if I had a place that would have allowed me to talk about what was going on for me in my life. I think that the biggest improvement I could make would be to open the meeting with some talks about medical stuff but then also leave a lot of time to talk about the mental portion of our lives such as my anxiety eating.

This participant identified the need to have a space where she could explore her mental health needs instead of just the medical components of the surgery.

Although some participants spoke about how they felt as though they could discuss these topics in their post-surgery groups, some participants felt as though they couldn't bring up these topics because the group facilitator wasn't someone they felt was "well versed" in the area of maladaptive eating behaviors (n=6). These were the same participants who identified that their facilitator was the dietician. These members spoke about how they felt as though their dietician was not "versed" in coping skills for their maladaptive eating. One participant shared her

experience of not feeling comfortable to share due to the fact that she didn't feel as though the clinician was skilled in that area:

> The problem with the groups was that I never felt like I could share about my history of bad eating even after I had the surgery because the group would be judgmental and the worst was that I don't think the group leader knew anything about it. I think that a major improvement would be that the group leader would be someone trained to deal with people with eating disorders because that is really important.

This participant's inability to feel comfortable sharing her eating behaviors came from her perception that the dietician would not be able to provide her the coping skills she needs to overcome the maladaptive eating.

Another theme that arose when discussing improvements to post-surgical counseling was the fact that many participants felt as though the post-surgical groups should be mandatory for all patients (n=7). This was an interesting finding because the majority of those individuals stated that they originally didn't want to go to support groups but were pressured by peers. Once they had attended their first meeting, they then found them to be beneficial. One participant explained,

> I would make going to support groups more mandatory so that people would actually go to get the mental health support they needed. A lot of people aren't prepared before the surgery and then they feel lost and dazed after, well at least I did. If the program I was in had told me that I had to go to a bunch of support groups right after surgery than I don't think I would have struggled so much in the beginning. I also think that it should be mandatory because people don't want to look at the reason why they got fat, they just want to fix being fat.

This participant was able to identify how he wished that there had been more discussion about post-surgical support groups and he also recognized the fact that for him he could have been more successful if he had begun to attend them directly after the surgery.

Another participant was even more adamant that post-surgical counseling be mandatory, and also encouraged less of a focus on the pre-surgical preparation:

> I just think that it should be mandatory that you go to support groups after surgery and I think that you should have to check into them and be followed longer after surgery. At least my program was relaxed about this and I don't think that it helps for life after surgery. I think that it needs to be more structured and to tell you the truth, where they lose time in the beginning focusing on the psychological stuff, should be dedicated to support after surgery. The follow up after surgery is the most important part of the surgery.

This participant's enthusiasm to have mandated support groups came from her experience of identifying her own need for support and also recognizing the fact that she had not felt prepared by the pre-surgical intake.

The final theme on this topic was the need expressed by a majority of participants for more informal groups and supports that better transition patients into "life after surgery" (n=7). One participant spoke about how they thought that the formal support groups held by their hospital were important but wished that programs focused on informal groups and events for bariatric patients:

> I think that formal support groups were amazing but I think that my program should have had informal groups as well. The more informal the groups the better because I feel that when people are in formal groups they tend to tense up and they don't open up about

> their issues. I think that if people could go to a group that was centered around a dinner or lunch or something then they would be more relaxed and maybe would share more about what was going on with them.

This participant described how she was able to identify that the support groups held by her hospital were more formal than she would have liked them to be. She also went on to describe how she wanted an informal support group that she could attend which would be focused on community and support building. This participant also spoke about how she felt isolated at times and misunderstood by individuals who had not completed the procedure.

Another participant shared a similar desire for informal supports. He explained that although his program had initially offered informal programming, they were discontinued due to financial issues:

> When I first started going to the support groups after my surgery, the program would also sponsor dinner events and other events like bowling and walking and stuff. These were really great because I was able to connect with people and found myself actually sharing more there than at the other groups. When we were doing stuff as a group I felt like I could share my issues with eating and my cravings, and it was a place where I wasn't looked down on because the atmosphere was relaxed. They eventually got rid of those because the insurance didn't want to pay the people that put them together but I still think to this day how great those were and how much I miss them.

