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Walden University

College of Allied Health

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Theresa Niles

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Abstract

Body Dysmorphia in Post-Weight Loss Surgery Patients

by

Theresa Niles

MSP, Walden University, 2016

MAFP, Argosy University, 2014

BSP, University of Phoenix, 2012

AB, University of Phoenix, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

February 2025

Abstract

Although there is a known link between weight loss surgery and body dysmorphic disorder, research has not been conducted on the experiences of individuals experiencing these two phenomena. Using a phenomenological approach, this study examined the research question: What are the lived experiences of post-weight loss surgical patients with diagnosed body dysmorphia? Self-discrepancy theory was used as the overarching theoretical framework. Interviews were conducted with ten participants, and the data were analyzed using Quirkos software and inductive coding, examining clusters of themes within the narrative transcripts. Themes emerging included focusing on physical rather than mental health in the post operative timeframe, use of support systems, struggles in activities of daily living, multiple areas of body dysmorphic concern, consideration or completion of post-surgical cosmetic surgery or alternatives, and body positivity and body image struggles. Of note were themes of lack of planned and coordinated postsurgical psychological care as well as the need for reassurance-seeking from loved ones. This research has given voice to those experiencing body dysmorphic disorder following weight loss surgery. It may be of value to this population as well as family members and healthcare providers in helping to inform postsurgical policies for screening relative to mental health specific to body image, processes for inclusion of mental health follow-up alongside physical follow-up, and treatment planning with consideration for mental health support for improving outcomes and quality of life for future postsurgical weight-loss patients.

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Dedication

This dissertation is dedicated to all my friends and family who have supported me throughout this process. First, I would like to thank my parents, who have been a constant source of support throughout my life and who never fail to encourage me in all my endeavors. I would also like to dedicate this dissertation to my best friend and sister, Constance, who has always pushed me to never simply accept the minimum or status quo, but to push for more in my life. Finally, I would like to thank all the incredible professors at Walden University who have helped to support me through this journey.

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Chapter 1: Introduction to the Study

Introduction

Body dysmorphic disorder (BDD) is a psychological disorder that involves a person's preoccupation with one or more perceived defects or flaws in their physical appearance which they believe look ugly, unattractive, abnormal, or deformed (American Psychiatric Association, 2022). BDD is an obsessive-compulsive disorder (OCD)-related diagnosis and, as with other OCD-related diagnoses, the degree of preoccupation must be significant and detrimental to daily living (American Psychiatric Association, 2022). This can be examined in several ways, and clinicians can make a diagnosis of BDD through a variety of screening tools as well as through direct care clinical interview (International OCD Foundation [IOCDF], 2024; Phillips & Feusner, 2010). The IOCDF (2024) indicates that BDD affects between 1.7% and 2.9% of the general population. This condition may come about as the result of a variety of factors, but it may potentially be acquired due to the changes that occur in the body as the result of weight loss surgery (WLS; Coughlin et al., 2013).

People who undergo WLS often experience a rapid and dramatic loss in overall body weight, which may impact an individual's overall sense of self and satisfaction with personal appearance (Munoz et al., 2010). Many individuals who undergo WLS report a difference between their presurgical conceived ideal body size and what they then considered to be an ideal body size after surgery (Munoz et al., 2010). Indeed, even some individuals who undergo body contouring surgery after WLS may then become fixated on other areas that they find unattractive (Song et al., 2006). This can potentially lead to a

fixation on any perceived body defects or areas the individual feels are unattractive, which may result in increased BDD symptomology.

Prior to undergoing WLS, common medical practice includes a variety of medical tests in addition to, in most cases, a psychological screening to determine appropriateness for surgery (Mechanick et al., 2020). In the postsurgical timeframe, patients are encouraged to be seen regularly for monitoring, but post-psychological care is not indicated in the general guidelines for surgery unless the patient has begun to demonstrate psychological instability (Mechanick et al., 2020). Research has not been conducted on the lived experiences of post-weight loss surgical patients with BDD. The social implications of this research include the potential for future development of postsurgical psychological screenings or treatment interventions. Such screenings or treatments, if deemed appropriate based on further investigation of the lived experiences of post-weight loss surgical patients with BDD, could help improve quality of life for these patients. In this chapter, I will explore the background of the issue to be examined in this study, the problem being studied, the research questions, the conceptual framework of the study, and the nature of the study. I will then provide definitions for the study; examine the study's assumptions, scope, delimitations, and limitations; and provide the significance of the study.

Background of the Problem

The problem this research addressed is that some individuals who have undergone WLS develop BDD or find that symptoms of a preexisting condition of BDD are exacerbated after the surgery. In this research, I sought to address the gap in the literature

regarding the lived experiences of post-WLS patients with BDD to discover any similarities that existed in the experiences of these individuals and, thereby, to determine whether screening or treatment might provide a decrease in those symptoms or avoid issues of body dysmorphia in post-WLS patients. The number of individuals who choose to pursue WLS has been increasing regularly (Mechanic, 2020). The benefits of WLS include a reduction in overall mortality and a decrease in medical conditions such as diabetes and cardiovascular disease (Thompson et al., 2016). On the other hand, behavioral modifications such as diet and exercise, which have long been the most common means of working to achieve weight loss, are typically noted with only moderate weight loss and typically do not provide long-term weight loss. Thompson et al. (2016) indicated that psychiatric conditions are typically considered a contraindication for surgery due to the assumption that "poor mental health prior to surgery leads to poor weight loss and worsening psychiatric symptoms post-surgery" (p. 2). Therefore, individuals with preexisting BDD or other forms of body image difficulties are typically not able to undergo WLS until receiving counseling and verification that they are psychologically stable to proceed (Thompson et al., 2016).

According to Munoz et al. (2010), people who seek WLS are often noted to have dissatisfaction with their body shape, and this dissatisfaction can be manifest in various forms of psychological distress, such as "body dysmorphic disorder, low self-esteem, bulimia nervosa and high dietary restraint" (p. 2). This same study indicated that, among individuals seeking WLS, 91% indicated that they would do anything to lose weight, even if the attempt resulted in their own death. Once WLS had been completed, however,

the Munoz et al. study indicated that individuals were noted to decrease their considered "ideal body image" as illustrated by a continued decrease in what the participants considered to be ideal size and shape. That is to say, as weight loss continued, individuals were noted to consider only smaller and smaller sizes to be acceptable and felt that, as they were now able to lose weight thanks to surgery where they may have been unable to do so previously, their ideal body shape should be smaller (Munoz et al., 2010). This continual change in body shape in what individuals consider to be the most appropriate and ideal body shape could potentially lead to fixation on deficiencies in the body and frustration with areas that the individual feels are not perfect, despite weight loss post-surgery.

Research by Zhou et al. (2015) indicated that 90–96% of individuals who undergo WLS develop areas of the body that are considered unattractive to the individual or, potentially, physically unhealthy, involving issues such as intertriginous dermatitis and difficulty engaging in certain forms of physical activity. Zhou et al. stated that up to 90% of post-WLS patients express desire to undergo body-contouring surgery, though this is not always for a health-related reason and can often have more to do with a focus on perfecting appearance. Individuals involved in this research described their body with terms such as "melted candle" or "like a shar pei" (Zhou et al., 2015, p. 3). Research completed by Muller et al. (2018) explored the way in which mental illness may have a negative impact on overall weight loss and examined preoperative mental illness and its impact on overall ability to lose weight and to keep weight off once lost. This research indicated that, in the case of individuals who have preexisting mental illness, there is an

increased risk of weight regain, and the individuals typically have lower long-term weight loss. The presence of mental illness prior to surgery, especially if the individual is receiving psychotropic medications, typically precludes the individual from receiving surgery (Muller et al., 2018), but the development of postsurgical psychological illness can still be noted in individuals who undergo WLS and, as indicated by Zhou et al., can lead to the desire to undergo additional surgery to further perfect the body. Additionally, mixed methods research by Geraci et al. (2015) indicated that weight regain post surgically can also lead to increased psychological distress and the development of psychological and psychosocial difficulties. In essence, this means that an individual may experience weight loss and then regain the weight, leading to psychological distress, but they may also lose the weight and be able to keep it off, but still be unhappy with their physical appearance despite reaching a previously established goal.

In reviewing the various studies focused on the concept of body image and the psychological impact of WLS, the gap in understanding the development or continuation of body dysmorphia in WLS patients becomes increasingly clear. Due to this, additional research on the lived experiences of BDD in post-WLS patients is needed to address the gap in the literature and gain a greater understanding of any similarities that might exist in the experiences of these individuals. At the conclusion of this research, additional recommendations for care in the postsurgical phases are recommended, which could produce positive social change for those who are seeking or have recently completed WLS.

Problem Statement

The problem this research addresses is that some individuals who have undergone WLS develop BDD or find that symptoms of a preexisting condition of BDD are exacerbated after the surgery. In this research, I sought to address the gap in the literature regarding the lived experiences of post-WLS patients with BDD to discover any similarities that exist in the experiences of these individuals and, thereby, to determine screening or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in post-WLS patients. According to the Centers for Disease Control and Prevention (CDC, 2024), the prevalence of obesity in adults in the United States alone went from 30.5% to 42.4% from just 2017 to 2018. The statistics for severe obesity have increased at the same time from 4.7% to 9.2% (CDC, 2024). As a result, the number of people seeking surgical remedies for weight loss has also increased. The American Society for Metabolic and Bariatric Surgery (ASMBS, 2024) estimated that the number of surgeries went from approximately 215,666 in 2016 to 279,967 in 2022. The types of surgical procedures available for weight loss include a variety of options including endoscopic sleeve gastroplasty (ESG), Roux-en Y gastric bypass (RYGP), gastric band, biliopancreatic diversion with duodenal switch (BDP-DS), revision, and other, less commonly performed procedures such as intragastric balloon insertion (ASMBS, 2024). Each of these surgeries carries its own potential complications, both during and after surgery, but one factor that may not be as commonly recognized is the psychological impact of a dramatic change in appearance post-surgery. According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American

Psychiatric Association, 2022), individuals experiencing BDD are preoccupied with one or more perceived defects or flaws in their physical appearance, which they believe look ugly, unattractive, abnormal, or deformed. The DSM indicates that these preoccupations are intrusive, unwanted, time-consuming (occurring, on average, 3–8 hours per day), and usually difficult to resist or control (American Psychiatric Association, 2022). People who undergo WLS often experience a rapid and dramatic loss in overall body weight, which may impact an individual's overall sense of self (Munoz et al., 2010). The problem this research addressed is the gap in the literature regarding the lived experiences of post-WLS patients with BDD.

Purpose of Study

The purpose of this study was to address the gap in the literature regarding the lived experiences of post-WLS patients with BDD to discover any similarities that might exist in the experiences of these individuals and, thereby, to determine screening or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in post-WLS patients. Using an interpretivist model that holds that human behavior cannot always be generalized between studies and is heavily influenced by environmental factors as well as the individual's situation, I used a phenomenological qualitative approach to examine these factors more fully (Creswell, 1998). The study explored concepts such as the individual's changing perceptions of their body, their preoccupation with their body and appearance changes, and concepts surrounding their own personal image of the ideal body shape. By examining the commonalities in these experiences, themes emerged that can help to inform potential for changes in postsurgical

care for those undergoing WLS. This may include additional screening for BDD symptomology in the postsurgical timeframes, or an inclusion of required postsurgical mental health screening and recommendations for treatment as needed. Additionally, themes were noted regarding changed experience related to COVID-19 social distancing that may help to inform research into further options for home-exercise and telehealth therapy.

Research Question

This research explored the perceptions and lived experiences of individuals who underwent WLS and experienced symptoms of BDD. I sought to discover any similarities that might exist in the experiences of these individuals and, thereby, to determine if further research should be conducted into screening or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in post-WLS patients. Using narrative inquiry, this phenomenological research explored what the lived experiences of these patients were and examined their perceptions of the changes they had experienced. After consideration of these objectives and review of existing literature, the following research question was developed: What are the lived experiences of post-weight loss surgery patients with body dysmorphic disorder?

Theoretical Framework

This research explored the concept of body dysmorphia through the lens of self-discrepancy theory (Higgins, 1987) and body image. Originally proposed by Higgins, the theory of self-discrepancy involves the idea that there are three domains of self. These include the *actual self*, which involves the way that people perceive themselves and their

own attributes. The next domain of self, according to the self-discrepancy theory, is the *ideal self* (Higgins, 1987). These ideal elements are constructed of traits that that people believe others (or they themselves) would like them to possess (Higgins, 1987). The third and final domain of self is the *ought* self, which involves one's "sense of duty, obligations or responsibilities" (Higgins, 1987, p. 2). The concept of self-discrepancy as it applies to body image involves the concept that there is a difference between one's perceived actual self and one's ideal or ought self. Vartanian (2012) stated that discrepancies in body image can lead to behaviors such as "dieting, exercising, elective cosmetic surgery, and bariatric surgery" (Vartanian, 2012, p. 5). Research has indicated that food will often be used as an escape mechanism when one is experiencing emotional turmoil. Therefore, when one is experiencing a discrepancy between the actual and perceived self, it is possible that the individual may engage in maladaptive behaviors such as overeating and binge eating (Vartanian, 2012). As those seeking WLS are typically seeking to change their body shape and size, the potential for discrepancy between the ideal and actual self is already in place, and this could potentially lead to various psychological disorders, including BDD (Munoz et al., 2010).

Nature of the Study

This qualitative phenomenological study employed a narrative inquiry approach. Using narrative inquiry, I explored the lived experiences of people who had undergone WLS and had BDD. Through gaining a greater understanding of these individuals' lived experiences of the postsurgical process and their experience of body dysmorphia, including a personal exploration of their own beliefs and ideas, I gained a greater

understanding of how body dysmorphia may impact an individual post-surgery. By applying the concepts of self-discrepancy theory with the idea that those undergoing WLS experience differences between the ideal and actual self and have sought to change it, this research was able to use narrative inquiry to its best advantage by examining the overall sense of self and body image the individual experiences in the postsurgical phase. By using the lens of self-discrepancy theory, I was able to search for the dissonance point at which the discrepancy of self has been created in these individuals that led to the development of BDD. I developed a set of guided interview questions to use during interviews to help provide a logical framework to the discussion and focus on exploring the research goals (see Appendix A). These guided interview questions served as the sole sources of data for this research. Once participants were interviewed, the information was analyzed for commonalities and synthesized into a composite account using a heuristic inquiry approach (Patton, 1990).

The target population of this study was individuals who have undergone WLS who self-report a diagnosis of BDD. Those individuals who met the full screening criteria (discussed in further chapters) were invited to participate in the study. As this was a phenomenological study, Creswell (1998) recommended between five and 25 research participants. As such, I attempted to recruit between 10 and 15 individuals from within this population for study, and 10 participants were identified and participated.

Definitions

Body dysmorphic disorder (BDD): An obsessive-compulsive disorder-related diagnosis in which the individual displays a preoccupation with one or more perceived

defects or flaws in their physical appearance, which they believe look ugly, unattractive, abnormal, or deformed (American Psychiatric Association, 2022)

Weight loss surgery (WLS): For the purposes of this research, WLS is defined as any procedure that involves surgical revision of the gastric bypass system for the purposes of decreasing a person's overall body mass index. The types of surgical procedures available for weight loss include a variety of options, including endoscopic sleeve gastroplasty (ESG), Roux-en Y gastric bypass (RYGP), gastric band, BDP-DS, revision, and other, less commonly performed procedures such as intragastric balloon insertion (ASMBS, 2024).

Self-discrepancy: The idea that there are different forms of self-identity, the actual, ideal, and ought self, within a personality, which may come into conflict with one another (Higgins, 1987).

Body image: The image one has of oneself from a mental perspective when they think of their own body.

Assumptions, Scope, Delimitations, and Limitations

This research was conducted in a phenomenological framework through the use of qualitative analysis of narrative inquiry. I sought to address the gap in the literature regarding the lived experience of post-WLS individuals with self-reported diagnoses of BDD. Bryman (2016) indicated that all research contains assumptions, limitations, scope, and delimitations, which must be addressed in order to fully understand the subject matter within. Being aware of these factors allowed me to understand and address the various

possible ways that these limitations might impact the information and, most important, the results and findings of the research.

Assumptions

Assumptions can be understood as statements made in a study or issues presented that the researcher believes to be true (Leedy & Ormrod, 2018). During the process of this study, as the main source of data involved guided interviews, I made the assumption that the participants were honest and not making any deliberate attempts to deceive or falsify information. I relied upon self-report from participants as verification of the presence of BDD and postsurgical status and therefore relied upon the assumption of their honesty that they experienced symptomology. Next, I assumed that the sample size chosen would be representative of the population of individuals who had undergone WLS and had possible body dysmorphia. I requested of participants that they not describe the study or the questions they answered with other individuals until they had been told that the study was complete, and I assumed that they did so.

Scope

In any research study, it is important to remember that the information applies primarily to the area in which research subjects are recruited. Due to this, research must always acknowledge any limitations that may be imposed by the geographical area in which the research was conducted. As this was a phenomenological study, Creswell (1998) recommended between five and 25 research participants. As such, I attempted to recruit between 10 and 15 individuals from within this population for study, and 10 participants were identified. A phenomenological qualitative study was most appropriate

for this research, as this form of research is appropriate for nonnumerical research involving gaining a greater understanding of concepts, experiences, and opinions on a subject (Creswell, 1998). Other studies used different models and approaches such as factor mixture modeling (FFM), which was used in a quantitative study by Longley et al. (2019). This process was appropriate for this study as its purpose was to assess latent structures within BDD itself. However, as this research study was focused on a qualitative approach that involved examining the concepts and feelings of the individuals who experience this psychological disorder, a phenomenological approach was more appropriate. The scope of the study would have been impacted if, for example, I had been unable to recruit the hoped-for number of individuals who had a diagnosis of BDD. Had this happened, it would have caused an inability to verify transferability of the research findings if the sample size had been too small or there had been too many variances between sampled individuals. Participants stated during the process of consent that all individuals participating were over the age of 18 and therefore were not from a protected population such as minors, and the assumption in consent is that they are not living in incarceration or deemed as requiring a guardian of person to make medical and healthcare decisions. Recruitment was conducted via online support forums for post-WLS individuals, and this helped to avoid selection bias as the individuals using these forums come from multiple areas around the United States and, in some cases, other countries, as international forums for WLS support were used for study recruitment, though no international participants were identified. I also made use of the Walden participant pool as a secondary measurement to ensure sufficient participants for the

study. Recruiting from an online participant pool ensured that, geographically, participants were unlikely to be homogenized and, therefore, pre- and postsurgical experiences were assumed to be different. This helped to ensure transferability of data as it can be applied to multiple demographic groups.

Delimitations

Delimitations within a study can be understood as factors that, similar to limitations, limit the scope of the study. However, in contrast to limitations, delimitations are factors that researchers have themselves placed upon the study (Bloomberg & Volpe, 2015). One of the main delimitations of this study was the choice to exclude individuals who had not yet undergone WLS from inclusion in the sampling. BDD can impact individuals at any stage of life, and those considering WLS may be considered to be at greater risk of BDD due to their dissatisfaction with their weight (Munoz et al., 2010). Another delimitation of the study was the criteria of requiring a previously, clinically diagnosed diagnosis of BDD as per self-report. As this study was focused on the experiences of post-WLS individuals who had experienced BDD, people who did not have a formal diagnosis, either current or in remission, of BDD were not considered for inclusion in the study. Additionally, though the phenomenological study included questions about exercise and eating habits both pre- and post-surgically, the primary focus of this research was on the overall experience of one's changing body and perceptions of it, rather than focusing in detail on caloric intake, pounds lost or regained, or time spent exercising. However, it is acknowledged that these are delimitations of the

study and could potentially be areas that other research studies could benefit from exploring.

Limitations

Limitations can be best understood as issues and circumstances that the research cannot control, and that can potentially impact the validity of the study (Leedy& Ormrod, 2018). This study had several potential limitations. The first challenge for this study was recruitment and the determination of possible BDD in the participants. I posted a recruitment letter to WLS support forums and public sites for individuals who had undergone WLS, such as social media sites (Facebook, Instagram, etc.) and online support groups. Additionally, to increase the possibility of reaching a greater participant pool, I recruited through Craigslist. I attempted to recruit using ResearchMatch, but after review of their criteria and assisting in contact between ResearchMatch and Walden, I was told that Walden was not eligible to participate in their group.

During initial email contact, I verified that all participants, regardless of the platform through which they found the study, met eligibility requirements. Individuals were asked to email me with their interest if they met the criteria for participation (over 18 years of age, previously underwent WLS, and have or have had a diagnosis of BDD). The recruitment flyer indicated that the study was looking for people who had been told by a clinician that they had or had had a diagnosis of BDD. There are also limitations inherent in all qualitative research in that it is more likely to be difficult to analyze as not all data fit into specific categories. Additionally, it is important to note that it was possible that the data would not yield conclusive answers or provide enough consistency

in themes to draw conclusions (Creswell, 1998). This research attempted to review data until saturation of data was reached, but there continue to be areas that the scope of the study did not allow to be explored to their fullest potential.

I also entered into this study with an understanding of the assumption of my own personal bias with this topic, as I had undergone WLS. This information was disclosed to the participants. In this research study, I used an epoche or bracketing technique to suspend judgment about the information that I received and focused only on the data (Sorsa et al., 2015). I also managed this bias by having multiple editors and reviewers for data and made use of self-monitoring devices such as regular debriefing with an individual outside of the study and a research journal during interview, to explore potential bias (Peterson, 2019).

Significance

The climate of the world in the 2020s, during which this research was conducted, has been drastically changed from even that of 2019. The COVID-19 pandemic, the social focus on inequality amongst races, and overall political upheaval took the media by storm. Much of the public focus has been riveted to these subjects. However, with these worldwide concerns, it can be easy to forget an inequality and form of prejudice that many experience daily: public and personal reactions to obesity. Frederick et al. (2020) indicated that weight stigma can be associated with "job discrimination, interest in WLS, experience of physical pain, depressive symptoms, and negative experiences at fitness facilities" (p. 1). The concept of obesity as unhealthy and the perception of the person as having negative traits that they should be able to control have brought with them a

general impression that people who are overweight are at fault for their situation and that being overweight is a crisis that requires solving (Frederick et al., 2020). Given that the statistics for obesity in the United States alone indicate that at least 41.9% of Americans are considered obese (CDC, 2024), this indicates that a significant portion of the population is likely to encounter this form of prejudice and racism on a daily basis. Many individuals undergo WLS to decrease their overall body weight, but undergoing WLS is not a guarantee that an individual will achieve their ideal body weight or, even if they reach their desired weight loss goal, that they will move past such concerns or not regain weight lost. In this study, I sought to examine the lived experiences of individuals with BDD, especially in light of the changes to activities of daily living that took place for many individuals due to COVID-19. In examining the commonalities in these experiences, themes emerged that can help to inform potential for changes in postsurgical care for those undergoing WLS. This includes additional screening for BDD symptomology in postsurgical timeframes, and/or an inclusion of required postsurgical mental health screening and referral for treatment as necessary. Additionally, themes noted related to COVID-19 and its impact on both mental health and access to care, as well as initial social distancing and inability to access things such as exercise at gyms, may help to inform research into further options for home-exercise and telehealth therapy. The social implications of this research include the potential for future development of postsurgical psychological screening and treatment or interventions. Such treatments, if deemed appropriate based on further investigation of the lived experiences

of post-weight loss surgical patients with BDD, could help improve quality of life for these patients.

Summary

People who undergo WLS typically do so with the intention of improving their health and overall quality of life. However, people who undergo WLS may also develop BDD (Vartanian, 2012), and there is a gap in the literature regarding the lived experiences of post-WLS patients with body dysmorphia. This chapter provided a foundation of the problem and purpose of the study and introduced the theoretical framework and significance of the study while also exploring the background. A review of relevant literature related to the study will be provided in Chapter 2.

Chapter 2: Literature Review

Introduction

The purpose of this study was to address the gap in the literature regarding the lived experiences of post-WLS patients with BDD to discover any similarities that might exist in the experiences of these individuals and, thereby, to determine tools, testing, or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in post-WLS patients. This chapter will begin with an explanation of the literature search strategies used and an exploration of the theoretical framework of this study before reviewing the literature on the concepts being studied and providing a summary and conclusions for the chapter.

Literature Search Strategies

To conduct this research, I focused mainly on resources found through the Walden University Library. Through the Walden University Library, I was able to find peer-reviewed articles and doctoral-level dissertations. The library provided electronic search through PsycINFO, SAGE Journals, SocINDEX, ProQuest, EBSCOhost, and ProQuest Digital Dissertations. I attempted to limit my research to the time period between 2010 and 2024, but there were some pertinent research studies from earlier that were also included. Google Scholar was also used in some instances. Websites were also used for current obesity statistics and number of weight-loss surgeries performed. Keywords included *post weight-loss surgery* (including bariatric and gastric-bypass surgery), *self-discrepancy theory*, *body image*, *eating disorders, bariatric surgery and mental health*, and *body dysmorphic disorder*.

Theoretical Framework

Self-discrepancy theory (SDT) was first proposed in 1987 by Higgins. In its most basic form, SDT explores the idea that people make comparisons between what they perceive to be their actual or "real" identity, and other versions of themselves (Higgins, 1987). These other versions can be thought of as the reflection the individual would most like to see when they look in the mirror or when they think back on themselves and their past (Higgins, 1987). Higgins theorized that an individual's personality was made up of three different conceptual versions or domains. He proposed that differences in these domains, and the way in which one perceives oneself in them, can cause negative emotions and psychological distress (Higgins, 1987). He further postulated that these differences help to explain why some individuals will react in a certain way in certain circumstances, such as with remorse at the death of a loved one, while others may feel anger instead (Higgins, 1987).

At the heart of SDT are the three domains of self (Higgins, 1987). These domains are the *actual* self*,* the *ideal* self, and the *ought* self. However, SDT not only encompasses these selves (which will be explained in more depth later), but also explores and incorporates the viewpoints of significant others (Higgins, 1987). Each of these domains of self can then be viewed from the perspective of one's own thoughts and what an outside person, such as a parent or loved one, might think (Higgins, 1987). Despite the fact that the initial research into SDT was conducted in 1987, recent studies by Watson et al. (2016) indicate that there is long-term validity in the concept of personality constructs as related to SDT.

I will first explain each domain individually, and then examine the idea of the different perspectives of self. Once these concepts have been explored, I will examine the way in which the theory defines different forms of discrepancy and their effect. Finally, I will examine the application of this theoretical framework in psychological care.

The *Actual* Self

The first domain of self is the *actual* self, which is the way in which one perceives oneself and one's own attributes (Barnett et al., 2017; Higgins, 1987). This can be best explained by thinking of a person's sense of self-concept as an amalgamation of how they think of their attributes such as their attractiveness, intelligence, and charisma (Barnett et al., 2017; Higgins, 1987).

The *Ideal* Self

The second domain of self is the *ideal* self, which can be described as the ways in which a person feels that they should behave and the most ideal elements of their personality that they believe either themselves or an outside person would like to possess (Higgins, 1987). The ideal self encompasses the idea of things one should do, or ways one should behave that one believes will provide a positive outcome. An example of the *ideal* can be found in the idea of a shy or introverted person feeling that, for the best success, they should be more outgoing or friendly.

The *Ought* Self

The final domain of self, according to the originally proposed consent of SDT, is the *ought* self. This domain of self involves the responsibilities that one accepts as important or the duties that one considers oneself to hold, either to oneself or others

(Higgins, 1987). An example of the *ought* self might be an individual who grows up in a Christian household and holds strong beliefs in the concept of paying tithes, or 10% of their income, to the Church.

The *ideal* and the *ought* self both incorporate the importance of changes and things that one can or should do. By following the concepts and ideas of the *ideal* self, positive outcomes are presumed. The *ought* self also provides positive outcomes, but this is often formed through a sense of duty and obligation (Carver et al., 1999).

Although not part of Higgins's original concept of self-discrepancy, it is important to note the introduction to SDT of the concept of the *feared* self. Carver et al. (1999) proposed the additional concept of self, involving the negative characteristics that one does not wish to embody. This concept of the *feared* self is an important addition because it explores the idea of avoidance and fear of consequences in response to the desire to prevent becoming the *feared* self (Carver et al., 1999). In the case of individuals experiencing body dysmorphia in relation to WLS, for example, the *feared* self may be a self that involves the possibility of regaining weight lost after surgical interventions or the idea that the things they see as negative will never change.

Perspectives of Self

It is important to remember, when considering SDT, that more than the individual person's perspective may be considered when exploring these ideals, as people often think not only about what they themselves think is important, but what others think about them as well (Higgins, 1987). It can be easiest to think of this concept using vantage points. An individual may look at themselves in a mirror, and that is one vantage point.

However, if one were to imagine someone else looking at them, picturing what that person is seeing, that is an entirely different vantage point (Barnett et al., 2017; Higgins, 1987). The other person picturing the individual may be anyone such as a parent, loved one, or friend, but this person would be an individual whom the person considers important or significant in their lives (Barnett et al., 2017; Higgins, 1987). This concept of examining the self from various vantage points is important to understand within SDT. When one experiences a discrepancy between these viewpoints, one experiences a dissonance or discrepancy.

Discrepancies

As the name of the theory suggests, SDT examines not just the different forms of self and the way in which the self is viewed, but also the way that these viewpoints can then impact both emotion and behavior. When individuals experience a discrepancy between their own perceptions and the perceptions of a significant other, negative feelings can arise such as remorse and regret (Higgins, 1987). SDT explores these discrepancies by examining them as actual/own versus ideal/own, actual/own versus ideal/other, actual/own versus ought/other, and actual own versus ought/own.

Actual/Own Versus Ideal/Own

In this discrepancy, one is looking at the difficulty through the perspective only of one's own beliefs and thoughts (Higgins, 1987). The individual may feel that they are not behaving in a manner that is appropriate. For example, if an individual feels that it is important to always keep their promises, then realizing that they had made a promise to

someone and then failed to keep their word might cause sensations of guilt and a sensation that they should be blamed or castigated in some way.

Actual/Own Versus Ideal/Other

This discrepancy may be understood most readily by examining the idea of behaviors that one might have in the way that they approach a situation (Higgins, 1987). If a person marries a conservationist, for example, then they may feel that their spouse may wish them to recycle regularly. If that person were to then throw a soda can into the garbage rather than recycling it, they might feel a sense of guilt or shame for not living up to their significant other's beliefs and expectations. Discrepancies of this kind are most often associated with feelings of shame and guilt for not living up to another's expectations (Barnett et al., 2017).

Actual/Own Versus Ought/Other

This discrepancy can best be understood as not living up to someone else's expectations. If a person subscribed to Christian beliefs in tithes, for example, but was unable to provide a tithe due to financial difficulties, they would experience a discrepancy in the actual/own self when compared to their ideal/other self (Higgins, 1987). This, in turn, can lead to feelings of fear, shame, self-criticism, and social anxiety (Barnett et al., 2017).

Actual/Own Versus Ought/Own

This discrepancy might be best described as failure to meet one's own expectations (Higgins, 1987). This can relate very easily back to the main concept of this study through an example of an individual who has undergone WLS. If that individual set

a goal to lose 50lbs within 6 months after surgery and then found that they had lost only 20lbs within that timeframe, or if they had gained weight instead, they might experience feelings of self-dissatisfaction and guilt, which could lead to a sensation of deserving to be punished (Geraci et al., 2015).

Current Studies Related to Self-Discrepancy Theory

Since its first inception by Higgins, SDT has been applied to examine a wide variety of concepts. The idea of discrepancies within the self and the ways in which one may attempt to compensate for these discrepancies has been explored in several arenas. For example, a quantitative phenomenological study conducted by Levinson and Rodebaugh (2013) made use of SDT to examine acculturation and self-discrepancies within Asian populations in which treatments such as self-system therapy could be beneficial in treatment of anxiety and depression within these populations. By applying principles of self-discrepancy to the idea of acculturation and unconscious behavioral modification to avoid negative social interactions, the researchers were able to examine the ways in which participants responded to various stimuli. A descriptive qualitative study by Busseri and Merrick (2016) explored the ways in which discrepancies could be found in forward thinking processes. Undergraduate students in this qualitative study were asked to describe their ideal, ought, and undesired lives 5 years in the future. By applying concepts of Higgins's SDT, the researchers were able to find commonalities in themes of factors that individuals did not wish to perceive in their future as well as life satisfaction overall. This allowed them to help participants examine the perceived discrepancy between their current and their envisioned lives. A quantitative study by

Barnett et al. (2017) used SDT to investigate the relationships between self-discrepancies as measured by the Integrated Self-Discrepancy Index and Positive and Negative Affect Schedule—Expanded. The study was able to support that positive and negative affective states were associated with self-discrepancies of thought. More specifically, sadness was correlated with the ideal-own discrepancy and indicated that these individuals may experience more distress when they feel that they are not meeting their own expectations. It is noteworthy that the study found that guilt was not associated with the should-own discrepancy, and this is like results found in other studies. However, the overall results of the study supported the idea of specific affective states being associated with specific self-discrepancies in thought. The final study to be examined in relation to SDT and current research is research conducted by Barnett and Womack (2015). This quantitative research study explored both the normal and pathological aspects of narcissism through the lens of SDT. The research examined the links between narcissism and emotion to determine whether self-discrepancies could provide an explanation for the variance in self-esteem and narcissism by examining self-state representations. The study also examined which specific self-discrepancies were associated with various areas of narcissism including self-esteem, vulnerability in narcissism, and grandiosity in narcissism. The study verified that self-discrepancies explained variance in self-esteem in cases of narcissism and found that the actual-ideal and actual-should predicted negative self-esteem. Self-discrepancies provided a statistically significant, if small, contribution to explaining variance in overall narcissism, self-esteem, grandiosity, and vulnerability.

Overall, the study provided evidence supporting SDT and self-regulatory models of narcissism.

Each of these studies helps to demonstrate the ways in which SDT can be used to develop a guide for identifying discrepancies between the actual, own, perceived, and ought selves. This form of discrepancy is at the heart of BDD in that individuals experiencing symptoms of this disorder experience a discrepancy between their actual, own, perceived, and ought selves. This also formed the basis for analysis and review of discrepancies in thinking within this study.

Literature Review

In this section, I review the existing literature on the following concepts—BDD, BDD testing, and the existing literature on WLS—and finally, I present a review of any connection between WLS and BDD. Each of these sections will be followed by a subsection to describe the strengths and weaknesses of the literature. This will then be followed by the summary and conclusions of the chapter.

Body Dysmorphic Disorder

In understanding BDD, one must understand first that it is considered by the DSM-5-TR (American Psychiatric Association, 2022) to be a subset of OCD, and just like OCD, involves not just a single element of fixation or compulsion, but a compulsion to the point that it is clinically relevant and disruptive to the person (Phillips & Fausner, 2010). This means that the individual with a diagnosis of BDD experiences anxiety and distress regarding their appearance, on average, at least 3–8 hours a day (American Psychiatric Association, 2022). Therefore, people with a diagnosis of BDD experience

anxiety and distress when thinking about beliefs that they have one more defects or flaws in their appearance. Typically, these individuals feel that these defects or flaws make them ugly, unattractive, abnormal, or deformed in some way, and they then focus on these flaws to the point that they experience symptoms of anxiety or distress a great deal of the time (American Psychiatric Association, 2022).

Quantifying exactly what 3–8 hours would look like can be difficult, but if a person were to consider that 8 hours a day is an average workday, then the picture may look different. This indicates that 7 days a week, the person is experiencing anxiety and distress related to their body, for the same amount of time that they may put into a day at their job. The person experiencing BDD may feel a compulsion to check in the mirror repeatedly or pull at their clothes to ensure that they fit appropriately. However, that same mirror checking or clothing adjustment, rather than alleviating symptoms of anxiety and distress, may in fact increase it (Phillips & Feusner, 2010). This is an important factor when one also considers that insight for individuals with BDD has been shown to be poorer than for those with OCD. In fact, a phenomenological research study by Mancuso et al. (2010) indicated that individuals with a delusional component to their BDD would typically experience a greater severity of BDD symptoms and are often found to experience comorbid diagnoses such as major depressive disorder and social anxiety disorder. Paranoid personality disorder and obsessive-compulsive personality disorder have also been associated with BDD (Mancuso et al., 2010). Phenomenological studies by Mohajerin et al. (2019) have shown that people with delusional beliefs are typically shown in approximately 2–4% of OCD patients, whereas 27–60% of BDD patients have

been identified with delusional beliefs. Further phenomenological research by Rossell et al. (2020) indicated that delusional beliefs in BDD patients can have a wide range of presentations and symptomology. However, their research indicated that delusional patients with BDD may include a symptom course such as social isolation, functional impairment, and high rates of suicide.