This participant spoke about how he felt most comfortable in these groups because he didn't have to worry about the "awkwardness" of sitting in a group session that was highly structured. It is also important to identify that the participant felt as though the support group had been discontinued for financial reasons although the members of the group found it to be beneficial.

In compiling these findings the theme of informal support group was one that was interesting because it seemed as though participants were looking for experiences to support as one participant said, “a permanent lifestyle change.” When asked to elaborate she stated that being able to be in an informal support group that does activities such as eating dinner together is an experience where she can put her learned coping skills to use and also have a comfortable place to discuss other issues that are burdening her. She said that, “when you learn it in the class it’s one thing but to use it in reality is another.” This again illustrates the fact that this participant felt as though informal support was an important part of the bariatric surgery procedure.

**Summary**

This chapter presented and summarized the experiences of twelve participants that were interviewed about counseling before and after bariatric surgery. These interviews were transcribed verbatim and then coded using thematic analysis to identify salient themes with regard to pre-surgical intake and also post-surgical counseling and support. Unfortunately, the majority of participants reported that their intake clinicians were from an outside source and were not part of their multidisciplinary team (n=9), contributing to the strong theme of clinicians not understanding what the patient has experienced in the past or will experience during and after the surgery.

It was also identified that a great number of participants identified as feeling alienated by their families and loved ones due to the fact that they didn’t understand the participants experience with obesity and then bariatric surgery. This alienation led to participants feeling vulnerable and judged. These feeling of being judged and misunderstood were only amplified when many participants attended their pre-surgical intake and eventually their post-surgical support group. There was an overwhelming sentiment that participants felt as though intake

clinicians were either not invested into the intake or lacked the knowledge to successfully complete an intake with patients who were enrolled in a bariatric surgery program. This trend later continued when patients attended support groups and identified that the group facilitators were not “well versed” in problematic eating behaviors that participants exhibited or were unable to create a therapeutic container that was safe for all participants. This led to groups members being confrontational and judgmental which again led to the overwhelming feelings of feeling unsupported.

Although many participants spoke about barriers they faced as a member of a support group, the majority of participants spoke about the benefits of having post-surgical support groups. They also identified that they had encountered a great number of barriers to either receiving those services or to feeling comfortable within the support groups themselves. Many participants believed that their bariatric surgery programs should have dedicated more time to post-surgical support rather than “preparing” individuals to have the surgery. Most participants felt that after surgery they were left to navigate life after surgery alone and didn’t have the amount of supports they felt they needed after the surgery (n=7). The following chapter will further discuss these findings and how they are relevant to the previously reviewed literature. The following chapter will also consider the implications of the data, implications with regard to social work practice, and recommendations for the future.

# CHAPTER V

## Discussion

The objective of this qualitative study is to explore the perspectives of bariatric surgery patients regarding their experiences with counseling options and support groups both prior to and post bariatric surgery. This study also sought to identify particular components of these patients' mental health counseling experiences that have been beneficial, as well as barriers for patients seeking counseling and support. These topics were explored through in-depth, 45 minute, semi-structured interviews with 12 participants who had also undergone bariatric surgery. The responses were then analyzed and compared to identify key themes. This chapter will be structured in the following way. The first section will explore the most salient themes from these participants' interviews while comparing them to relevant literature. The second section will discuss the study's strengths and limitations. The third section will explore clinical implications for social workers. The fourth section will discuss recommendations for future research and the final section will be the conclusion.

### *Key Themes*

As stated above, the objective of this study was to explore the perspectives of bariatric surgery patients regarding their experiences with counseling options prior to and post-bariatric surgery. There were a few important findings related to the pre-surgical "intake," a psychological evaluation which is generally required by as a clearance to have BS surgery.

One important theme was the patient's awareness that the intake clinician was not a major part of their multidisciplinary team of providers (n=9). This is an important finding because as identified in the Greenberg and colleagues (2005) article, it is important for bariatric surgery patients to be overseen by a multidisciplinary team of providers that are well connected and consistent in their form of practice. The majority of participants who attended these pre-surgical intakes felt as though their clinicians were not invested in the intake and were not knowledgeable about common stressors for BS patients, particularly vulnerability to feeling ashamed, isolated, and misunderstood. For most participants their feelings of isolation and shame were something that was unexpected when working with a mental health professional and left them feeling alienated and unheard.

Even though the participants in this study were not expecting to encounter discrimination in their BS program, it has been identified that obese patients tend to be discriminated against within the medical community. According to a study held by Kaminsky and Gadaleta (2002) on the experiences of bariatric surgery patients, many obese patients feel as though medical facilities are not able to meet their needs and are generally pessimistic about their ability to regain control of their weight. The study also focused on patients' perspectives after working with their bariatric surgery program psychologist. When asked to explore their experience with their programs psychologist four individuals out of 34 felt as though their sessions were non-supportive or negative. The current study affirms this finding that patients can leave intake sessions feeling alienated and ostracized in a time when they should be receiving as mush support as possible. As stated by one of the study participants,

> I don't think that he (the clinician) was trained in working with people who were going to get the surgery. All he had to do was make a decision on that person and decide if they

were ready in the head to have it. Again I don't think that he was ready and able to work with people who were going to have bypass.

This participant also identified in her interview that she did not feel confident in the clinician's ability to properly conduct the intake session which was problematic because she was unable to identify her maladaptive eating behaviors.

As stated in the article by Inge and colleagues (2004), all BS patients should receive a strong recommendation from their intake clinician to attend mental health counseling after surgery to continue to monitor their maladaptive behavioral patterns that existed prior to surgery. This is an important finding to connect to this study's findings because the only patients that identified receiving support for their maladaptive eating behaviors post-surgical intake were the same participants who identified that their intake clinician was either a member of the staff working within the bariatric program or was part of an affiliated agency that had an office within the program. Due to this fact it is clear that some of the participants who had intake clinicians from outside of their agency could have benefited from identifying their maladaptive eating behaviors and seeking support pre and post-surgery for those patterns.

When participants were asked to identify what the content of their session consisted of, it became evident that there was a lack of consistency between the evaluations tools used in those intake sessions. A few participants spoke about how they were asked to complete different forms of psychological examinations which included MMPI evaluations, Beck inventory scales, Mini-Mental Status exam and Narrative Life Experience worksheets. One participant stated, "I had to do what the doctor called a Mini-Mental, whatever that is. All I have to say is that it was like 200 questions." These experiences were completely different from other patients who identified that

their intake sessions consisted of a few questions regarding supports, or simply questions about how their lives would change if they had the surgery. One participant stated,

> All they did was basically asked a few questions, and then it was over. It was done faster than it took to start the session. I thought that they were going to ask questions about your life and how you had gotten so fat but in the end the questions that they asked didn't really have any importance.

This inconsistency between intake sessions is also observed by Wolfe (2006), who points out that beyond concern for standards of care, inconsistency in assessment also makes it impossible to study outcomes of pre-surgical intake procedures.

Although bariatric surgery is a medical procedure, the preparation for the surgery is not one that is completely standardized. In having this unstandardized intake, patients are not being screened similarly across agencies, and for that fact some patients are being screened out of the procedure while others are being allowed to complete it even though they share the same maladaptive behaviors. One participant was open in her statement about how she believes that in retrospect she shouldn't have been approved for the surgery:

> In looking back at that intake session, I don't think that I should have been approved for the surgery. I was an emotional eater that ate all day due to stress. When I said that to the psychologist, he asked me if I would try and change that pattern. I said yes and he told me that I was prepared for surgery. I don't think that I should have been approved because I think that both he and I knew that I would continue to eat that way even after surgery. I also knew someone from another program who told her psychologist that she used to eat when she was bored and she had to go to three more sessions with him before he passed her.

This participant's statement demonstrates the need for standardized guidelines and protocols for pre-surgical intakes to enable consistency between agencies and better support for patients' mental health needs.