BDD is potentially underdiagnosed in the professional community. Between 1993 and 2008, five quantitative studies were conducted in which researchers examined various factors for patients with BDD. Phillips et al. (1996) examined the prevalence of body BDD in patients with atypical depression in a quantitative correlational study. Conroy, Menard, Fleming-Ives, Modha, Cerullo, and Phillips, (2008) examined the prevalence of BDD characteristics in an adult inpatient setting in a quantitative correlational research study. Grant, Kim, and Crow, (2001), conducted a quantitative survey research study and examined the prevalence and clinical features of BDD in both adolescent and adult inpatient psychiatric hospitals. Phillips, McElroy, Keck, Pope, and Hudson, (1993) conducted a quantitative survey examined 30 cases of BDD presentation and symptomology. And in 1998, Zimmerman and Mattia conducted a quantitative comparison study to explore BDD in psychiatric outpatient settings for recognition, prevalence, comorbidity, demographic, and clinical correlates of BDD. Phillips and Feusner (2010) summarized these five different studies of diagnosis for BDD in which the researchers screened patients for symptoms of BDD. In all five of these quantitative studies, the patients who were diagnosed as having BDD did not have this mental health diagnosis within their record. Phillips and Feusner (2010) further indicated that

embarrassment and feelings of negativity about both the symptoms and their own body impacted their decisions about whether to disclose symptoms. This study by Phillips and Fuesner indicated that patients would rather at times focus on their depressed mood, anxiety, or discomfort in social situations.

Each of the five studies described above took place between 1993 and 2008, and the further study completed by Phillips and Fuesner, which examined the literature of these took place in 2010, limits their current reliability in terms of current data. A more recent weighted prevalence study of literature examined the prevalence of BDD across various clinical settings. This study by Veale, Gledhill, Christodoulou, and Hodsoll (2016) indicated that BDD is still often poorly indicated in clinical settings. The researchers examined the prevalence of BDD across multiple settings and BDD was found more prevalent than anorexia or bulimia. The study further indicated that individuals with BDD may often fail to seek help or may seek help in potentially non-therapeutic ways such as arranging cosmetic surgery or engaging in obsessive and avoidant behaviors. A more recent study conducted by Law, et al. (2023) reviewed mental health outcomes for patients who underwent WLS and highlighted areas such as depression, anxiety, and eating disorders as areas that were improved post-WLS but noted that there was a significant harmful association between suicidality, self-harm, and alcohol use disorders (AUD) (2023). However, body-dysmorphic disorder was not amongst the mental health disorders reviewed.

As will be discussed in greater depth later in this review, people undergoing WLS are typically seeking to improve their physical health. Its therefore important to explore

the treatments that might be required to assist people with BDD. Treatment for BDD may include a variety of therapeutic options, but some of the most common include cognitive behavioral therapy (CBT) and potential medication management in the form of a selective serotonin reuptake inhibitor (SSRI) (Veale, Gledhill, Christodoulou & Hodsoll, 2016). However, a more recent qualitative correlational research study by Mohajerin, Bakhtiyar, Olesnycky, Dolatshahi, and Motabi (2019), has shown that dysregulated emotion is also a factor in treatment of this disorder. This study indicated that the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) may be a beneficial therapy as it makes use of emotion focused CBT (ECBT). The treatment helps to focus on emotional dysregulation and helping the patient to find means of regulating these emotions and the compulsions behind them (Mohajerin, et al., 2019).

Strengths and Weaknesses of Studies on Body Dysmorphic Disorder

In the various studies described above, many strengths and weaknesses were noted. For example, both the studies by Philips, Nierenberg, Brendal, and Fava (1996) and Conroy, et al., (2008) used a quantitative methodology to examine BDD prevalence and the clinical features associated with it. They used similar testing methods including the Body Dysmorphic Disorder Questionnaire (BDD-Q), the Beck Anxiety Inventory (BAI) and the Center for Epidemiological Studies Depression Scale (CES-D) to determine symptoms characteristics and severity of symptoms in patients. This use of multiple forms of assessment of symptoms provided a robust exploration of symptom presence and severity. However, the study by Conroy, et al., (2008) did not address comorbid disorders and notes that body mass index (BMI) was based upon self-report for

height and weight and therefore may have had inaccuracies in data. Both the Conroy and Phillips (1996) studies were also conducted exclusively at a private, non-profit teaching hospital in the Northeastern United States, and therefore generalizability of the results to other areas could not be verified. The 2001 study by Grant, Kim, and Crow provided insight into the prevalence of BDD in areas other than this private hospital setting but used only the BDD-Q and was still conducted at a university teaching hospital and so there continue to be questions of further generalizability of results. The study by Mancuso, Knoeson, and Castle (2010) was phenomenological in nature and provides additional support to findings of delusional and non-delusional BDD variants, especially as related to supporting common characteristics of lack of insight. This study, like several others, made use of the BDD-Q, but also made use of the dysmorphic concern questionnaire (DCQ), the self-rating depression scale (SDS), the social anxiety interaction anxiety scale (SIAS), the Yale-Brown Obsessive-Compulsive Scale (BDD-YBOCS), and diagnostic interview for clarification and exploration of symptoms. This provides a more robust exploration of symptoms and is more recent than several of the other research studies examined in this section. This study also provided insight into medication management of BDD symptoms including citalopram, escitalopram, venlafaxine, and atypical antipsychotic (quetiapine) use. However, like several other studies, this study was limited only to St. Vincent's Health and Body Image Disorder Service, and therefore generalizability is difficult to establish. This study established possible future scales that could be used to establish insight such as the Brown Assessment of Beliefs Scale (BABS) and the Overvalued Ideation Scale (OIS). This

particular study was also focused more on the delusional aspects of BDD as opposed to overall symptoms and prevalence, as previous studies had been. Out of the studies discussed above, it is also noteworthy that many are 10-20 years old. A more recent study examined here was conducted by Mohajerin, et al., (2019) and involved a randomized controlled quantitative analysis. This study, as opposed to the other discussed here, focused more on the specifics of a form of treatment for BDD using the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP). This is an emotion-focused cognitive behavioral therapeutic technique that was designed to target emotional regulation processes. The study was able to verify that UP treatment may be beneficial in treatment of BDD, but because it was the first study of the benefits of this form of treatment, its results cannot be verified against other studies. A weakness of the study was that all interventions were conducted by a single therapist and at a single facility, and therefore generalizability of results can be difficult. Some of the diagnostic measures used in this study, such as the Brown Assessment of Beliefs Scale (BABS) and the Beck Depression Inventory (BDI) were used in other studies. However, the study also used different diagnostic measures such as the Appearance Anxiety Inventory (AAI) and the Difficulty in Emotion Regulation Scale (DERS). The final, more recent study to examine with regard to strengths and weaknesses was completed in 2020 and conducted by Rossell, LaBuschagne, Castle, and Toh. This study was qualitative in nature, which provides greater correlation to the current research study. The study was based in Australia and made use of the Yale-Brown Obsessive-Compulsive Scale, Modified for BDD (BDD-YBOCS), which was also utilized by other studies discussed here. However,

it also made use of the Mini International Neuropsychiatric Interview (MINI) with the Body Dysmorphic Disorder Diagnostic Module (BDD-DM), and the Positive and Negative Syndrome Scale (PANSS). The Peters Delusion Inventory (PDI) was the primary focus of this study and used as a means of determining delusional ideation. This assessment tool was not designed to assess full-blown delusion but was used to explore unusual beliefs and mental events, and therefore the generalizability of results may be in question. However, the study did provide robust cohort sizes and only minor variations in PDI scoring, and the study is more recent than previously mentioned studies of BDD.

Now that the diagnosis of BDD has been explored more fully, I will examine testing measures that can be used in the diagnosis and treatment of body dysmorphia.

Body Dysmorphic Disorder Testing

As with all psychological diagnosis and treatment, one must first assess that an individual is, in fact, experiencing symptoms of BDD. Several screening instruments have been developed for use in clinical practice, but only a few will be discussed here.

One of the earliest screening tools for BDD was the Body Dysmorphic Disorder Questionnaire ([BDDQ]; Biby & Biby, 1998; Phillips & Feusner, 2010). The BDDQ was designed to be a quick-test, screening tool that could be used to determine if the client should come in for additional testing and interview. The Body Image Disturbance Questionnaire (BIDQ) is a self-report measure which is a modified version of the BDDQ. Using a 7-item assessment, the BIDQ examines the level of distress a person experiences as associated with concerns about their appearance and their overall body dissatisfaction (Cash, et al., 2014). According to Phillips and Fuesner (2010) these screening tools

should be followed with the use of a structured clinical interview. One of the more recent scales is the Yale-Brown Obsessive Scale, Modified for BDD, which involves a semi-structured interview based on a 12-item inventory and measures for items such as avoidance, compulsions, and obsessions (Phillips, et al., 2011; Wilhelm, et al, 2016). The Body Dysmorphic Disorder Foundation website also includes a link a screening tool designed specifically to help individuals screen both their symptoms and their severity. The screening tool is called the Cosmetic Procedure Screening Questionnaire (COPS) for BDD and provides a 9-item survey that allows individuals to report their symptoms with a range of 0-72 (Veale, et al., 2012). Each of these tools provides a means of both determining the likelihood of a BDD diagnosis and also provides a measure that can be used to determine the progression of treatment (Phillips, et al., 2011; Wilhelm, et al., 2016; Veale, et al., 2012).

Strengths and Weaknesses of the Literature on Body Dysmorphic Disorder Testing

In the various studies described above, there are a variety of differences between each, and each carries its own strengths and weaknesses. For example, Biby and Biby (1998), though an older study, provided a correlational examination of BDD with depression, somatization, and obsessive-compulsive tendencies, as well as the overall effects of self-esteem. The study estimated 60% of participants to have dissatisfaction with appearance whereas previous studies conducted similarly had demonstrated a higher rating of 70%. However, this study chose to exclude those with eating disorders, whereas previous studies did not do so. The study was also biased toward females as there were 78 female participants and 24 male participants. The study used the Symptom Checklist

90-Revised, but only used 35 of the questions involved focus on specifics regarding the existence of somatization, OCD tendencies, and depression. This study was also conducted using results only from individuals in undergrad studies at Midwestern University. The 2011 study by Phillips, et al., was a qualitative study examining aesthetic sensitivity and views in BDD patients. This study examined 50 participants with BDD and 100 individuals without BDD who were categorized as either art and aesthetic sensitive (generally working or having studied in art), or non-art sensitive. Therefore, the participants were divided into groups of 50 for each section. Participants were aged 18-40, which excluded younger individuals, and this can be significant as BDD can be noted in adolescents. The study assessed for BDD using the Yale-Brown Obsessive-Compulsive Scale, modified for BDD (BDD-YBOCS), the Beck Depression Inventory (BDI), a Values Scale to study aesthetic values, and a self-objectification questionnaire. The Phillips (2011) study did make use of SDT to examine elements of discrepancy between the actual and perceived self, which lends to application to the current study. However, the study had several limitations as there was selection bias in the BDD group as it was focused primarily on facial concerns as opposed to including all forms of distorted thinking, and there was no verification of comorbid disorders. Cash, et al., (2014), involved a quantitative study using online correlational examination of body image. The study was focused entirely on women, limiting its generalizability, and was limited to students enrolled in introductory psychological courses at a large university. It was also heavily weighted toward Caucasians, with 60% of the study population being made up of this group. The study mainly focused on the Body Image Disturbance

Questionnaire (BIDQ), but information was verified through the use of the Positive and Negative Affect Schedule (PNAS), the Upward Appearance Comparison Scale (UACS), and the Eating Disorder Examination Questionnaire (EDEQ). The study was limited by lack of long-term follow-up after the study, the fact that only female students from a single university were surveyed, and the fact that all diagnostic information was limited to self-report. The final study to be examined here is the study by Veale, Gledhill, Christodoulou, and Hodsoll (2016). This is the most recent of the studies examined in this section and was a weighted prevalence study examining multiple studies and types of surveys used in the diagnosis of BDD. The study examined the types of surgery used to deal with issues of BDD, the prevalence of BDD in multiple settings, and provided estimates of BDD in both adults and adolescents. As with most other studies examined, there was a higher number of females to male in most of the studies represented, with a 1.27 weight of women to men in the community and 1.67 weight of women to men in student populations. All studies were also conducted in the United States or Europe, and so generalizability to other populations (especially those of third-world countries) was not conducted. The study also excluded research that was not published in English. However, the results indicated that BDD was found to be more prevalent than other eating disorders such as anorexia or bulimia and provided estimates of BDD in both adult and youth populations. Another option is the body dysmorphic disorder syndrome scale (BDD-SS). The BDD-SS was developed to help examine the severity of symptoms associated with BDD (Wilhelm, et al., 2016). This scale was designed to be used in both clinical and research settings and examines a wide variety of symptoms associated with

BDD including compulsive behaviors related to appearance, thoughts and feelings that are negative in nature regarding the self, and areas of avoidance (2016). The test measures 54 yes and no questions related to symptoms of BDD. These are then divided into 7 conceptually similar symptom groups and rated on a scale of 0-10 for severity, with 0 being no problem and 10 being very severe (Wilhelm, 2006). This provides both an overall examination of the likelihood of the individual having BDD symptoms, as well as the severity of those symptoms. The scale allows for the exploration of negative cognitions and avoidance behavior as well as OCD behaviors as a result of appearance concerns. Some of the weaknesses of this instrument include that, as this measurement is newer, it's test-retest reliability has not yet been established, but it was proven both valid and reliable as a screening measurement for BDD (Wilhelm, et al., 2016).

Now that I have examined BDD and its diagnosis, I will examine WLS itself and provide additional information on the link between WLS and BDD.

Weight Loss Surgery

The American Society for Metabolic and Bariatric Surgery (ASMBS) estimates that the number of surgeries has gone from approximately 215,666 in 2016 to 279,967 in 2022 (ASMBS, 2024). The types of surgical procedures available for weight loss include a variety of options including Endoscopic Sleeve Gastroplasty (ESG), Roux-en Y gastric bypass (RYGP), Gastric Band, BDP-DS, Revision, and other, less commonly performed procedures such as intragastric balloon insertion (ASMBS, 2024). WLS is typically undertaken by people with severe obesity with comorbid conditions such as diabetes and heart conditions (Coughlin, et al., 2013). Prior to undergoing WLS, common medical

practice includes a variety of medical testing in addition to, in most cases, a psychological screening to determine appropriateness for surgery (Mechanick, et al., 2020). In the postsurgical timeframe, patients are encouraged to be seen regularly for monitoring, but post-psychological care is not indicated in the general guidelines for surgery unless the patient has begun to demonstrate psychological instability (Mechanick, et al., 2020). However, according to Munoz, et al. (2010), many individuals who undergo WLS report a difference between their presurgical conceived ideal body size and what they then considered to be an ideal body size after surgery. The potential for BDD symptoms are clear and will now be explored further.

Strengths and Weaknesses of the Literature on Weight Loss Surgery

The studies referenced above each provided different types of information and reference and, therefore, had their own strengths and weaknesses. The study by Coughlin, et al., (2013) provided a potential resource for clinicians to use in determining a framework for thinking about postsurgical questions to ask patients to determine psychological and physical health in the postsurgical period. The study provided the 'WATCH' process, which involves asking specific questions of post-WLS patients such as, 'Have you lost more or less *weight* than medically expected?', 'Are you having a hard time *adhering* to the recommendations of surgical team?', 'Are you spending an excessive amount of time *thinking* about your weight, shape or food?', 'Are you feeling a sense of loss of *control* while eating?', and finally, 'Are you engaging in any *harmful* behaviors to lose weight'. While not specific diagnostic or evaluation tools, these are intended to be used as a framework of thinking in the postsurgical phase and the tool

lends itself toward the need described in the current study for a proper screening tool for risky post-WLS behavior or thoughts. However, this is not a full study in that there are no groups being examined or collection of data. Rather, the study examined outside studies and provided overall guidance to clinicians. The next study by Munoz, et al., (2010), examined pre- and postsurgical perceptions of body shape. The study used the Silhouette Figure Rating Scale (SFRS) and was conducted over a one-year period to examine changing perceptions in ideal body shape. The study provides excellent insight into postsurgical perceptions of body shape, but did suffer several limitations. In addition to being over 10 years old, it was also predominantly female, and two thirds of participants were Caucasian. This limits the generalizability of findings to those outside of this demographic though, as seen in previous areas of this literature review, this is not uncommon as most studies into both BDD, and WLS had higher female to male representation. The final study in this section to be examined was conducted by Munoz, et al., and is the most recent of the studies as it was completed in 2020. This study provides an overall review of the best practices in WLS and management. The study provided both examinations of current statistical data and also provided 85 numbered recommendations for whom should be considered appropriate for WLS and the procedures that could potentially be used. As with the Coughlin, et al. study discussed above, however, this research was not conducted based upon a specific clinical sample, but rather was a review of outside research with a systematic review of articles, and therefore no specific data collection procedures were used.

Weight Loss Surgery and Body Dysmorphia

When considering BDD and individuals who have undergone WLS, it is important to remember that WLS involves a significant change in the way that a person's body works to process nutrition. As discussed above, there are a variety of different types of WLS and each can have a different physical impact, but the most common and desired surgical outcome is the loss of excess body weight. However, several studies have indicated that this weight loss and the changes that take place in the body, not to mention the potential for later weight gain, can cause severe postsurgical psychological complications (Geraci, Brunt & Hill, 2015; Munoz, et al., 2010; Rigby, 2018). Many people who initially lose weight have noticed weight loss stopping and, at times, a regain of weight at approximately 1.5 to 2 years post-surgery (Geraci, Brunt & Hill, 2015). This can be related to a variety of factors that might include grazing behavior, lack of planned exercise, and food cravings, among other potential difficulties, and can lead to serious psychological maladaptive behaviors (Geraci, Brunt & Hill, 2015; Munoz, et al., 2010). However, the potential for weight regain is not the only source of potential psychological discomfort. A case study by Rigby (2018) noted that patients can also experience symptoms associated with fear that something negative will happen when eating (such as regain) and may engage in food avoidance and abnormal eating behaviors after surgery has taken place. This leads to the idea that there is likely a discrepancy within the body image of the individual that takes place once surgery has been completed.