Although many participants spoke openly about their dissatisfaction with their intake session (n=9), another key theme was that members of the multidisciplinary teams spoke to patients very rarely about mental health support options both pre and post-surgery. As the Wood and Ogden (2012) article states, up to twenty percent of patients who have this surgery are not receiving post-surgical support options from their multidisciplinary teams. This experience was a common one among participants, and out of nine participants, seven identified that they believed that counseling options were not discussed often enough and that this is an area in which their program could have improved. One participant in the study stated that she believed that if counseling options had been discussed more often then she would have been more successful in her transition to life after bariatric surgery:

> You know I think that the people in my program never really talked about counseling and support groups after surgery. Now that I think about it that is crazy. Why would you have a program where you ask people to change their lives completely but then you never tell them to go to one on ones or even go to support groups?

This is a theme that was identified by Greenberg and colleagues (2005) as well, explaining that patients who identify receiving information about post-surgical support groups from their multidisciplinary teams are more likely to self-report greater success after surgery.

Participants in the study also identified that when seeking post-counseling support it was a way for them to not only receive support around the procedure itself, but many used it as a tool to reconnect with peers and find support in different avenues of their lives not totally connected

to the procedure. Hwang and colleagues (2008) identified that patients who have supportive families and peers tend to identify greater success post-surgery. Therefore, they recommend that patients who do not have peer support attend post-surgical support groups on a more regular basis.

Although the majority of the participants in the study (n=8) identified as having supportive families and peers, they also identified that their family members and friends often did not seem to understand their experiences. For some participants they spoke about how their family or partners were extremely non-responsive and demeaning which left them feeling traumatized with regard to their obesity and inability to control their weight. This experience is explained in the book *Inside Out and Outside In* (2008) with regard to the impacts of relational trauma. This portion of the book discusses the "Victim-Victimizer-Bystander" dynamic and states that for many trauma survivors, they identify that in a time where they are being victimized by someone there is usually a bystander present that fails to help or remains unresponsive to the victim's needs. The victim then internalizes this pattern and it becomes the template to their future relationships. The literature then goes on to explain that when individuals are subjected to this trauma it creates a conflict of power and control in which victims need to find avenues where they can regain their sense of control.

This is an important theory to consider because many participants not only discussed the fact that this dynamic played out in their relationships with many of their close supports but also identified that this pattern continued into their post-surgical support groups. Multiple participants spoke about how their support groups transitioned from a space that provided support to a space that took on a "negative atmosphere" (n=8). This "negative atmosphere" was one that included

confrontation and at times a space where other members were openly judged on their inability to be as successful as others. As one participant stated,

> I did attended support groups after surgery and I really loved them! I really enjoyed going to them but then I eventually stopped going to them because the groups stopped being about the surgery and became more about being catty and judgmental to other people in the group.

This participant later went on to explain how most members would sit by quietly while a few particular members would become confrontational with other members who were struggling with the surgery. This illustrates the effects of the "Victim-Victimizer-Bystander" dynamic and also illuminates the fact that once some surgery patients were able to regain control of their weight they fell into the role of the victimizer when in the past they had been the victim.

Even though there has been little literature exploring why these dynamics have shifted in these support groups, this is a concerning and important finding in light of Livhits and colleagues' (2011) finding that ongoing participation in post-surgical support groups is associated with continuing weight loss after surgery. This theme is one that rang true to most, and many identified that without the support they received in these groups they would have struggled more after surgery. A number of participants also identified that their need for added supports was so great that they reached out to different modalities of support. Some of these modalities included individual therapy and also other group-based support groups such a Overeaters Anonymous, but most identified that online weight loss forum became their main support.

Hwang and colleagues (2009) discuss how online BS support groups are becoming an important part of post-surgical support. This finding was supported in the current study, as all

participants identified that online support was one of the most helpful mental health support modalities they utilized. Although this is finding is almost certainly biased due to the fact that all the participants in the study were recruited from an online BS community, it is nevertheless instructive to consider what led participants to seek support online. Some participants (n=5) identified that they began using an online community due to the change in their support groups dynamics from one of "unconditional support" to one of "confrontation and judgment" as discussed above. One participant shared her experience with this shift in group dynamics:

> Well from the time I started group support the groups began to get confrontational. This made it really difficult for me because I wasn't losing weight as fast as the other people in the group. At that point other people in the group would call me out and ask what I was eating and what I was doing wrong. It was really shaming and degrading to be in that group and have to be called out like that in front of so many people. That is when I stated using the online site because I found them to be really supportive and non-judgmental.

This participants experience can be examined through the theories of relational trauma and as stated above illustrated the fact that individuals who have experienced trauma at times take on the role of the victimizer in an attempt to regain control after experiencing trauma.

Another theme that was shared by many participants (n=9) was that online support groups became superior to the support groups run by their bariatric surgery agency because they were much more easily accessible and they knew that they could receive immediate feedback from their peers about issues they were facing. This was something that was discussed as well by Hwang and colleagues (2009) when they stated that fast responses to post-surgical issues was the reason why many BS patients were turning to the online modality.

Although this was the case there were other limitations to seeking formal support groups that led participants in this study to use online support groups. For example, Livingston and colleagues (2007) discuss how transportation to post-surgical support can be a major barrier for patients due to the fact that transportation tends to be limited in areas that are rural, or impoverished. Although this was the case for a few participants (n=2) a major theme that arose in this study was the fact that even for individuals with the means to find transportation to support group, the distance to attend those meetings made the travel unpleasant and for many participants was the driving force for their decision to stop attending support groups (n=6). One participant stated,

> Well the biggest obstacle was that I have to travel to the support groups that my agency provides. Those support groups are over one hour away and I hate having to get in the car to drive all the way there just to do the group for an hour. If the groups were more local then I would have attended them more often. At this point I just go if I think that it is something that I really need.

For this participant this obstacle was also compounded by the fact that their hospital offered a limited amount of support groups per month which made it difficult for them to find support when they actually wanted it (n=6). This is something that was mirrored by many other participants and was addressed as well by Greenberg and colleagues (2005) when they discuss how important it is for multidisciplinary teams to provide these supports to patients who have completed BS.

The final major theme that was identified by many of the participant in this study was the need to have more “wrap-around” support groups after surgery. When one participant was asked to discuss what he meant by “wrap-around” groups he stated:

> Well when I say that I mean that there needs to be more groups out there that are less formal and more informal. I think that there needs to be more groups where you can get out and do things like have dinner with other patients and do activities like walking. That helps you prepare for life after surgery. Our hospital used to offer groups like this where we would go for dinner and would practice techniques like mindfulness eating.

For this participant the ability to integrate support in all aspects of his life was something that was extremely important to him and this is an important theme because as many participants stated, informal support groups might help them to make lifestyle changes post-surgery. Leahey and colleagues (2008) discussed that mindfulness practices after BS have been found to be an incredibly affective modality for assisting with maladaptive eating behaviors. For participants to have had the opportunity to practice those exercises in an informal group setting, it can only foster an easier transition to a new lifestyle post-surgery.

Another participant spoke about how having an informal support group focused around dinner would be beneficial for her because it would help her build a better understanding of what she could and could not eat after surgery. This is important because as Elkins and colleagues (2005) demonstrate, identifying and maintaining healthy eating behaviors post-surgery is the most important part of the weight loss management. Again if BS patients could find these supports in an informal setting that fostered these characteristics while being enjoyable, then it could only be beneficial to their longtime weight loss goals. These informal support groups may also assist participants in navigating their intense feelings of isolation. As one participant discussed in his interview, having support groups that included events such as bowling and dinner made it easy for him to reconnect with peers after spending a lot of time isolating due to his discomfort with his weight. He went on to state that without those groups, he would have

found himself continuing those maladaptive patterns and would have been as successful in reengaging with peers.