Quantitative research by Arciszewski, Berjot and Finez (2012) examined the fact that self-discrepancies in body image and dissatisfaction can be related to issues with low

self-esteem and can lead to maladaptive behaviors such as disordered eating and other potential weight-related issues. Additionally, qualitative research by Zhou, et al (2015) indicated that 90-96% of individuals who undergo WLS develop areas of body change that are considered unattractive to the individual or, potentially, physically unhealthy such as intertriginous dermatitis (skin fold dermatitis or a rash that occurs within skin folds), and difficulty engaging in certain forms of physical activity. Zhou states that up to 90% of post-WLS patients express desire to undergo body-contouring surgery, though this is not always for a health-related reason and can often have more to do with a focus on perfecting appearance. Individuals involved in this research described their body with terms such as “melted candle” or “like a shar pei” (Zhou, et al., 2010, p. 3).

Strengths and Weaknesses of the Literature on Weight Loss Surgery and Body Dysmorphia

The various studies described above provided a unique understanding of the connection between WLS and BDD, but each study carried its own strengths and weaknesses. The study by Arciszewski, Berjot, and Finez (2012), provided an examination of the malleability of beliefs in body image based upon ‘thin-ideal’ images in the media. While relevant to the current study in several ways as it explored body image as a whole and perceptions of body image, it also made use of SDT as the lens through which it explored participant’s discrepancies in thought as related to body image. However, the study was, as with many of the studies examined around this subject, a female-only study and conducted by a female examiner. It examined only students in their first or second year at the University of Reims and participants ranged in age from

18-26 years. In addition to the low sample size and difficulty in generalizability of data, the study used a computer program that was specifically designed for the study, and therefore test-retest reliability is unable to be determined for this measure. By contrast, the study by Geraci, Brunt and Hill (2015) used a mixed methods approach with a heavy lean toward quantitative data analysis and provided a very robust sample size of 667 patients who ranged in age from 22-84 years. This study, however, also made use of an instrument developed to address long-term bariatric outcomes as there was no other current instrument in place that examined the factors being studied to the depth required. This means that test-retest reliability was unable to be verified for this instrument. However, the questionnaire included information on demographic items as well as milestones for highest and lowest weights before and after surgery, surgery type, and relationship status. The instrument used a 26 question, five-point Likert-scale to gain a greater understanding bariatric outcome, dietary adherence, health impacts, and the overall success of the surgery as perceived by the participants. Open-ended questions provided qualitative data but were very general and the variety of responses could potentially impact the results. It is also important to note that overall generalizability is complicated by the fact that the majority of respondents were from a single Midwestern Bariatric center in the United States and so ethnic and geographic diversity is questionable. The qualitative study by Zhou, et al., (2015) examined barriers to accessing body contouring surgery in the post-weight loss period. It provided an examination of the healthcare system barriers to body contouring surgery, which included prolonged wait for surgery and lack of advocacy by healthcare professionals, as well as individual barriers

including fear of the body contouring surgery, perceptions of others, difficulty in seeking information, and the logistics of the surgery. The most common barrier, however, was cost. This study was qualitative in nature and participants were recruited from Toronto Western Hospital Bariatric Surgery Program, limiting generalizability of results to other areas. Additionally, this study had a small sample size of only 10 individuals: 5 participants who had undergone WLS followed by body contouring surgery, and 5 participants who had undergone WLS but did not receive follow-up body contouring surgery. As with other studies, the participants were predominantly female as well. Finally, the most recent of the studies discussed in this section was conducted in 2018 by Rigby and examined a transdiagnostic approach to food avoidance after WLS. This was a case study and, therefore, had only one female participant. Several testing measures were used including the Beck Depression Inventory (BDI), the Burns Anxiety Inventory (BAI), the Quality of Life enjoyment and satisfaction questionnaire SF (Q-LES-Q-SF), the Weight and Lifestyle Inventory (WALI), and the Fear of Food Measure (FOFM). The individual in the case study was given a diagnosis of depressive disorder and it was noted that her mental health worsened in the postsurgical timeframe. Some of the limitations of this study involved the fact that it was a single-case study and therefore requires a larger scale study to provide additional verification of efficacy for the interventions described. However, it does provide support for transdiagnostic interventions in comorbid diagnoses and outlines potential benefits to specific treatment.

After a thorough review of the current literature on the subject, it becomes clear that individuals who undergo WLS are at risk of developing BDD or may find that their

weight loss (or lack thereof) may impact a preexisting diagnosis of BDD. However, prior to this study, research had not yet been conducted into the lived experiences of post-WLS patients with BDD. Whether the issue comes from the fear of regaining lost weight or through living with the changes to the body after weight loss, the potential for body dysmorphia in post WLS patients becomes clear. Research into this area may help to discover any similarities that might exist in the experiences of these individuals and, thereby, to determine tools, testing, or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in post WLS patients.

Summary

Previous research studies have identified the fact that BDD can coincide with WLS. However, no studies could be found that specifically related to the lived experiences of individuals who have undergone WLS and have BDD. Therefore, a need exists to better understand these lived experiences and the pathologies surrounding the development of BDD in post-WLS patients. This research sought to address the gap in the literature regarding the lived experiences of post-WLS patients with BDD to discover any similarities that existed in the experiences of these individuals and, thereby, to determine if additional tools, testing, or therapy might provide a decrease in those symptoms or avoid issues of body dysmorphia in post WLS patients

Chapter 3 of this research will provide the research design and rationale, define the role of the researcher, examine the methodology for participant selection, instrumentation used, procedures for recruitment, participation, and data collection,

explore the data analysis plan, examine issues of trustworthiness in the research, and finally, explore all ethical procedures and concerns involved in the research.

Chapter 3: Research Method

Introduction

The purpose of this study was to examine the lived experiences of post-WLS patients with BDD. The study sought to discover any similarities that exist in the experiences of these individuals and, thereby, to determine tools, testing, or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in future post-WLS patients. Chapter 3 contains the research design and rationale; the role of the researcher; the research methodology to be used with an explanation of the instrumentation to be used; the procedures for recruitment, participation, and data collection; and finally, an exploration of the issues of trustworthiness and ethical procedures used in the study.

Research Design and Rationale

The research question for this study was the following: What are the lived experiences of post weight-loss surgery patients with body dysmorphic disorder? Using a phenomenological qualitative approach, it explored concepts such as the individual's changing perceptions of their body, their preoccupation with their body and appearance change, and concepts surrounding their own personal image of the ideal body shape. Using purposeful selection, I recruited 10 individuals who had undergone WLS and, either before or after the surgery, received a diagnosis of BDD. Once initial prescreen questions were completed, individuals were qualitatively interviewed until a saturation of data was reached (Lowe et al., 2018). This study explored the lived experiences of post-WLS patients with BDD.

Using narrative inquiry and open-ended, guided interview questions, I explored the lived experiences of people who had undergone WLS and had BDD. By encouraging participants to examine their own beliefs, ideas, and experiences of living with BDD, I gained a greater understanding of the phenomenon of body dysmorphia and how it may impact an individual post-surgery. This enabled me to discover any similarities that existed in the experiences of these individuals and, thereby, determine tools, testing, or therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in WLS patients. By applying the concepts of SDT and body image, this research was able to use narrative inquiry to its best advantage by examining the overall sense of self and body image the individual experienced in the postsurgical phase. After participants were interviewed, the information was analyzed for commonalities and synthesized into a composite account using a heuristic inquiry approach (Patton, 1990). Further detail will be developed in the following sections.

Role of the Researcher

As in any qualitative study, I, as the researcher, was the primary tool used in the research. As discussed in Vagle (2018), in qualitative research, the researcher is the instrument used for data collection, data interpretation, and data analysis. I conducted guided interviews through the use of open-ended questions to explore the topic. As a participant-observer, I developed a relationship with participants by building rapport during the interview, coordinating the location in the form of scheduling telephone interview meetings, and interacting with the participants to glean their reactions during interview (Hammer et al., 2017).

However, it must be noted that there is bias present in all research studies. My own personal bias is that I have personally undergone WLS. In this research study, I used epoche or bracketing technique to suspend judgment about the information received and focus only on the data (Sorsa et al., 2015). I disclosed to all participants that I had undergone WLS and that my experience of body changes in the postsurgical period sparked my interest in this as a research topic. I avoided using participants with whom I had personal experience. I attempted to be open and empathetic during interviewing and to listen to their points of view and experiences without interjecting my own.

Research Methodology

This research used a qualitative methodology, and therefore the data were interview-response-based rather than numerical or statistical. However, there are data in the form of demographic information and prescreen questions (see Appendices A and B) that were used in addition to the review of interview responses. Therefore, neither a quantitative nor mixed methodology approach was appropriate to this study. Qualitative, phenomenological research allows researchers to examine a participant sample's perceptions of their environment and circumstances and, therefore, allows for interpretation of data based upon the experiences of the individuals (Vagle, 2018). The purpose of this qualitative research study was to address the gap in the literature regarding the lived experiences of post-WLS patients with BDD.

Participant Selection Logic

The population in this research was composed of individuals who had undergone WLS who received a diagnosis of BDD either pre- or post-surgically. Using

phenomenological research, I was able to understand the lived experiences of the participants and explore commonalities and themes through the use of guided interview and data analysis (Vagle, 2018). Participants were selected based on a purposeful selection technique (Creswell, 1998) to allow for selection of individuals who best met the criteria of the research study. As this is a phenomenological study, Creswell (1998) recommended between five and 25 research participants. As such, I attempted to recruit between 10 and 15 individuals from within this population for study, and 10 participants were identified. During the research, I looked for specific themes within the participant's answers such as how they had experienced the change in their perceptions of their body as they experienced (or did not experience if they were unsuccessful in meeting their goals) changes in their body in the postsurgical period. I looked to determine if common word patterns existed, such as participants making use of terms such as "defective," "abnormal," "mirror," or "grooming." By examining related themes in interview questions, I was able to explore the lived experiences of post-WLS patients with BDD. All participants were interviewed until saturation of data was achieved. As per Lowe et al. (2018) and Sheperis et al. (2017), saturation of data was achieved when new data received no longer provided additional insight into the emerging phenomenon. Creswell (1998) further indicated that saturation of data has been achieved when no further insights or issues can be identified, and data begin to repeat. Therefore, 10 participants were interviewed, and data were analyzed until no further insights into the current issue were evident. Eligibility to participate in the study was determined based on selection criteria including requirements that the participants

- be at least 18 years of age or older
- have a stated history of WLS (endoscopic sleeve gastroplasty [ESG], Roux-en Y gastric bypass [RYGP], gastric band, BDP-DS, revision, or intragastric balloon insertion)
- have a stated pre- or postsurgical diagnosis of BDD

Instrumentation

For this research, I was the primary instrumentation as I was collecting, analyzing, and interpreting data using guided interview and open-ended questions. The narrative questions, described in Appendix A, were designed to explore the overall experience of body dysmorphia in people who have undergone WLS. The questions were designed based on a combination of BDD criteria as listed in the DSM-5-TR (American Psychiatric Association, 2022) in addition to descriptions of BDD and maladaptive behaviors explained in research into BDD such as Mohajerin et al. (2019), Muller et al. (2019), Rossell et al. (2020), Thompson et al. (2016), and Wilhelm et al. (2016). Demographic questions (Appendix B) included age, gender identification, type of WLS, length of time since surgery, post-WLS cosmetic procedures (if any), and mental health treatment experience. These questions were designed to help me gain a greater understanding of the lived experiences of post-WLS patients with BDD and were the primary source of data.

Procedures for Recruitment, Participation, and Data Collection

For this research, I first obtained Walden University Institutional Review Board (IRB) approval for the research itself. Once that approval was received, I began recruiting

participants. Study participants were recruited from WLS support groups and discussion boards online such as social media sites (Facebook, Instagram, etc.) and online support groups as well as using Craigslist. I contacted the administrators of the groups/boards and explained the research that I was proposing. I provided the administrators with the research information letter (Appendix I) and requested permission to post a recruitment advertisement (Appendix J). Additionally, to increase the possibility of reaching a greater participant pool, I recruited through groups such as Craigslist and the Walden Participant Pool. During initial email contact, I verified with all participants, regardless of the platform through which they found the study, that they met eligibility requirements. Participants contacted me via email if they met the requirements for participation (over 18 years of age, post WLS, and having a current or past diagnosis of BDD). Once participants verified this information via email, provided consent, and confirmed their interest in participating, I then set up meetings with each participant. I requested video interviews but, per participant comfort, interviews were conducted via phone if necessary. The interview process took approximately 1 hour to complete and constituted the third data collection event.

Once a date for the interview had been set and before the interviews proceeded, I provided participants with confidentiality information and explained the process of the research as well as my research goals via email. I obtained permission to proceed as well as permission for all recording and transcripts taken via consent, which was emailed to participants. Participants were asked to email back their responses directly to the consent with the statement “I consent.” I explained that I changed all names in any written

documentation to protect participant confidentiality. I also informed participants that they could withdraw their consent to participate at any time and, once consent was withdrawn, all documentation, data, and recordings with their information would be deleted.

Once all consent had been obtained, I provided each participant with a time and date for their interviews and contacted them via phone, as per their preferences. Data were collected via interviews that were recorded and transcribed and demographic data. I reviewed confidentiality with participants during the interview process, providing an additional summary of the interview to respondents to complete member checking for the research process. After completion of interviews, participants were debriefed once again, with an explanation of the goals of the study and confidentiality. The participants then received a typed summary of the interview via email and were asked to review it for accuracy and provide corrections, if necessary, a process that took approximately 10 minutes. Finally, participants were asked to speak with me one final time to review my interpretations and provide feedback in a member checking procedure as the fourth and final data collection event and study exit procedure. Finally, the participants will also be provided a one- to two-page summary of the completed study and contact information for any questions that they might have and the opportunity to receive a copy of the full research study if requested. Once the research has been completed, analytic triangulation will be completed by having a peer not involved in the process of the research review findings and data to help provide an outside evaluation of the strengths and weaknesses of the research (McMahon & Winch, 2018). The study was able to recruit 10 participants.

Data Analysis Plan

Data analysis in qualitative research can be best understood as deliberately focusing on minutiae of details within a data sample (Vagle, 2018). The methods for performing data analysis may include a variety of options such as a selective or highlighting method as well as more wholistic approaches. Each of these processes can be further broken down into specific methodologies such as the Colaizzi-Style, which involves extracting specific statements and organizing them into clusters of themes (2018). I used the Colaizzi-Style and analyzed clusters of themes with the help of Quirkos software. I looked for specific themes within the participant's answers such as how they had experienced the changes in their perceptions of their body as they experienced (or did not experience, if they were unsuccessful in meeting their goals) changes in their body in the postsurgical period. I looked to determine if common word patterns existed, such as participants making use of terms such as "defective," "abnormal," "mirror," or "grooming." By examining related themes in interview questions, I was able to explore the lived experiences of post-WLS patients with BDD to discover any similarities that existed in the experiences of these individuals. This research highlights the need for additional screening or potential referrals for therapy that might provide a decrease in those symptoms or avoid issues of body dysmorphia in WLS patients. No discrepant cases or data were noted that contradicted most data collected during research, though these would have been examined as a negative case sampling and explored during data analysis as outliers with potential implications on study validity during discussions, conclusions, and recommendations in this research study.

Issues of Trustworthiness

To ensure that this study provides positive social change, I used the following methods to ensure the credibility, transferability, dependability, confirmability, and intra- and intercoder reliability of my data.

Credibility

Credibility in research refers to the ability of the research to be verified as grounded in reality and verified (Amankwaa, 2016). This often involves procedures such as triangulation of data and member-checking. All participants were interviewed until saturation of data was achieved. As per Lowe et al. (2018) and Sheperis et al. (2017), saturation of data is achieved when new data received no longer provide additional insight into the emerging phenomenon. I also performed member-checking by providing participants with a one- to two-page summary of the research study with the option to receive a final copy of the research study at the study's conclusion should they desire it.

Transferability

Transferability of data refers to the applicability of the research to the world and the field beyond the research study itself (Amankwaa, 2016). As participants were recruited online, variation of geographic location and, thereby, surgical and postsurgical experiences, was established. This lends itself toward transferability of data. Transferability of data was also established by providing a detailed explanation of the online nature of the research and interviews as well as the interview process itself.

Dependability

Dependability in research involves the process of ensuring that the conclusions drawn by the researcher match that of the data that the researcher has collected (Amankwaa, 2016). I ensured dependability by having an outside researcher review my processes of data collection, analysis, and results to determine whether my results were accurate and act as an external audit of my findings.

Confirmability

The process of confirmability involves acknowledging one's biases and ensuring that the results of a research study are based upon the facts presented during research, and not the researcher's own personal bias or opinions (Amankwaa, 2016). I entered into this study with an understanding of the assumption of my own personal bias with this topic, as I had undergone WLS. This information was disclosed to the participants. In this research study, I used epoche, or bracketing technique, to suspend judgment about the information that I received and focus only on the data (Sorsa et al., 2015). I also worked to manage this bias by having multiple editors and reviewers for data and made use of self-monitoring devices such as regular debriefing with an individual outside of the study and a research journal during interviews, to explore potential bias (Peterson, 2019).

Intercoder Reliability

Intercoder reliability refers to the process of coding data that will be used in the research analysis to provide an ordinal scale of measurement to categorize responses and data (O'Connor & Joffe, 2020). I used Quirkos software to help organize and collate data and built a coding database through it to help provide analysis of the interview responses.

Ethical Procedures

As this study involved human participants, I submitted this proposal to the Independent Review Board (IRB) of Walden University. They assessed and approved of this study plan prior to my contacting any participants. All participants within the study remain anonymous and are referenced within the study by a non-descript nomenclature of participant 1, 2, 3, etc.

During data collection and analysis, and after all participant eligibility, consent, and confidentiality was established, I conducted live interviews via phone. I did request video interviews but, per participant comfort, interviews were conducted via phone. I requested verbal permission to record the session so that verbatim notes could be taken for data analysis. All information will be kept in password-protected files stored on my hard-drive and erased after 5 years. During this 5-year data retention period, I will maintain control of this data and will not allow others to have access to participants' identifying information. Should any participants withdraw consent, refuse consent, or withdraw from the study, data will be deleted as per consent agreement. This study was not conducted within my own work environment and no incentives or gifts were provided to participants, which allowed avoidance of power differential outside of the researcher-participant relationship. All attempts were made to ensure participant confidentiality.