### *Strengths and Limitations*

When looking at this study I believe that the largest limitation is also its biggest strength. The 12 participants who were recruited for the interviews were located on an online BS community that is open to all individuals who are going through the BS process. This is a limitation due to the fact that it excluded many individuals that may not have had access to the internet or may not be affiliated with online support groups. Although this is the case I also believe that this was the study's biggest strength because the individuals who are on a public BS sites already seem more willing to share their experiences with BS in a space that is open to many viewers. I believe that this is an amazing strength because participants felt extremely comfortable sharing their experiences with me which led to fruitful discussions on study topics.

Another limitation to this study was the fact that demographically it was homogeneous. All the participants in the study identified as White/Caucasian and out of the twelve participants, ten identified as women and two identified as men. This was a limitation to the study because it would have been fruitful to have received narrative responses from a wider diversity of individuals.

Diversity within this studies population would have been beneficial due to the fact that as discussed in the literature review there are genetic differences in weight loss between Caucasian patients and patients who identify as Hispanic or African-American. Buffington and colleagues (2006), identified that Caucasian women lost weight more rapidly because they biologically could break down fat more rapidly than their Hispanic or African-American counterparts. This is

important with regard to this study because it would have been beneficial to identify if participants who identified as Hispanic or African-American felt comfortable in support groups after surgery which were identified to be judgmental and confrontational for members who did not shed weight as quickly.

Although there was homogeneity regarding participants' ethnicity/race, one of the major strengths of this study was the fact that since this online database is open to members from all over the United States, this allowed for participants to be recruited from nine different states. This diversity within states of residence allowed me to account somewhat for possible regional differences, and to consider how BS agencies in different settings can better support patients. In this study I was able to identify what area of residence individuals came from and I was able to compare my finding to the work by Livingston and colleagues (2007), which identified that individuals from rural communities tend to have greater difficulty attending post-counseling support. This is due to the fact that they must travel a great distance to attend support meetings. Participants from my study mirrored this finding by stating that they too had difficult locating support systems if they lived in more rural communities.

### *Clinical Implications for Social Workers*

This study was geared towards identifying the perspectives of bariatric surgery patients with regard to pre and post-surgical counseling. While exploratory and relying on the experiences of a limited group of participants, the findings from this study can help to suggest ways for social workers and other mental health clinicians to reflect on their own practices in pre-surgical intakes and post-surgical counseling.

The primary implication of this study for mental health clinicians is the fact that as clinical social workers and other professionals we must recognize when our own clinical skills are not sufficient for working with a particular population. Many of the participants in this study believed that their pre-surgical clinicians were not knowledgeable enough about bariatric surgery, and due to that lack of knowledge they were unable to help patients feel contained, safe, and supported. This again is important because as stated in section 1.04c of the Social Work Code of Ethics:

> When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm (National Association of Social Workers, 2013).

Many participants reported that clinicians were not adequately prepared for the pre-surgical intakes, leaving them feeling vulnerable and with feelings of shame. They also discussed the fact that their intake clinicians were unaware of their maladaptive eating behaviors and spent very limited time assessing the psychosocial aspects that affected them prior to and after surgery.

The secondary implication as mental health professionals is that if we are working with a BS population then we need to continue to identify the importance of continued mental health support both in preparing for surgery, and perhaps more importantly, after surgery. Most participants said they felt counseling and support groups were not discussed enough during the preparation period and they didn't understand how important it actually would be to their success post-surgery. This is also compounded by the fact that many participants discussed the fact that their post-surgical support groups were generally not facilitated by mental health clinicians. This

is important because in a therapeutic space where participants are being asked to speak freely about their stories with many difficult life experiences, they are leaving the session feeling judged, demeaned and victimized by other group members. It is clear that the group facilitators in those sessions are not educated in identifying group dynamics and that leads to participants feeling alienated from support.

Group sessions facilitated by clinical social workers or allied mental health professionals would be able to attend to group trauma dynamics, as well as issues such as confidentiality, and varying group member needs. It is also important to identify that the group facilitator could be better able to identify when patients may be triggered by others, and they could also keep in mind the fact that many of their members have discussed traumas in their lives. This trauma informed practice would be beneficial in bolstering members' sense of self and avoid the "Victim-Victimizer-Bystander" dynamic that is often playing out in these groups.