Summary

This chapter provided an explanation of the methodology, research design, data collection and analysis process, and the instrumentation used in the study. This phenomenological research study addresses the gap in the literature regarding the lived

experiences of post WLS patients with BDD. Study participants included individuals recruited from WLS support groups and discussion boards who reported a diagnosis of BDD. Participants were provided with confidentiality statements, informed consent documentation, and their anonymity is protected. The results of this study provide indications for potential screening and assistance with mental health treatment post-surgically.

Chapter 4: Results

The purpose of this study was to better understand the lived experiences of individuals who have undergone WLS and experienced BDD. The study had one main research question: What are the lived experiences of post-weight loss surgery patients with body dysmorphic disorder?

This chapter will present accumulated data for this study and findings based on the research question, which was designed to better understand the lived experiences of people who have undergone WLS and experienced BDD. Chapter 4 presents the results of the qualitative exploration of the study, which was conducted using in-depth, semi-structured interviews in which participants shared their experiences. The chapter begins with an overview of the research setting, introduction of participant demographic information, the data collection process, and then outcomes. Data collection will be described, including location, frequency, and duration of data collection and how data were recorded. Variations in the data collection from the plan in Chapter 3 are also presented. The chapter has an analysis of the evidence of trustworthiness, including credibility, transferability, dependability, and confirmability.

Setting

This study was conducted using online sourcing of participants and then telephone interviews with 10 participants beginning in September 2022 and ending in June 2024. Participants responding to the invitation to participate in the study contacted me via email. Initial screening questions included verification that the participant was over the age of 18, had undergone WLS, and had a previous or existing diagnosis of

BDD. Once initial screening questions for verification of eligibility to participate were completed, the consent form was emailed, which included information on seeking assistance with any potential emotional dysregulation or crises as necessary. Once participants replied with consent, we scheduled a date and time for the interviews. Each participant requested to complete a phone interview rather than an interview via Zoom, Skype, or one of the other video options available. The interviews lasted between 45 and 60 minutes and were recorded digitally and transcribed verbatim. One element that may have influenced the interviews was the fact that, as was noted in further detail later, participants all requested phone interviews rather than video. As with all research conducted without visual input, this did limit any potential notes on body posture and facial expression. I then reread and edited the transcripts for any needed adjustments. I presented final transcripts via email to participants for member check and accuracy. After member checking, no changes were made to the original transcripts. I was in Washington state for each of the interviews, and participants remained in their home states. I identified participants using the Walden University Research Participant Pool and additional contacts using Facebook social support groups, Tumblr social support groups, Instagram, and Craigslist.org, as well as using the snowball method.

Demographics

Ten individuals who had undergone WLS and who had a diagnosis of BDD were identified and agreed to participate. The research sample consisted of three male and seven female participants. Participant locations varied, with two participants from Florida (one male, one female), two participants from Texas (one male, one female), two

participants from New York state (one male, one female), and one participant each from Washington state (female), Virginia (female), Maine (female), and California (female). The types of WLS varied, and some participants did undergo more than one surgery. Six participants underwent RYGP, four had ESG, two participants underwent a gastric band or lap-band, and one participant underwent a stomach stapling, or vertical banded gastroplasty (VBG) procedure. Two participants underwent two or more WLS procedures, and two had postsurgical abdominoplasty (tummy tuck) procedures. Table 1 reflects demographic data, and Figure 1 provides a wordcloud review of some of the most commonly stated words used during the interview process.

Table 1

Participant Demographic Data

Participant	1	2	3	4	5	6	7	8	9	10
Sex	F	M	M	F	F	M	M	F	F	F
Location	VA	TX	NY	WA	TX	NY	FL	FL	ME	CA
Relationship status	D	S	S	M	S	S-E	M	S	M	M
Type of surgery	VBG	RYGP	ESG	Band	RYGP	ESG	RYGP	Band	RYGP	ESG
Year of surgery	1989	2015	2015	2003	2008	2019	2013	2003	2017	1998
Second surgery (if applicable)	RYGP	N/A	N/A	N/A	N/A	N/A	N/A	RYGP	N/A	N/A
Year of second surgery	UKN	N/A	N/A	N/A	N/A	N/A	N/A	2015	N/A	N/A
Postsurgical cosmetic abdominoplasty (if applicable)	Yes x2	No	No	No	No	No	Yes	No	No	No

Note. Roux-en Y gastric bypass (RYGP), endoscopic sleeve gastroplasty (ESG), “band” gastric band or lap-band, and vertical banded gastroplasty (VBG), single (S), married (M), single-engaged (S-E), divorced (D), unknown (UKN).

Figure 1

Wordcloud

Data Collection

For participant recruitment, I received permission from the Walden University IRB (Application #08-22-23-0408810) to post a request for participants in this research study. I initially posted with the Walden University Research Participant Pool and then contacted the administrators of various WLS support groups on Facebook as well as attempting to contact support groups such as Bariatric Pal and Obesity Action Coalition, but unfortunately, I was told that I would not be able to recruit participants through these venues. I also attempted to contact three surgeon groups who conduct WLS but was unable to obtain approval through these groups either, and so I focused my efforts on

social media support groups and the Walden Participant Pool. My first participant found the study through the Walden University Research Participant Pool. I searched for the various administrators of Facebook- and Instagram-based WLS support groups and contacted the administrators directly with the message noted in Appendix G. At first, I did not receive responses from administrators. I was able to verify that posting was permissible on two of the support groups, and so I posted the recruitment flyer with a specifier to delete if not allowed. No posts were deleted. From this, I received contact from four participants. I was contacted by 12 individuals who stated that they felt they had symptoms of BDD but did not have a formal diagnosis. I was also contacted by six individuals who stated that they did have the diagnosis, but after receiving the consent form, they did not follow up further. I did contact ResearchMatch, a group like the Walden Participant Pool, after discussing it with my chair. Unfortunately, as Walden does not have a contract with ResearchMatch, I had to contact Walden administrators, who communicated back and forth with ResearchMatch, and I was ultimately informed that Walden students were not able to make use of ResearchMatch. After discussing it further with my chair, it was recommended that I consider widening my pool using Craigslist. I submitted a request to the Walden IRB for a change to make use of Craigslist posting and, upon approval, posted the recruitment flyer in multiple cities. This yielded greater results with an increased number of participants who contacted me, though I continued to receive messages from participants who felt that they had symptoms of BDD but did not have a formal diagnosis. I also had several additional interested parties who met criteria but did not respond further after receiving the consent form. This

lengthy process of participant recruitment, including non-follow-up and noneligible interested parties, considerably extended the length of time I was in data collection. It was not until June 2024 that I was able to complete 10 interviews, which was the minimum number of participants identified for this study.

All interviews were conducted via phone as participants specified a preference for this versus Zoom, Skype, or other platforms that involved camera. The interviews were recorded for accuracy and transcribed for subsequent member checking and analysis. The interviews were completed within 45–60 minutes each. Once transcripts had been reviewed and verified, the transcripts were hand-coded for initial checking and then submitted for analysis using Quirkos software.

Data Analysis

Qualitative data analysis was performed using password-protected Quirkos software. The initial process entailed downloading the transcripts of the interviews into the Quirkos software. There were no discrepant cases in the research study. The interviews were recorded and transcribed verbatim. The data analysis using this software generated similarities and extracted themes. It also highlighted differences and similarities in relationships. I then used inductive coding to review for patterns, and codes were derived from the data similarities relative to the research question.

Data analysis demonstrated relationships that were substantive to the themes and theories for this study described in Chapter 2. Themes in relation to Higgins's SDT were explored, and significant relationships were noted between (a) discrepancies between the

actual/own versus ideal/other self and (b) discrepancies between the actual/own versus ought/own selves.

Evidence of Trustworthiness

Credibility

For qualitative research, credibility is derived from accuracy reflecting participants' experiences (Lincoln & Guba, 1985) as well as verification that the research is grounded in reality and verified (Amankwaa, 2016). All participants responded well in interviews, with breaks offered and provided as needed, and regular check-ins to ensure that participants were not feeling overwhelmed by discussing their experiences with BDD. Participants stated that the experience was positive, with several members stating that, in general, they did not typically discuss their dysmorphic experiences, even in therapy. To ensure verification of data, all members who participated in this study were provided a summary transcript of the interview via email to confirm accuracy of the information provided.

Transferability

Transferability of data refers to the applicability of the research in the field beyond the research study itself (Amankwaa, 2016). All participants in this study were recruited online and, though all participants were located within the geographical United States, participants were located within multiple states. Participants also had a variety of WLS types. As all participants were located within the United States, transferability of data outside the United States is not possible to verify. All participants within this research study also verified that they had undergone WLS, and therefore the data would

not be transferrable to any populations that did not undergo WLS. However, it is very possible that there may be some elements of association between other individuals who have undergone WLS and experienced BDD, and the results of this study may be relevant in future explorations of post-WLS and BDD.

Dependability

Dependability in research involves the process of ensuring that the conclusions drawn by the researcher match that of the data that the researcher has collected and may be replicated in other studies (Amankwaa, 2016). During data collection, participants were recruited from the Walden Participant Pool; from Facebook, Tumblr, and Instagram support groups; and from Craigslist, and participants were referred by other participants. The interview data were collected using audio recordings and verbatim transcriptions. Identification of themes and data analysis were completed using Quirkos software. The audit trail for this study includes audio recordings and/or verbatim transcription, consent forms, and data from Quirkos software.

Confirmability

Confirmability of data involves acknowledging one's biases and ensuring that the results of the research study are based upon the facts presented during the research and not the researcher's own personal bias or opinions (Amankwaa, 2016). I entered this study with the understanding of my own potential bias with the topic, as I had undergone WLS, and this information was disclosed to participants. I used epoche, or bracketing, to suspend judgment about the information I received and focus on the data (Sorsa et al.,

2015). I also made use of debriefing with my chair and colleagues outside of the study and made use of a journal to explore potential bias (Peterson, 2019).

Intercoder Reliability

Intercoder reliability refers to the process of coding data that will be used in the research to provide an ordinal scale of measurement to categorize responses and data (O'Connor & Joffe, 2020). I initially hand-coded the data to identify main themes, then made use of Quirkos software to help organize and collate the data and built a coding database through it to help provide analysis of the interview responses.

Ethical Procedures

I utilized ethical principles throughout the research process and honesty in data collection, analysis, and reporting. Participants were informed on the research design and purpose. The participants were informed during the consent that they had the right to not participate, to avoid answering any questions with which they were uncomfortable or that caused tension or deep emotions, and that their consent was voluntary and could be revoked at any time. As the study involved human participants, I submitted the proposal to the IRB of Walden University, which assessed and approved the study prior to my contacting any participants. All participants within the study remain anonymous and are referenced within the study using nondescript nomenclature such as Participant 1, 2, 3, and so on. Participants were given a resource for seeking mental health assistance after the interview and, for those already seeing a therapist, verification that follow-up with this individual was completed. There was no compensation for participation in the study, and each participant was given contact information for the researcher.

Although video interview via Zoom, Skype, or other platforms was offered, all participants requested phone interviews, and many discussed avoidance of cameras as a rationale for their preference for phone interviews. All information is kept in password-protected files stored on my hard drive and will be erased after 5 years. During this 5-year data retention period, I will maintain control of these data and will not allow others to have access to participants' identifying information. This study was not conducted within my own work environment, and no incentives or gifts were provided to participants, which allowed avoidance of power differential outside of the researcher–participant relationship. All attempts were made to ensure participant confidentiality.

Results

The following findings and themes were relevant to the research. They demonstrated some of the shared experiences of the 10 participants in the study on their experience of WLS and BDD. The overall themes noted within the research study were a focus on medical and lab findings in the postsurgical phase (as opposed to mental health); use of mental health services, which were sought individually rather than being encouraged by surgical team; reassurance-seeking; struggles with dating, sex, and intimacy; focus on the gym and workouts; clothing; food and cooking; areas of specific concern within their bodies; considering or completing postsurgical cosmetic surgery; avoidance of cameras and mirrors; difficulties with weight-regain and the impact of COVID-19; and finally struggles with body positivity and body image. Table 2 provides an overview of the themes and provides a list of which participants endorsed each theme. Each theme will then be expounded on in the following sections.

Table 2

Physical Health Areas of Focus

Participant	1	2	3	4	5	6	7	8	9	10
Focus on med & labs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Labs and bloodwork	✓			✓		✓	✓	✓	✓	
• A1C									✓	✓
• Diabetes				✓	✓				✓	
• Blood pressure							✓	✓		✓
• Protein intake					✓	✓	✓		✓	✓
• Sleep apnea							✓		✓	
• Diarrhea & nausea					✓					
• Infections					✓				✓	
• Rashes in folds of skin							✓			
• Health & "being healthier"	✓	✓			✓	✓	✓	✓	✓	✓
• BMI			✓					✓		✓
Participant	1	2	3	4	5	6	7	8	9	10
Support systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Family members	✓				✓	✓				✓
• Spouse/significant other				✓			✓		✓	✓
• Friends			✓				✓	✓	✓	✓
• Physician (PCP)						✓				
• Gym trainer/gym members		✓	✓			✓	✓	✓		
• Online support systems									✓	
Participant	1	2	3	4	5	6	7	8	9	10
Reassurance-seeking		✓	✓	✓	✓	✓	✓	✓	✓	✓
• Spouse/significant other				✓	✓	✓	✓		✓	✓
• Children							✓		✓	
• Friends			✓		✓		✓	✓	✓	✓
• Relationships ending with support seeking		✓			✓			✓		
Participant	1	2	3	4	5	6	7	8	9	10
Dating, sex, intimacy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Dating post-surgically	✓	✓	✓		✓					✓
• Positive dating experiences			✓							✓
• Sex			✓	✓	✓		✓	✓		✓
• Avoidance of intimacy/sex			✓	✓	✓			✓	✓	✓
• Discomfort with nudity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant	1	2	3	4	5	6	7	8	9	10
Activities of daily living	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Gym/workout		✓	✓			✓	✓	✓		
• Clothes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Food/cooking			✓				✓		✓	✓
• Weight regain and COVID-19 impact		✓	✓	✓	✓	✓	✓	✓	✓	✓
• Cameras and mirrors	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant	1	2	3	4	5	6	7	8	9	10
Areas of body dysmorphic concern	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• Skin	✓	✓	✓			✓	✓	✓	✓	
• Back	✓					✓				
• Legs				✓				✓		✓
• Stomach	✓	✓	✓			✓	✓		✓	
• Hair/hair loss					✓	✓			✓	✓
• Arms	✓	✓								✓
• Breasts						✓				
• Folds	✓						✓		✓	
• Buttocks/butt										✓
Participant	1	2	3	4	5	6	7	8	9	10
Considering or completing postsurgical cosmetic surgery or alternatives	✓	✓	✓		✓	✓	✓	✓	✓	
• Completed	✓							✓		
• Considered	✓	✓	✓		✓	✓	✓	✓	✓	

Participant	1	2	3	4	5	6	7	8	9	10
Participant	1	2	3	4	5	6	7	8	9	10
Body positivity and body image	✓						✓	✓		

Focus on Medical and Lab Findings Post-surgery

Each participant in the study indicated that they were followed closely by medical professionals regarding their recovery and weight-loss after surgery. However, no postsurgical recommendations were made for mental health assistance nor were mental health difficulties screened. Labs and bloodwork were described by participants 1, 4, 6, 7, 8, and 9 as an area of focus for their physicians. For example, participant 1, when asked if mental health was asked about in the postsurgical period, stated, “No, it was completely ignored. Other people are attached to themselves, and they don’t understand. It’s always ‘Are your lab levels good? Are your vitamin levels ok? They don’t ask about the rest,” (Participant 1). Participants 9 and 10 discussed that there was a specific focus on A1C (a measure of blood glucose or blood sugar levels) for them, and participants 4, 5, and 9 mentioned diabetes as a precursor to having WLS. Participant 9 stated, “I got the surgery because of my diabetes. I developed type 2 diabetes and I was able to stop taking my diabetic meds after the surgery and my A1C got really good!” (Participant 9). Participants7, 8, and 10 discussed improvements to their blood pressure. Participants 5, 6, 7, 9, and 10 discussed either physician recommendations for protein intake, increasing protein intake to assist with difficulties such as hair loss, or checking protein levels via labs. Participant 5, in discussing postsurgical hair loss, stated, “It was so scary! And eventually I started wearing wigs. And I mean, the doctors kept telling me to up my protein and that it was normal, but I mean, what’s normal about losing your hair?”

Participants 7 and 9 discussed sleep apnea as precursors for surgery. Participant5 discussed difficulties with diarrhea and nausea post surgically and participants 5 and 9 discussed infections that had to be treated post surgically with antibiotics. Participant 7, in discussing excess skin, stated, "…it was always sweaty. And I'd get rashes and stuff in the folds and I couldn't do anything about it. I'd have to put a cloth between the folds to keep the sweat from making them get rashes and I used diaper cream and stuff." Eight participants, 1, 2, 5, 6, 7, 8, 9, and 10, discussed health in general in terms of physician focus on health, becoming healthier, or what "healthy" looked like. Three participants, 3, 8, and 10 discussed their BMI as being an area of focus with participant 8 stating that, after they had reached a previous goal weight, their physician recommended decreasing this goal as their BMI was still too high for their height.