The final area in which it is necessary to identify the importance of having social workers as group facilitators is with regard to the fact that many participants spoke about how they would like to have informal groups dedicated to developing more in-depth peer supports. If social workers were able to identify these needs in their group they would have the ability to empower their members in a way that allowed them to create informal support groups that meet their needs for added peer support.

### *Recommendations for Future Research*

In looking at the limitations of this study and in taking into consideration the finding that came from the study, there are a few recommendations that could benefit future research. The first recommendation would be that this study could have benefited in identifying what type of

clinician was holding these participants pre-surgical intake. This is an important recommendation because in identifying what field of mental health the clinician is associated with, it could shed light into what type of clinician could best suite these clients' needs. It is unclear if the intake clinicians were social workers, psychologists, psychiatrists or counselors but for most participants they stated that they felt unheard and as though their past life experiences weren't properly examined.

The next recommendation for future research would be that this study could have benefited from recruiting from different populations. This not only includes different racial and ethnic populations but also patients who do not use online support groups and come from more diverse areas of residence. In having a more diverse population, this study may have been able to identify other obstacles to receiving support options prior to and post-surgery.

The final recommendation for future research would be that future studies should focus more in-depth on how trauma affects the lives and experiences with surgical support. In this study the theme of trauma did come up in discussions but there was limited space to explore these avenues due to the fact that the interviews were held in an online session where risk assessment and emergency planning couldn't be done in a way that would ensure the fact that participants weren't triggered by the topic material.

### *Conclusion*

With obesity in the United Stated becoming a more publicized epidemic, more individuals are turning to BS as a means to regain control of their weight and foster a new lifestyle that promotes healthy living. As an individual who has struggled with weight and used BS as a means to shed the weight, I understood the difficulties associated with the procedure and

the obstacles that I faced in my own process. For that fact I believed that it was time to better understand the process of BS from patients' perspectives and identify which aspects of the mental health portion of the procedure were beneficial to patients and which aspect were in need of improvement.

I hope that the perspectives of other BS patients will help to change the ways BS is thought about. It is not solely a medical procedure, but also has significant mental health aspects of BS as well. I also hope that the findings gathered from this study will assist clinical social workers and other mental health clinicians to identify areas where we can provide BS patients with more support and provide them the best chance possible to achieve their post-surgery weight loss goals, as well as to find ongoing support and affirming connections.

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## Appendix A

The following will be posted to the online BS community [redacted];

Post Title: “Looking for participants to take part in a study on the perspectives of pre and post-surgical counseling after having gastric bypass.”

Post Message: Hello, My name is Daniel Rodrigues and I am a Graduate Student at the Smith College School for Social Work in Northampton Massachusetts. I am looking for volunteer participants who would be willing to share their experiences with counseling both prior to surgery and after surgery. As a person who has had gastric bypass I believe that patient perspectives are an important part of understanding the process of gastric bypass, and I would be interested in exploring how others have experienced counseling.

This study will be held through a Skype interview, which will last about 45 minutes and will be used in my thesis which will be completed this summer.

To qualify for this study you must meet the following criteria;
1) Participants will have had to have completed the Roux-en-Y gastric bypass procedure. 2) Participants will have reached their self-determined weight loss goal.
3) Participants will have had to have completed a psychological intake prior to surgery. This must have been completed through your weight loss program.
4) Participants will have had to have attended counseling after surgery. These could include individual counseling, group therapy or gastric support groups
5) Participants will be able to hold a Skype video interview after they have been selected as a study participant.

Participants will be excluded from the survey if they are under the age of 18, or if they are unable to hold the interview in English. This is due to the fact that English is my first language.

If you would like to be a participant or would like to know more about the study, please contact me at [redacted].

Thank you for your interest!

## APPENDIX B

Interview Guide

Demographic Questions:

- How old are you?
- What is your sex?
- What is your race/ethnicity?
- What state do you currently live in?
- What town/city do you currently live in?
- At what type of agency did you have your surgery?
- How long has it been since you have had your surgery?

Identifying perspectives of BS patients:

Prior to being a candidate for bariatric surgery

- What types of mental health counseling did you attend prior to enrolling in your gastric bypass program?
- Tell me about your experience with counseling prior to having gastric bypass.

Experience with the pre-surgical intake

- Tell me about your experience with the pre-surgical psychological intake process?
- What were some of questions they ask you in your pre-surgical intake?
- How do you believe the pre-surgical psychological intake process prepared you for life after surgery?
- How do you believe the pre-surgical intake affected your overall experience with the gastric bypass procedure?

Assessing which post-counseling resources were discussed

- Tell me about your team of treatment providers during the preparation for surgery.
- How often did your treatment team speak to you about counseling options after surgery?
- What types of counseling services were explained to you before you had the procedure?

Experience of post-surgical counseling

- What types of counseling have you attended after your surgery?
- What is your experience with counseling after surgery?
- How do you believe your experiences with counseling after surgery have affected you overall experience with the gastric bypass procedure?

Assessing difficulties in receiving services and identifying improvements

- What types of obstacles, if any, have you encountered in receiving counseling prior to or after surgery?
- What recommendations do you have for improving pre and post-surgical counseling?

## Appendix C

## Informed Consent Form

Dear Participant,

My name is Daniel Rodrigues and I am a second year Masters student at the Smith College School for Social Work located in Massachusetts. I am holding a study that focuses on the perspectives of bariatric surgery patients who have gone through gastric bypass. The main focus of this study is to identify what it was like to go through pre-surgical and post-surgical counseling programs. My interest in this topic is due to the fact that I am also a former gastric bypass patient, and I am interested in exploring how other gastric patients perceived the process of pre and post-surgical counseling.

Your participation in this study is requested because you are former bariatric surgery patients that has had surgery, reached your self-determined weight loss goal and have attended both pre and post-surgical counseling. In having this experience you will be able to speak about your experience with the procedure and how counseling affected your overall experience with the process. I will ask you to provide information about yourself such as your age, area of residence, race/ ethnicity, and gender. I will also ask you questions about your experience with bariatric surgery. The interview will be conducted through Skype, which will be audio recorded for transcription purposes. The interview will last about 45 minutes.

The risk of participating in this study may be that some questions may remind you about difficult situations you encountered through your experience with bariatric surgery. In the case that you find yourself having difficulty discussing these topics, you can state that you would like to end the interview, or you may also refrain from answering that particular question. I will also provide you with a list of local organizations that provide therapy services in the case that you experience any emotional distress during the interview.

The benefits of participating in this study are that you will be able to discuss your experiences with pre and post-surgical counseling, and this information will allow me to better understand how these procedure impact patients. Although you will receive no direct compensation for your participation, your interview may provide information on how pre and post counseling services are useful to patients or how they may be changed so that they can better meet the needs of the patient. All information gathered in this interview will be used in my Master's thesis and will presented to fellow students and faculty at Smith College. There is also the possibility that this study will be published.

Your participation in this study is completely confidential and I will take all precautious to mask you identity. Your informed consent will be stored in a safe and locked filing cabinet, separated from other study materials. Your audio recording of the interview will be saved on a password protected hard drive which will also be separate from other study materials. During our time together you have the ability to withdraw from participation at any point since your participation is completely voluntary. You also have the right to not answer any questions that

you do not wish to answer. If you decide at any point to withdraw from the study, your previous answers will be immediately destroyed. After the interview has taken place you also have the right to withdraw from the study and you have until April 1, 2013 to do so.

If you have any questions, you can contact me at [redacted]. If you have any concerns, you may also contact the chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Participant's Signature:_____ Date:_____

Researcher's Signature:_____ Date:_____

# Appendix D

SMITH COLLEGE

**School for Social Work**
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 2, 2013

Daniel Rodrigues

Dear Daniel,

Thank you for making all the requested changes to your Human Subjects Review application. You have provided solid reasons for areas we asked for greater explanation and descriptions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms**: All subjects should be given a copy of the consent form.

**Maintaining Data**: You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments**: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal**: You are required to apply for renewal of approval every year for as long as the study is active.

**Completion**: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: David Byers, Research Advisor