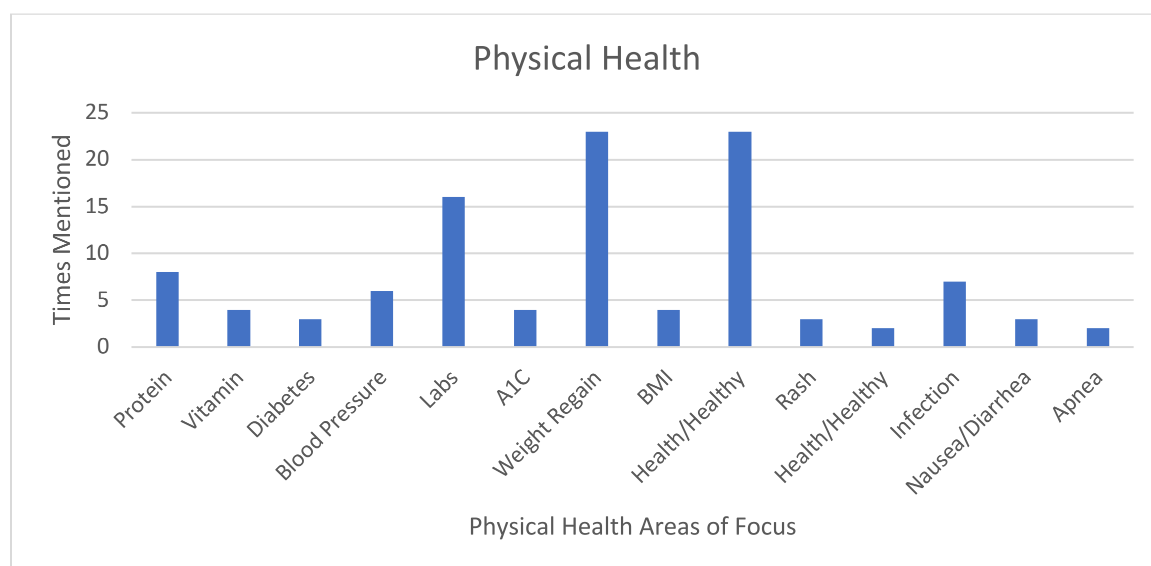
Mental Health Therapy

All ten participants in this study endorsed that they were either actively seeing a therapist or had sought one out after surgery and engaged in treatment. However, no participants indicated that their WLS surgeon or physicians involved in the WLS process recommended follow-up with a therapist. Participant 2 mentioned, "I saw an, I don't know, the person who does the pre-surgery check stuff? Yeah, I saw that but nothing else. But I was having some other issues so I went to see one, and that's how they told me I had the body-dysmorphic disorder." Participant 3 described seeking a therapist out post-surgically when they began to experience anxiety. Like participant 2, they stated, "I had to go see someone before, you know, as part of the thing to make sure I could do it. But after that I wasn't seeing anyone until then," (Participant 3). Participant 6 did mention

that their physician recommended that they see a therapist, but the focus was on depressive and anxiety symptoms and no mention was made of BDD, which was later screened and diagnosed by their therapist. Participant 9 discussed seeking a therapist when they began to note their family members becoming frustrated with reassuring them about their looks and feeling depressed. They stated, "I realized that they were reassuring me a lot and my husband was starting to really struggle with it and getting frustrated. And I was getting depressed because I was gaining weight back and I just looked nasty. So, I finally decided to talk to someone," (Participant 9). Participant 10 also discussed that mental health was not discussed until they mentioned depression symptoms. Figure 2 below reviews areas of focus discussed during interviews.

Figure 2

Physical Health Areas of Focus



Support Systems

During interviews, participants were asked to discuss support systems that they had in place post-surgically. Participant 6 mentioned their primary care physician as being a great source of support and the individual who encouraged them to seek therapy services. This participant also stated that their girlfriend was someone who supported them even when they struggled to believe them. They stated, "…I wasn't believing her when she said I was beautiful, but she understands that it's not that I don't believe she believes it, does that make sense?" (Participant 6). When reframed for verification as the participant believing that she's sincere, but doesn't necessarily agree, the participant stated, "Yeah, yeah that's it. I know she loves me, and I know she thinks I'm beautiful," (Participant 6). Another, participant 7, discussed their gym trainer as being very helpful and encouraging, stating, "…I went to start at the gym and I found this trainer who was really supportive and helpful… he had worked with other people who'd had WLS and so he was really eager to help me and show me how to do things." Online support groups were mentioned as beneficial by participant 9, who, when speaking of their experience with anastomotic leaking (a potentially life-threatening condition in which the new connection between intestines and stomach do not fully heal and leak digestive juice and partially digested food, [John's Hopkins 2024], stated, "…I had gotten involved in some groups right beforehand online and they helped me realize what was happening even before the doctors did, so I got help right away." Six participants described family members such as spouses, significant others, and children, as support systems, and four described friends and even people at the gym as being sources of support. An outlier for

this was Participant 5. This participant indicated that they went to see a therapist only after their husband left because their family did not support it. They stated, "…my family isn't really big on therapy. They don't like, they aren't really supportive. They think you need to trust in God. So even me getting the weight surgery was a big deal to them and they didn't like it," (Participant 5). Support systems, while beneficial in some instances, could also be sources of uncertainty when they became coupled with reassurance-seeking or when fixations and perseverations became barriers.

Reassurance-Seeking

Six of the participants, 4, 5, 6, 7, 9 and 10, discussed the struggles that they experienced regarding seeking reassurance from family members and friends. Participant 4, for example, stated that their husband was very supportive, stating, "He's amazing. Even now, he tells me how beautiful I am even though I know I'm not." When asked if the participant felt beautiful, they replied, "No, not at all. I don't know that I ever did." Family and friend support structures were described as essential by many participants, with participant 7 describing how their wife helped with meal prep and was constantly encouraging them while also stating that she was "…the best thing about my life." The same participant also described times when their wife became frustrated with the need to constantly reassure them and with their fixation on the features they felt were unsightly. Similarly, Participant 9 discussed their husband as being very supportive, but added that:

> I know it can get annoying for my husband because he gets tired of reassuring me all the time." They went on to state, "…all the time he's telling me how beautiful I am and how he loves me, and he does, just like my kids love me, but… you

> know… part of me wonders if he would like me better if I could just be normal and if I didn't have this evidence that it took surgery for me to lose weight and I still couldn't keep it off.

This participant went on to state that eventually, their husband was reassuring them daily that they looked alright and even their children were:

> …starting to change the way that they [the participant's children] spoke to me. They sort of, they took their cues from my husband and were telling me that I was beautiful, and it didn't matter about the skin and that my hair was nice and, I mean, that was hard to realize, that my kids were starting to have to reassure me too. I mean, a 7-year-old shouldn't be telling you, "Mom, don't worry, you're beautiful." How many kids do you know who do that?

Participant 6 described their reassuring-seeking with their girlfriend by stating that their girlfriend frequently tells them that they are beautiful and is supportive. However, they also described having difficulty believing the supportive statements. They described:

> It got a little hard there at first, because I wasn't believing her when she said I was beautiful, but she understands that it's not that I don't believe she believes it, does that make sense?

When clarified and reframed to the participant conceptually as believing their girlfriend is sincere while also not agreeing with the statements, they agreed that this was the case. In this case, the participant was able to work through the difficulty and stated that they are getting married to their girlfriend in the winter. However, three participants (2, 5, and 8) described relationships breaking up due to the fixation and need for reassurance and one

participant (Participant 4) discussed starting couple's counseling due to reassurance seeking.

Dating, Sex, and Intimacy

Dating, sex, and intimacy were factors that were discussed in both positive and negative terms by all participants. Five participants, 1, 2, 3, 5, and 10, discussed dating, with three (2, 3, and 10) indicating that they dated briefly after surgery and losing weight, and two (3 and 10) discussing positive dating experiences. Participant 2 stated, "I went on a few dates when I got to feeling healthier. Girls at the gym were talking to me and I went out with a couple. That was a fuckin' trip, girls asking me out," (Participant 2). When clarified that this was unusual for the participant, they stated, "Yeah, I didn't get asked out. I've always been the fat kid. And I dated a girl for a while. We went to the gym together. But that didn't last, and I don't date anymore," (Participant 2). Participant 5 described that, due to postsurgical hair loss, they constantly wore wigs. They stated that, "I take them off to sleep, but I mean, that's another thing. When I was talking to people online, there's always this next step of meeting. And if you're kissing or wind up in bed, I mean, what happens to the wig?" (Participant 5). When asked if intimacy was uncomfortable for them, they stated, "I guess so. Like, I don't want to take off the wig, and you need to right? Like, that's how it works. But I don't like the way I look without the wig, and I don't want anyone to see me without it," (Participant 5). Participant 7 discussed that sex with their wife significantly improved after surgery with alternative positions and increased frequency being a very positive factor for them. However, 6 other participants (3, 4, 5, 8, 9, and 10) described avoidance of sex. Participant 8, when asked if

fixation on perceived defects or imperfections interfered with sex, said: "I mean, for me it did. I didn't want to get naked with people because, I don't wanna see all'a that. It's gross and nasty. All saggy." Participant 3had a similar statement when discussing sex and intimacy, stating that they "…just kept thinking about all that skin." They stated that the person they were dating, whom they'd met online, was beautiful, and during a date they were "…hitting it off", but that they then "…kept thinking about what would happen if she saw me. Saw how disgusting I was." The participant went on to describe going into a panic attack on a date. They described:

> We finished a movie and were out in the car and were sort of like, you know, kissing and stuff, and all I could think about was what she was going to think when I took off all my clothes and she saw all that skin.

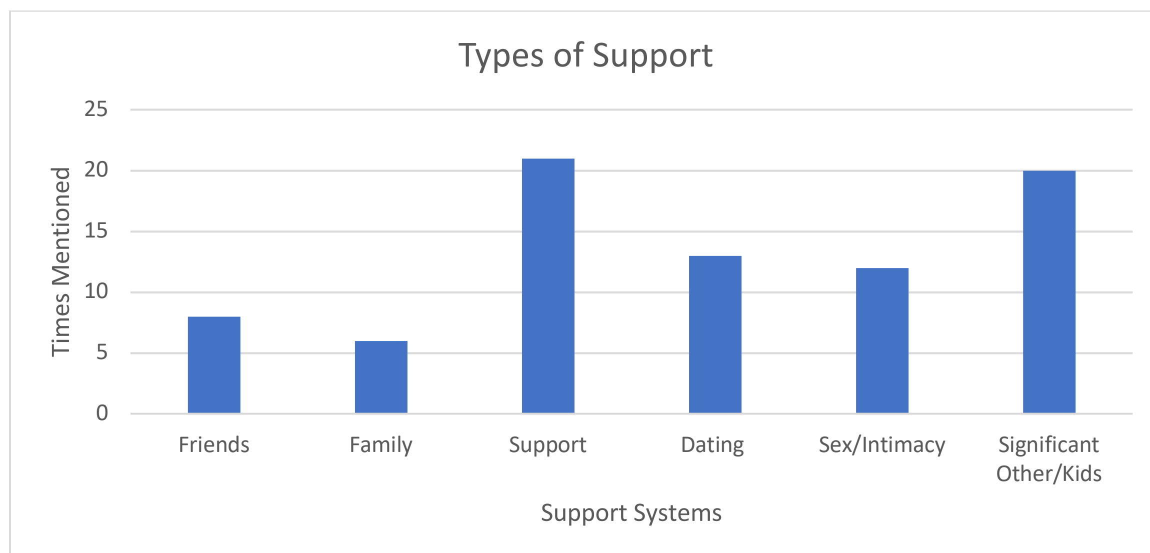
Participant 10 described not wanting to undress. They stated, "I didn't want to have sex because, I mean, I'd have to take off my clothes for that. And the guys I was dating were really cute. And that was cool, because, you know, cute guys being into me." When clarified that this was new for the participant, they stated:

> Oh yeah. Like I said, I was the fat girl. So, I didn't really have a lot of guys interested in me growing up. But after I lost weight, I was dating more. But I didn't, um, I didn't want to go like, you know, too far. Because what would they think when they saw me like that? Like, what I looked like out of my clothes (Participant 10).

Figure3 below reviews different types of support systems and processes that were discussed during interviews.

Figure 3

Types of Support



Activities of Daily Living

During interviews, the participants in the study identified multiple areas in which they had experienced specific difficulties or fixations since WLS and while experiencing BDD. These included increased time at or avoidance of the gym and workouts, focusing on clothing, food and cooking, and weight-regain as well as the impact of the COVID-19 pandemic, and finally camera and mirror avoidance.

Gym/Workout

Going to the gym and workouts or exercise were endorsed by participants 2, 3, 6, 7, and 8. Participant7 discussed engaging in exercise and workout at home as they disliked going to the gym. They stated that they had a trainer who worked with them regularly immediately after surgery and that it was a very good experience. However, they stated that they stopped going to the gym and when they returned, this trainer had

moved to another job. A new trainer was offered who made comments about surgery not fixing things if lifestyle was not fixed and told the participant that they were "…letting [themselves] down," which they stated made them feel worse. This experience caused the participant not to go back to that gym and, when they considered finding a different gym, COVID-19 took place, and they have not yet returned to regular gym attendance. Two participants, 1 and 4, discussed difficulties with physical health such as knee trouble or knee surgeries causing them to be unable to engage in exercise regularly and described this as a barrier during their weight loss journey. Guilt for lack of exercise or going to the gym was endorsed by participants2, 3, 6 and 7. Participant 2, for example, discussed their experience with the gym and, specifically, the COVID-19 lockdown by saying (when asked about the impact of COVID-19):

> Everything changed. I had the surgery in 2015, and I was going [to the gym] all the time. And then I couldn't go, and being away was kind of good. Because I couldn't see the guys anymore… I tried going back after the lockdown, but I had started gaining weight back and I was guilty.

Participant 2 described the gym as both a benefit for them at first, and then conversely a difficulty. They mentioned that, prior to WLS, they did not like going to the gym as they were the "big kid" all their lives and received negative attention and comments. However, they described a positive experience in that, after WLS and as they consistently went and other members of the gym saw them losing weight, they began to be supportive and engage with them more. They went on to describe that, as they lost weight, they stopped avoiding looking into mirrors at the gym and the 'guys' at the gym,

rather than making fun of them, were making fun of their sweatpants "falling off", which they described as cool and fun. However, they stated that, as they focused on improvements to their arms and abs, this led to difficulties with dysmorphic symptoms. They stated:

> Even as I lost weight, [I] was looking at my arms and they were all fat. Like never smooth muscle like the other guys. I had all these stretch marks… Every time I went to the gym, I started going more often, and I saw all the stretch marks on my arms. I switched to tighter clothes, but I always wore a t-shirt. And the more weight I lost, the more I saw all the hanging skin (Participant 2).

They went on to describe feeling thinner and healthier at first, but then having this transition to fixation on "…big arms with muscles like the guys at the gym and no skin hanging down and no stretch marks." This then transitioned to difficulty with going during the pandemic, and feelings of guilt and remorse for their feelings of lack of progress.

Clothes

Universally, all ten participants mentioned clothes as something that could be an area of dual pride and frustration or shame for them. Clothing was mentioned in the context of either continuing to wear larger clothes to hide perceived defects, or getting rid of baggier or bigger clothing, with participant 3 mentioning a ceremony of going out and putting their old clothes into a barrel and burning them when they decreased to a lower size. Participant 10 also described a breakthrough for them coming when they were able to go to the beach in a bikini. They described the experience as:

> Terrifying! I was sure it would be a bunch of people making fun of me or staring at me. But there were other people there who were big, and they didn't care. They just, you know, were them. So, I sat on the beach for a long time and sort of watched. Then I pulled a big throw and towel I was wearing and finally just said fuck it and went in.

Four participants, 3, 6, 9, and 10, discussed smaller clothing or "cute" clothing, with two, 6 and 9, discussing the positive experience of watching their clothing size decrease, while two others (3 and 10) discussed frustration with an inability to decrease to a lower size clothing because of excess skin.

Food/Cooking

Four participants, 3, 7, 9, and 10, discussed their involvement with food in the postoperative setting as being complicated. Participant 3 stated that they,

> had a hard time when it came to the ground diet… when it came to that super-mushy food, I couldn't do it… I switched to other food earlier than they said I should, and the doctors were worried I was going to break my stitches and stuff, but I did ok (Participant 3).

Participant 9 struggled more with junk food in the post-pandemic period. They stated that, "After Covid I started eating more junk food again. Because the kids were home and that was stressful. And then I was making more meals for them," (Participant 9). However, Participant 10, discussed that finding healthier ways to cook in the postoperative period encouraged them to go back to school and get a culinary arts degree. They state that they now work in a bakery specializing in healthy options such as sugar-

free baked goods and foods for people with celiac disease. However, other participants (3 and 9) discussed difficulties with having junk food around the house which increased cravings and increased the likelihood of weight regain. Participant 3 stated that, during the pandemic, "I couldn't go to the gym, and I couldn't keep up with all the things I was doing. All I had was my house and food all over the place… I started gaining weight back and I'm back up over 300." They went on to state that this feels like failure to them.

Weight Regain and COVID-19 Impact

Out of the ten participants, nine (2, 3, 4, 5, 6, 7, 8, 9, and 10) discussed difficulties with weight regain post-surgically. Participant 4 became quite emotional on this subject as they stated that they had had gained back the weight that they had lost post-surgically and now weighed more than they did pre-surgically. During the discussion, they stated, "…I don't think I've admitted that to anyone. I just feel like such a failure," (Participant 4). Seven participants (2, 3, 4, 5, 6, 9, and 10) discussed those as mainly taking place or getting worse after COVID-19. All participants in the study mentioned an impact of the COVID-19 pandemic on their mental health or engagement with others. COVID-19 was also discussed as a barrier to seeking mental health treatment as either they were unable to find providers (participants 9 and 10) or there was a necessity for telehealth and camera use (participants 3, 9, and 10). As noted in the previous section, camera use and the requirement to be on camera during COVID-19 was a difficulty reported by all ten participants. COVID-19 also impacted participants' ability to go to the gym and engage in regular exercise, with participant 7 discussing that they had their children with them all

the time and had to focus on assisting them with school and keeping them happy, which included having more food and junk food around the house increasing cravings.

Cameras and Mirrors

One theme that evolved very quickly was a dislike or avoidance of camera use and repeated mirror checking or avoidance of mirrors. Although initially I had intended to complete video interviews via Zoom, Skype, Teams, or another video platform, all participants in the study indicated a preference for telephone interview rather than video. During the interviews, this was discussed more fully and all participants indicated things such as attempting not to look in cameras (avoidance) due to fixation on what they saw and their perceived defects, which then caused emotional distress. Participants 1, 6, 7 and 10 also endorsed, if recordings were made of themselves, re-watching the recordings and staring at themselves while critiquing the areas they disliked. Participant 1 described that, "I see myself in the video camera and I don't recognize myself. I watch it over and over and it's very jarring because I can't see it. I can see it, but I don't feel it. I don't feel attached to what I'm seeing." This also extended to mirrors. Seven of the participants (1, 2, 3, 4, 6, 7 and 9) discussed mirrors as a source of frustration. They indicated that, in addition to focusing on mirrors and fixating on their reflections (1, 3, 6, 7 and 9), they also did things to avoid mirrors such as moving them (participants 2, 3, and 7) and wearing clothing to hide themselves when they had to see themselves in mirrors (participants 2 and 4). Participant 2, for example, stated that, "I avoid looking in mirrors. I try not to get on cameras or look in mirrors. I look at my phone in the elevator." Another participant said that, during Covid, they lived alone and, "…I couldn't go see my

friends anymore except on like facetime. But that meant that I had to be on camera. And I mean, that's why I didn't want to do this interview on a camera, because I don't want to look at myself," (Participant 3). Participant 4 stated:

> I'm a teacher, so I had to shift to being online for school. And I mean, that was hard enough! But then I've got a camera in my face all the time and I do not like cameras! (Participant 4).

When asked if the participant avoided cameras they stated, "Cameras, mirrors, all that stuff," (Participant 4). They stated that other teachers created support groups but that they didn't take part because, "That would've meant more time on camera!" They state that in teaching, they turn off the camera whenever possible, stating, "…usually it's so they focused on the PowerPoints, but I didn't want to see me either," (Participant 4). Cameras were also a source of frustration for participant 6, who stated that they had to do client meetings on camera and were constantly moving the camera around to avoid areas of their body that they didn't like. Participant 7 also discussed avoiding the camera when they were asked to get onto the camera by their children's teachers. They stated:

> I did a lot of taking photos right after the original surgery as I lost weight, and I took a few photos after the abdominoplasty, but I didn't really like how I looked. I was spending a lot of time focusing on my stomach and my back flab and my sides. So, I preferred not to look in cameras or to look at photos. Because it's just embarrassing and uncomfortable (Participant 7).

Areas of Body Dysmorphic Concern

When discussing some of the things that had become frustrations or fixations for participants, several areas were endorsed repeatedly. Seven participants (1, 2, 3, 6, 7, 8, and 9) discussed skin or excess skin as being an area of focus. Participant 1, for example, stated, "I sit here for hours at night and just go, I can't believe all that skin. I can't believe how big and how gross." They also state that they,

> pull the skin to see if it [an upcoming abdominoplasty] would help, trying to imagine, because I have the big mirror next to my bed. Sitting down it all [the skin] relaxes all over. I pull at it to see if it would possibly help. I'm worried that it won't be enough (Participant 1).

Participant 2 described noting excess skin at the gym. They stated,

> The more weight I lost, the more I saw all the hanging skin. The doctors said I did better than some people because of the gym, but I still had a bunch of loose skin, and it was all hanging down along my arms and my stomach (Participant 2).

Participant 3 discussed that excess skin caused them to have difficulty decreasing clothing sizes because the skin prevented closure of clasps. Participant 6 stated,

> There were all these like, not really rolls on my stomach, but just… I guess it sort of sags? Just like sagging skin all over the place. On my stomach and my back and then my breasts sort of got lost in the skin. Anytime that I wasn't wearing baggy clothes, I could see all that sagging stuff all over the place. And I hated it (Participant 6).

Participant 7 discussed excess skin as causing difficulty during sex as the excess skin would, "get in the way." Seven participants (1, 2, 3, 6, 7, and 9) discussed their stomach, and six participants (1, 2, 6, 7, 8 and 9) discussed excess skin which crossed into multiple areas, though the back and stomach were the main areas discussed regarding excess skin. Four participants (5, 6, 9 and 10) discussed hair loss as a significant concern for them. Participant 5, for example, discussed their hair and hair loss as being the first area of fixation and concern for them post-surgically. They stated that they had always had big hair which was very big and curly. They stated that, post-surgically, "I had lost a bunch of hair. And the doctors told me it was normal and so I didn't think anything of it. And when the weight loss slowed down it got better, but eventually it just kept going… to the point that it was really thin," (Participant 5). Participant 9 stated that it was, "…nerve wracking to have my hair suddenly falling out. Every time I showered, I noticed that I had more hair in the drain, and I'd have a lot fall out when I brushed my hair." Two participants discussed their back (participants 1 and 6). Three participants (1, 2, and 10) discussed their arms and upper arms as areas of focus and three participants (4, 8, and 10) discussed their legs, with participant 10 specifying their thighs and participant eight discussed their lower calves and ankles (described by participant as "cankles"). Participant 6 discussed their breasts, and participant 10 mentioned their buttocks. When discussing these areas of concern and fixation, common words used were fat (participants 2, 4, 5, 7, 8, 9, and 10), nasty (participants 4, 7, 8, 9,), gross (participants 1, 3, and 8), wrinkly (participants 3, 8, 9, and 10), sag/saggy/sagging (participants 6, 8, and 9), cottage cheese (participants 3, 7, and 10), rolls (participants 6 and 9), lumpy (participants 4 and

6), ugly (participants 4 and 8), bump or bumpy (participants 3 and 4), and folds of skin (participants 7, 9, and 10). Five participants (2, 3, 5, 6 and 9) also discussed that they showered frequently to deal with sweat, with concern about developing rashes in excess skin and skin folds being mentioned as areas of concern. Figures 4 and 5 below review the number of times these areas were mentioned during interviews.

Figure 4

Fixations/Focus

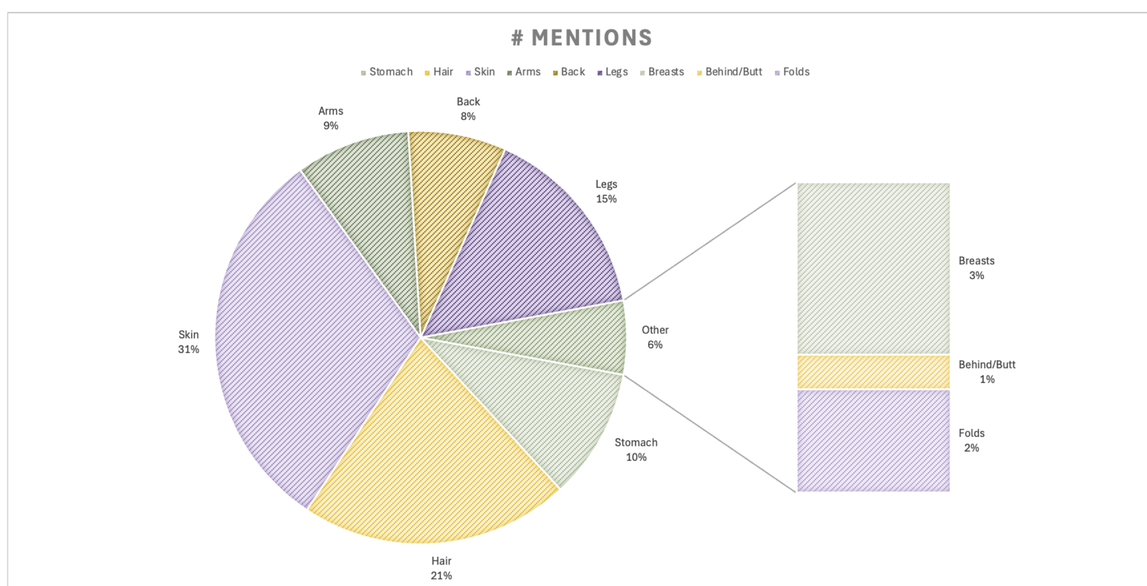
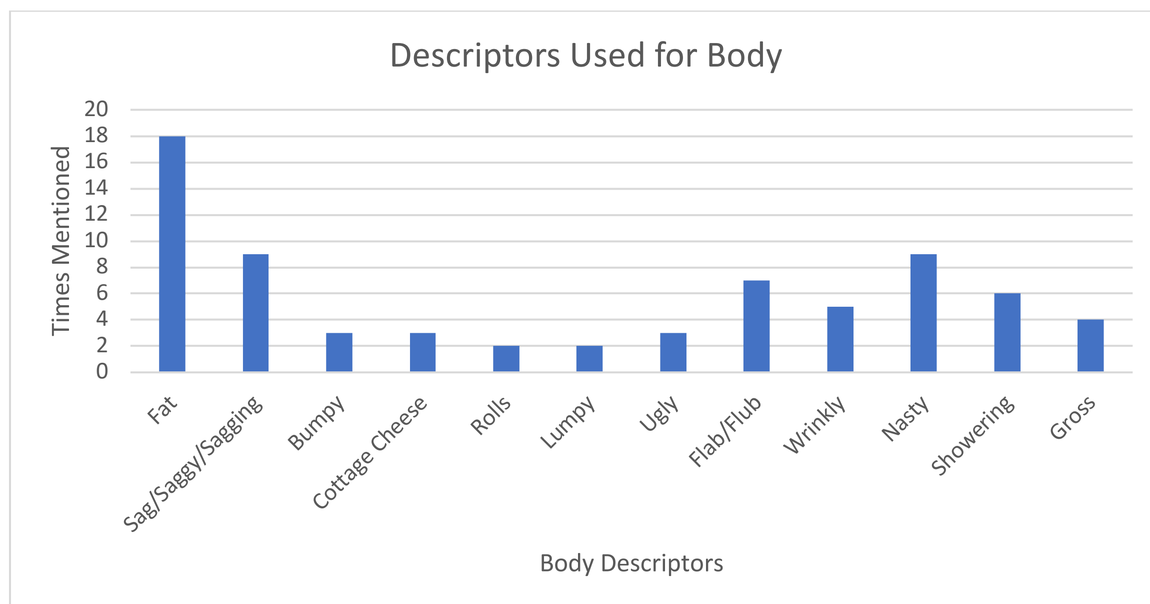


Figure 5

Descriptors Used for Body



Considering or Completing Postsurgical Cosmetic Surgery or Alternatives

As noted in the literature review, studies by Veal, Gledhill, Christodoulou, and Hodsoll (2016) indicated that individuals with BDD may often fail to seek help or may seek help in potentially non-therapeutic ways, such as arranging cosmetic surgery. Varantian (2012) also indicated that discrepancies in body image can lead to multiple, potentially maladaptive behaviors including elective cosmetic surgery. As such, I did want to review with participants whether they had considered or completed cosmetic surgery or alternative surgeries after WLS. Although only two participants (1 and 8) completed additional cosmetic surgery after their WLS procedures, eight participants (1, 2, 3, 5, 6, 7, 8 and 9) discussed having investigated or considered surgical procedures cosmetically. Participant 2 stated, “I thought about getting all the skin fixed, but I looked at surgery and it was going to be too much money. So, I worked out more.” Participant 3

stated that they researched surgery to remove excess skin and stated, “I did a lot of research on it during lockdown, and I may have gotten a little obsessed really.” They stated, “I didn’t want to get another surgery, but I was looking at the criteria and stuff for insurance to pay for it. Because I can’t afford it without,” (Participant 3). Participant 5 discussed having explored hair surgery for hair loss and participant 6 discussed having considered breast surgery. Participant 7 stated that

> The further into Covid we got, the worse it got. I was sort of constantly watching the mirrors and how much weight I was gaining back. And I was looking at another surgery… I thought maybe if I could get rid of the rest of the skin and fat on my stomach and back, it would go better this time (Participant 7).

Cost was a limiting factor for three participants (2, 5, and 8) with participant 9 stating that they had considered going outside the United States to seek cosmetic surgery as they had been informed it would be cheaper but having concerns about this and so not pursuing. Participant 7, who did proceed with a secondary abdominoplasty, stated that:

> …even after the abdominoplasty, because they didn’t do liposuction with it, I still had lots of cottage cheese looking around my stomach and my back… they did the surgery and removed stuff, but I still felt like I looked nasty.

Participant 8 underwent two weight-loss surgeries. They first underwent a gastric band procedure but described having the band removed due to frustrations with inability to swallow after the band was refilled with saline. They described going to the emergency room at one point as they were unable to swallow their own saliva due to the band being overfilled. This participant had the gastric band for approximately a year before it was

removed, then underwent gastric bypass approximately 10 years later. At the time of their interview for this study, they were considering an additional plastic surgery. They stated that the surgeon they had consulted about additional skin removal surgery recommended that they seek a therapist. The participant stated, "…it kinda surprised me really. I didn't figure a plastic surgeon would do anything but take my money I don't have, but the doctor said I should consider talking to a psychologist," (Participant 8). Another participant (10) discussed that, after having surgery, they gained weight back and were recommended for semaglutide medication therapy with Ozempic due to diabetes. Ozempic is a medication used to treat type 2 diabetes and can lower A1C and blood sugar and assist in weight loss (Novo, 2024).

Body Positivity and Body Image

When discussing concepts of body positive and body image, participants 4, 7. and 8 discussed that they had worked on body positivity prior to surgery and had undergone WLS, not because of a significant desire to lose weight, but for health-related concerns. Participant 8 described having had a silent heart attack or mini heart attack, and physician recommendations for weight loss to avoid the potential for further cardiac events or possible stroke. However, the same participant also indicated that, prior to surgery, they had become a yoga instructor. They described that this was important to them because, "It's ok to be a bigger person. We don't have to change for society. And I got lots'a men who like me just like I look and think I be lookin hot as hell." However, due to their health and cardiac issues, they decided to proceed with WLS. They then went on to describe an area that became a focus being what they called their "cankles" (calves and

ankles) as, when they were bigger (weighed more) the skin was smooth, but as the weight was lost, the skin began to sag in these areas. Participants 3, 6, and 7 discussed therapist recommendations to use more positive language when describing themselves as part of their therapeutic process and focus on body positivity.

Summary

This chapter provided an overview of the findings from the research study. The participants in this research study discussed their experiences with WLS and BDD. They shared the challenges that they experienced, including postsurgical infections, hair loss, and wrinkly, saggy excess skin amongst other struggles. They shared the difficulties in both seeking reassurance from family members while also feeling like a burden to family, and in some cases having family and relationships fall apart after surgery. Although participants described multiple situations of checking their appearance and fixating on it, they also described avoiding things like cameras in situations where they needed to focus elsewhere and finding it difficult to keep from checking their appearance in cameras if they had to be in front of them, which could be distracting and difficult.

The significance of the themes described in this chapter will be discussed further in Chapter 5 with interpretation and comparison of what has been found with the literature review in Chapter 2. The next chapter will also explore the theoretical framework and application of the findings to SDT. Finally, the study limitations, recommendations, and implications for further research will be reviewed along with the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological inquiry was to address the gap in the literature regarding the lived experiences of post-WLS patients with BDD to discover any similarities that might exist in the experiences of these individuals. The study was conducted using an interpretivist model, which holds that human behavior cannot always be generalized between studies and is heavily influenced by environmental factors as well as the individual's situation (Creswell, 1998). This chapter includes discussion of the major findings as related to the lived experiences of post-WLS patients with BDD, including both the positive and negative influences that impacted their lives. The chapter also includes the limitations of the study, areas for future research recommendations, and a summary.

The following was the main research question used to guide the study: What are the lived experiences of post-weight loss surgery patients with body dysmorphic disorder?

Participants universally endorsed four themes during the interview process. First, in the postsurgical period, there was a focus on physical health and labs. However, while a presurgical psychological evaluation was completed to verify appropriateness for surgery, no postsurgical psychological assessment or treatment was recommended, and therapy was sought on an individual basis. Second, participants discussed that having a strong family support structure was both beneficial and could be a strain in situations of constant reassurance-seeking, with some relationships struggling or ending due to the

postsurgical struggles. Third, participants discussed dating, sex, and intimacy, with both positive and negative experiences noted for each. Fourth, participants noted disruptions and changes in their activities of daily living, including using clothing to either hide areas that they found unsightly or highlight areas they found acceptable to draw attention away from other areas. This area also included a universal avoidance of cameras as they would fixate on their own images in situations where video-messaging was required. Participants described each of these difficulties that they experienced and the various ways that their lives had been impacted by their struggles. Understanding these struggles and encouraging healthcare providers to either encourage postsurgical psychological care and/or to screen for issues of BDD may lead to better outcomes in post-WLS patients when viewed from their point of view.

Interpretation of Findings

Participants in this study endorsed both positive and negative impacts of both WLS and their journey in dealing with BDD.

Physical Health Focus

The 10 participants in this study described a variety of challenges that they faced, with each participant stating that psychological and mental health was not discussed or reviewed post-surgically and a significant focus was placed on lab work, protein-intake and eating habits, and physical health. As noted by Coughlin et al. (2013), people who undergo WLS typically have severe obesity in addition to comorbid conditions such as diabetes and heart conditions. These areas would then be monitored in the postsurgical phase to verify if there is improvement in the condition (such as improvement in diabetic

conditions. This was confirmed by participants, who discussed a variety of areas that were focused on medically, but each participant stated that physical health, rather than mental health, was the focus in the postsurgical phase. They further stated that mental health treatment was sought on their own, and not at the recommendation of the medical professionals involved in their WLS. As noted in Mechanick et al. (2020), presurgical psychological screening for appropriateness is required, but no requirements are in place for postsurgical mental health screening or treatment. This is again confirmed by the fact that all participants stated that postsurgical medical care and medical health were a focus. Although two participants did experience postsurgical infections and one mentioned breaking their stitches and getting "sick," in general participants responded that the postsurgical healing process went well, with some stating that they enjoyed the initial process of losing weight post-surgically.

Family and Friend Support

Participants all described family and friend support as being important to their recovery from both the WLS itself and during their struggles with BDD. This supports statements by Mancuso et al. (2010), who noted that there are both delusional and non-delusional BDD variants, especially as related to supporting common characteristics of lack of insight. Several participants in this study described reassurance seeking and difficulty believing others when they were reassured. The process of reassurance-seeking from family and friends became a large focus for participants, with multiple participants discussing significant others becoming frustrated with the need to constantly reassure them regarding body concerns. One participant discussed their children engaging in

reassuring behavior as well. Participants discussed break-ups and avoidance of dating and sex, with fear of how others would respond to seeing them without clothing being a commonly stated difficulty. Several of the participants discussed the struggles that they experienced regarding seeking reassurance from family members. While family and friend support structures were described as essential by many participants, with one participant describing how their wife helped with meal prep and was constantly encouraging them, and stating that she was "the best thing about his life," the same participant also described times when their wife became frustrated with the need to constantly reassure them and with their fixation on the features they felt were unsightly. Two participants described relationships breaking up due to the fixation and need for reassurance.

Dating, Sex, and Intimacy

Dating, sex, and intimacy were factors that were discussed in both positive and negative terms by all participants. Some participants in the study dated briefly and had positive experiences, with one participant describing improvements to their sex life after surgery. This is supportive of findings in the study by Law et al. (2023), which indicated that symptoms of depression and anxiety were often improved with WLS. However, six participants described avoidance of sex and intimacy. Participants described difficulties with their own fixations on their perceived defects and imperfections and assumptions that others would see them in a negative light.

Activities of Daily Living

The participants in this study described a variety of activities of daily living that were either impacted by their dysmorphia or their weight loss journey. These included increased time at or avoidance of the gym and workouts; focusing on clothing, food and cooking, and weight-regain, as well as the impact of the COVID-19 pandemic; and finally, camera and mirror avoidance. Going to the gym and workouts or exercise were discussed in both positive and negative lights, with participants discussing both increased engagement at the gym and avoidance of the gym. Trainers were also mentioned in both positive and negative lights, with some trainers being a source of support and encouragement, and others making statements that increased the participants' feelings of negativity and distress. All 10 participants mentioned clothes as something that could be an area of dual pride and frustration or shame for them. Whether this was in the form of wearing larger clothes to hide perceived defects, or enjoyment in the process of getting smaller clothing, each participant described a relationship with clothing that hanged after surgery. This supports research by Phillips and Feusner (2010) in which it was noted that mirror checking and clothing adjustments were common symptoms noted and often, rather than alleviating symptoms, worsened them. Food and cooking were an area of interest for four participants, with one participant noting a new focus and interest in life in that they obtained a culinary arts degree and work in a bakery focusing on healthy options. However, the other three participants who discussed food and cooking mentioned food and cooking in terms of difficulties with having junk food around the house, which increased cravings and increased the likelihood of weight regain. The

impact of weight regain was also discussed as participants noted feelings of guilt with the regain of weight post-surgically. This supports research conducted by Geraci et al. (2015), Munoz et al. (2010), and Rigby (2018), which indicated that the changes that take place in the body, not to mention the potential for later weight gain, can cause postsurgical psychological complications. All participants in the study mentioned an impact of the COVID-19 pandemic on their mental health or engagement with others. COVID-19 was also discussed as a barrier to seeking mental health treatment as either they were unable to find providers or there was a necessity for telehealth and camera use. Rossell et al. (2020) indicated that social isolation, functional impairment, and high rates of suicide are common in patients with BDD. This was supported in this study with social isolation noted in multiple participants, with Participant 1 specifically stating that they experienced agoraphobia. COVID-19 also impacted participants' ability to go to the gym and engage in regular exercise as well as increased amounts of junk food around the house. Another area that has become an activity of daily living for many people in the post-COVID-19 world is one of camera use. Due to the pandemic, the use of cameras became quite common for many people as businesses and healthcare transitioned to use of cameras and telehealth more commonly. However, for participants in the study, a dislike or avoidance of camera use and repeated mirror checking, or avoidance of mirrors, was endorsed repeatedly. Participants discussed things such as attempting not to look in cameras (avoidance) due to fixation on what they saw and their perceived defects, which then caused emotional distress.

COVID-19 Impact

As participants in this study were all interviewed after the pandemic of 2020, specific questions were asked about the impact of COVID-19 on their mental and physical health and well-being and their weight loss journey. The necessity of telehealth and being on camera was mentioned as a limiting factor in desire to engage in mental health services via telehealth, and inability to go to the gym was also a frustration that led to weight gain and increased frustration around body image for participants.

Specific Body Part Focus

The areas of concern for participants were wide-ranging. Issues and frustrations around excess skin and sagging skin were the most discussed areas. Hair loss was the next most common response, with stomach, arms, and back all mentioned at approximately the same levels. Legs, including calves and ankles (cankles), were mentioned next, with breasts and buttocks being the least commonly mentioned. The most common descriptor used was fat, with nasty and sag/sagging/saggy being the next most common. Other terms used were flub/flab, bumpy, gross, cottage cheese, wrinkly, and rolls. This supports research by Munoz et al. (2010), which noted that many individuals who undergo WLS report a difference between their presurgical conceived ideal body size and what they then considered to be an ideal body size after surgery. Each participant noted that they experienced frustrations with what they had expected or hoped pre-surgically and their post-surgical outcomes.

Underdiagnosed

It is important to mention in the discussion of these findings that I was contacted by multiple individuals who stated that they had undergone WLS and experienced difficulties, but who did not have a diagnosis of BDD. As noted in Chapter 2, BDD is potentially underdiagnosed in the professional community. In multiple quantitative studies completed between 1993 and 2010, it was noted that patients who were diagnosed as having BDD within the process of the studies did not have this mental health diagnosis within their record (Conroy et al., 2008; Grant et al., 2001; Phillips & Feusner, 2010; Phillips et al., 1993; Phillips et al., 1996; Zimmerman & Mattia, 1998). Phillips and Feusner (2010) indicated that embarrassment and feelings of negativity about both the symptoms and their own body impacted their decisions about whether to disclose symptoms. This was also noted within this research study, with Participant 1 stating about BDD,

> I don’t discuss it. It’s much more private than my mental health. But that has always been the case. I don’t want to talk about it. I can talk about … [things] that occurred to me when I was little, but I’m being brave right now [talking about experience of BDD]

A 2016 study by Veale et al. (2016) indicated that individuals with BDD may often fail to seek help or may seek help in potentially nontherapeutic ways such as arranging cosmetic surgery or engaging in obsessive and avoidant behaviors. Participants in the current study mentioned that they often sought help from therapists for symptoms that may have been associated with BDD, such as anxiety and depression, but did not necessarily recognize

the symptoms that they were experiencing as BDD until it was pointed out by a healthcare professional. And, as stated, there were several interested parties in the study who stated that they felt they were experiencing symptoms but had never received a formal diagnosis.

Theoretical Framework

In Chapter 2 of this study, a review of Higgins's SDT (1987) was completed. The theory of self- discrepancy involves the idea that there are three domains of self, which include the *actual, ideal, and ought self* (Higgins, 1987). The concept of self-discrepancy as it applies to body image implies that there is a difference between one's perceived actual self and one's ideal or ought self. Vartanian (2012) stated that discrepancies in body image can lead to behaviors such as "dieting, exercising, elective cosmetic surgery, and bariatric surgery" (p. 5). This theory was confirmed by at least one or more participants in this research study, with participants reporting difficulty in identifying an ideal body weight or an inability to describe what "healthy" or "ideal" would look like. Those who could describe what ideal might look like stated that they did not believe they could achieve it or that they had dissatisfaction in their attempts, indicating a discrepancy between the ideal and the actual or ought selves. When asked about the concept of an ideal or normal body size, Participant 9, when discussing how their 5-year-old had remarked on the "flab" in their stomach, stated,

> it brings it home. That I'm not normal. I do all this work and I try to eat right and be healthy, but I'm still not normal or thin. [When asked what normal or ideal was to them, they stated] Probably a Size 8. That's, you know, that's healthy. And I

> mean, I was there. I was at that size, but not really. Because I have never really been that size because I have to wear bigger clothes because of all this skin. And I know it can get annoying for my husband because he gets tired of reassuring me all the time.

The participant was able to articulate and describe an ideal body image and what they considered to be ”healthy,” yet they also endorsed feelings of hopelessness and shame at being unable to reach this goal. This indicates a discrepancy in the actual/own versus ought/own self, which, as described by Higgins (1987), is best described as a failure to meet one’s own expectations and experiencing feelings of dissatisfaction and guilt (Geraci et al., 2015).

Discrepancies were also seen in the actual/own versus ideal/other self, which Higgins (1987) described as a discrepancy between what a person sees as their own actions or thoughts and what they feel others expect. Barnett et al. (2017) described this as having feelings of shame or guilt for not living up to others’ expectations, and this can be seen in this study when examining statements such as Participant 3 indicating that they

> kind of had a panic attack on a date because we finished a movie and were out in the car … and all I could think about was what she was going to think when I took off my clothes and she saw all that skin,

or Participant 10, who indicated,

> after I lost weight, I was dating more. But I didn’t, um, I didn’t want to go like, you know, too far. Because what would they think when they saw me like that? Like, what I looked like out of my clothes?

In both instances, the participants demonstrated discrepancy in the actual/own versus ideal/other self as they were assuming that the other individuals had a certain expectation for what they would look like, or that their appearance would be disappointing to the others, which led to avoidance of intimacy and, in some cases, dating altogether.

Limitations of the Study

Limitations of this study comprised multiple factors including the inability to verify trustworthiness of participant answers to research questions. Recruitment of participants was challenging and required a longer period of time than had initially been planned. There are also limitations inherent in all qualitative research in that it is more likely to be difficult to analyze as not all data fits into specific categories. The study relied upon self-report of having a diagnosis of BDD and WLS. Participants were assured of the scholarly nature of the study as well as confidentiality and the anonymity of their responses. I also entered into this study with an understanding of the assumption of my own personal bias with this topic, as I have undergone WLS. This information was disclosed to the participants. In this research study, I used an epoch, or bracketing technique to suspend judgment about the information that I received and focused only on the data (Sorsa, Kiikkala, & Astedt-Kurki, 2015). I also managed this bias by having multiple editors and reviewers for data and made use of self-monitoring devices such as regular debriefing with an individual outside of the study and a research journal during interview, to explore potential bias (Peterson, 2019).

Another possible limitation of the study was social desirability. This concept refers to participants answering difficult questions, especially those regarding their own

fixations, difficulties, and obsessive behaviors, in a way that put them in a positive light, rather than answering honestly (Krumpal, 2013).

According to Lincoln & Guba (1985), transferability of data is limited to the attitudes and beliefs of the researcher to apply information to their study. Therefore, transferability of the data in this research study must be acknowledged to potentially hold biases carried by the researcher, though attempts were made to limit this through bracketing and reliability processes. Each participant's experience of BDD is individual and specific to their life and circumstances, and therefore may differ in meaning and significance between individuals. People who experience BDD but who have not undergone WLS may also differ significantly, and therefore the data would not be transferable to other populations. Although it is not possible to verify that the findings and conclusions of this study are transferable to populations other than those specifically addressed here, the interview information and concepts may be relevant in considerations of assisting post-WLS patients to either prevent or lessen the symptoms of BDD.

Implications

This study provided insight into the lived experiences of people who have undergone WLS and experienced BDD. In general, many expected areas noted during the literature review in Chapter 2 were noted including areas of weight regain, appearance checking, and emotional distress. Discrepancies within the individual's sense of self were often noted as distressing and impacted participant's engagement with others and sense of self-worth. Additionally, the lack of postsurgical psychological screening and referral to therapy was clear in all participants in the study. As noted in Chapter 2, a variety of

screening measures are available to assess for BDD. The Body Image Disturbance Questionnaire (BDIQ) examines the level of distress a person experiences as associated with concerns about their appearance and their overall body dissatisfaction (Cash, et al., 2014) while the Yale-Brown Obsessive Scale, Modified for BDD, involves a semi-structured interview based on a 12-item inventory and measures for items such as avoidance, compulsions, and obsessions (Phillips, et al., 2011; Wilhelm, et al, 2016). The Body Dysmorphic Disorder Foundation website also includes a link a screening tool designed specifically to help individuals screen both their symptoms and their severity. The screening tool is called the Cosmetic Procedure Screening Questionnaire (COPS) for BDD and provides a 9-item survey that allows individuals to report their symptoms with a range of 0-72 (Veale, et al., 2012). In the future, either WLS physicians and/or the primary care providers who care for patients who have undergone WLS could make use of one or all these tools to assist with screening for BDD and referring for mental health services as necessary. Based on the information from participants in this study and the difficulties that they faced in the postsurgical period, as well as the benefit noted by several participants through accessing therapy services, this could potentially provide positive social change in either avoiding BDD or ensuring that treatment is accessed quickly. Not only could this be beneficial for the patients themselves, but also for the family members who may be impacted by their healthier outlook.

Recommendations

The lived experiences of the participants in this research study highlight the lack of mental health support post-surgically. Although all participants had sought out mental

health support, many experienced difficulties related to access (especially during the COVID-19 pandemic) and struggled with difficulties in both body image and perseveration on their perceived flaws. Further research would be beneficial in areas such as adding screening for BDD in the post-WLS follow-up period alongside medical and lab checks. Additionally, a trial or study of outcomes with a postsurgical mental health evaluation or therapy engagement in post-WLS is needed. Studies in these areas would bring further information for developing best practice in supporting post-WLS patients in both mental health and in navigating the changes they experience in their bodies.

Future studies in the exploration of BDD in post-WLS patients may benefit from not only reviewing screenings for BDD, but also the inclusion of mental health assessment and care in all aspects of the postsurgical process using a biopsychosocial model. The biopsychosocial model looks at all biological, psychological, and social influences that impact health and recovery (Purdy, 2024) and would include a review of a patient's mental health in addition to physical results such as labs and postsurgical healing. By incorporating screening tools for BDD and/or mental health check-ins, patients may feel more supported in their weight loss journey and be able to discuss any potential struggles with identity or discrepancies that may arise therein.

Conclusion

This study helped to highlight the lived experiences of individuals who underwent WLS and experienced BDD. It illustrated that the experience is different for everyone, but that common themes of lack of postsurgical mental healthcare assessment and treatment may negatively impact patient wellbeing and recovery. It demonstrated that the

use of support systems could be essential to recovery in both the health-related process of healing, and in the experience of and recovery from body dysmorphic concerns as well. The study noted that dating, sex, and intimacy were important to participants, though reassurance-seeking and concerns over areas of perceived defects could negatively impact these connections. Activity of daily living challenges were endorsed by all participants in this study. The study also demonstrated that BDD may remain under-diagnosed in general, especially in post WLS settings, and potential screening may be beneficial to aid earlier in the postsurgical setting so that mental health assistance can be encouraged.

It is important to encourage both mental health and physical health in all settings using a full biopsychosocial process of looking at a person in physical and mental wellbeing. In the post WLS setting, in which a person is expected to undergo rapid changes to their body, it is important to remember that these changes can have both a positive and a negative impact and providers can be proactive with assistance to avoid the potential for patients developing mental health difficulties, including BDD.

This qualitative research study provided clarity into the lived experiences of post-WLS patients who experienced BDD and the challenges that they faced. Further research is needed to broaden knowledge on the impact of BDD and other mental health difficulties in the post WLS setting on both patients and their families.

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Appendix A: Interview Narrative Questions

Overall conceptual questions:

a) How do individuals who have undergone WLS describe their experience of body dysmorphia?
b) How do the individuals describe their experience of changing perceptions in their body?
c) How do the individuals describe their experience of preoccupation with their body?
d) How do the individuals describe their experience of appearance concerns?
e) How do the individuals describe their experience of changes to their body?

Questions to help drive conversation where interviewee may have difficulty conceptualizing:

1) Describe the changes that you have noticed in your body.
2) Describe what your ideal body would look like.
3) Describe how you feel about seeing yourself in the mirror since surgery.
4) Describe how it makes you feel to see others who are closer to your ideal body type.
5) Describe your grooming routine and any changes that have happened since WLS.
6) Have you changed your exercise routine?
    a. If yes: Do you find that you exercise more regularly?
    b. Do you compare yourself to others while exercising?
    c. How has COVID-19 impacted your exercise routine?
    d. If no: Do you experience any sensation of guilt for lack of exercise?
7) Describe your experience of going into public and social situations since WLS.
8) Describe your thoughts about how others perceive you, before and after WLS
9) Describe your experience of post-operative plastic surgery and any considerations you've given to this

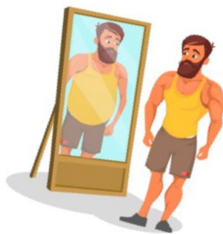
Appendix B: Interview Screening Questions

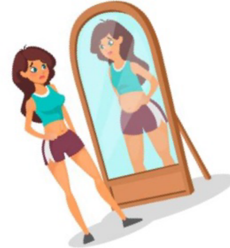
1) Are you 18 years of age or older?
2) Have you undergone weight loss surgery?
3) Have you been diagnosed by a clinician (either in the past or currently) as having body dysmorphia?

Appendix C: Recruitment Flyer

BODY DYSMORPHIC DISORDER AND WEIGHT LOSS SURGERY

Participants Needed for Research Study with Short Interview





PARTICIPANTS MUST BE:

18 years of age or older
Have undergone weight loss surgery
Have a current or past diagnosis of body-dysmorphia.

Time Involved: < 60 Minutes

The purpose of this research is to address the gap in the literature regarding the lived experiences of people with body dysmorphia who have undergone weight-loss surgery. I am conducting this study for my Walden dissertation.

If interested, please email theresa.niles@waldenu.edu

Appendix D: Recruitment Letter

Dear Participant:

My name is Theresa Niles, and I am a student in Walden University's Clinical Psychology Program. I am requesting your participation in my doctoral research titled: Body Dysmorphia in Post-Weight Loss Surgery Patients. The purpose of this research study is to gain a greater understanding of the lived experiences of individuals who have undergone weight-loss surgery and have a diagnosis of body dysmorphic disorder.

This study is open to any interested individuals over the age of 18, who have undergone weight-loss surgery and have been diagnosed with body dysmorphic disorder. Interested participants will email me and we will schedule time via email to complete a Zoom or Skype interview. This interview will include some basic demographic information.

Participation in this study is voluntary and you may withdraw your participation at any time. Participants are not required to provide names or any other identifying information.

Your participation in this research will assist in providing social change in the form of gaining greater understanding of the lived experiences of people who with body dysmorphic disorder who have undergone weight-loss surgery.

Sincerely,

Theresa Niles, MAFP, MSP, Doctoral Student, Walden University

Appendix E: Research Information Letter for Group Administrators

Dear Group Administrators:

My name is Theresa Niles, and I am a student in Walden University's Clinical Psychology Program. I am requesting your permission to post a recruitment flyer on your website to recruit participants for my doctoral research titled: Body Dysmorphia in Post-Weight Loss Surgery Patients. The purpose of this research study is to gain a greater understanding of the lived experiences of individuals who have undergone weight-loss surgery and have a diagnosis of body dysmorphic disorder.

This study is open to any interested individuals over the age of 18, who have undergone weight-loss surgery and have been diagnosed with body dysmorphic disorder. Interested participants will email me and we will schedule time via email to complete a Zoom or Skype interview. This interview will include some basic demographic information.

Participation in this study is voluntary and all participants may withdraw their participation at any time. Participants are not required to provide names or any other identifying information.

Your agreement to allow recruiting on your website for participation in this research will assist in providing social change in the form of gaining greater understanding of the lived experiences of people who with body dysmorphic disorder who have undergone weight-loss surgery.

Sincerely,

Theresa Niles, MAFP, MSP, Doctoral Student, Walden University