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# The Lived Experience of Bariatric Patients During the Pre-Surgical Evaluation

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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2025

Abstract

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## Abstract

Patients undergoing bariatric surgery have no standard of care for the pre-surgical evaluation process (PSE). Often, these patients look at the PSE as just another hurdle to jump through before reaching surgery. The PSE, however, offers an opportunity for mental health professionals to prepare the patient for the challenging lifestyle changes necessary for weight loss maintenance in the long term. The problem being studied is whether patients feel they are prepared for the unique mental health challenges, eating disorder challenges, and strict lifestyle changes during the PSE. The study followed a qualitative interpretative phenomenological analysis approach to explore the lived experience of patients who are 12-36 months post-operative with the PSE related to preparedness for mental health challenges, eating disorder challenges, and strict lifestyle changes post-bariatric. Self-efficacy theory and health belief models were a conceptual guide. Semistructured interviews were conducted using Zoom, and the coding was completed by hand. The analysis resulted in seven themes, including a) lack of assistance in preparation for lifestyle changes after bariatric surgery, (b) received some education and assurance from professionals to prepare for lifestyle changes after bariatric surgery, (c) had a discussion of one's support system after bariatric surgery, (d) did not find PSE to be helpful for mental health, (e) had some discussions about the possible mental health impacts of bariatric surgery, (f) need for a personalized and holistic approach to PSE, and (g) need improvements to follow-up care. The study contributed to positive social change by gathering input from post-surgical bariatric patients that can be used to improve the PSE process.

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Table of Contents

List of Tables

# Chapter 1: Introduction to the Study

Obesity remains a significant, complicated problem, making lifelong management techniques an essential aspect of any bariatric patient's life (Andromalos et al., 2019). Many factors contribute to obesity, like education, culture, and stress (Safaei et al., 2021). The American Society for Metabolic and Bariatric Surgery (ASMBS; 2022a) identified that bariatric patients must follow strict guidelines for the rest of their lives after bariatric surgery.

At this point, there is no standard of care during the pre-surgical evaluation (PSE) process (Sahar & Riazi, 2021). The PSE process is recommended by the ASMBS to be completed by a mental health professional with knowledge of the behavior changes required (ASMBS, 2022b). Research demonstrates that bariatric patients can experience multiple issues that include anxiety, depression, body dysmorphia, emotional eating, and cross-addiction both before and after surgery (Billing-Bullen et al., 2022; Ivezaj et al., 2019; Varns et al., 2018). This qualitative study was conducted to understand better the lived experience of bariatric patients with their PSE. Bariatric patients often consider the current PSE part of a check-off list and not a helpful tool for long-term success. The PSE process has a vague direction or purpose (Sahar & Riazi, 2021).

This study has social implications for gaining an understanding of experiences related to the PSE to understand how its role can improve long-term outcomes. The research indicated that the PSE currently has no standard of care and is often looked at by patients as just another clearance that needs to be completed. Mental health providers have an opportunity to provide direction for lifestyle change while addressing possible

mental health issues that can arise post-surgically. Results from the study could help current mental health practitioners in bariatric better understand what improvements could be made to mental health preparation and the PSE process for the required behavior changes necessary after bariatric surgery.

In this chapter, the background of the current research will be summarized. Also, in this chapter, the problem statement and need for the research will be presented, and the purpose of the study will be connected to the problem statement. The conceptual framework will be presented, and key terms and ideas of the literature will be summarized.

## Background

The research demonstrates that the PSE is an opportunity for mental health professionals to contribute to the lifestyle changes and challenges a patient may experience post-surgical (Sarwer & Heinberg, 2020). The mental health professionals conducting the PSE can contribute to the patient's well-being by discussing lifestyle changes, mental health challenges, body image, emotional eating, cross-addiction, and follow-up care.

### Lifestyle Change

Pre-surgical mental health evaluations should provide a direction for the lifestyle change necessary for the best bariatric success (Sarwer & Heinberg, 2020). Research shows that patients have difficulty with adherence to lifestyle changes in the long term (Ariel-Donges et al., 2020; Assakran et al., 2020). The literature points out that many

patients have a negative experience with the pre-surgical process they underwent (Sahar & Riazi., 2021).

The lifestyle changes asked of bariatric patients include hitting protein goals, a lifetime commitment to a vitamin regimen, avoiding processed sugary foods, and an overall shift in eating habits related to portions and eating speed (ASMBS, 2022a). The lifetime commitment to a behavior change can make it difficult for long-term success. Self-efficacy plays a significant role in creating the necessary lifestyle changes asked of bariatric patients (Dahlberg et al., 2022). Through the PSE process, mental health professionals can build that self-efficacy piece with the bariatric patient. The patient can feel better prepared to accept a lifetime commitment to change. Bariatric surgery is a significant commitment that requires an acceptance of long-term changes and follow-up care. Attending support groups and ongoing mental health and nutrition follow-up post-surgery is integral to the bariatric process (Andreu et al., 2020). Bariatric surgery can help patients have a better quality of life and reduce medical costs. However, a multidisciplinary approach with mental health professionals, nutrition professionals, and physicians is essential to creating these long-lasting changes (Mechanick et al., 2019).

**Mental Health**

The literature points to possible lifestyle changes related to mental health, such as depression and anxiety. Some patients felt unprepared for the changes in their relationship with food, leading to depression and unrealistic body image expectations (Billing-Bullen et al., 2022; Liisa et al., 2022). Patients were found to utilize more mental health services post-bariatric surgery (Morgan et al., 2020). Billing-Bullen et al. (2022)

and Sarwer et al. (2019) found that patients who dealt with binge eating struggled with lifestyle changes because they did not work on changing their relationship with food before surgery. The new relationship with food has been identified as a significant factor in mental health distress from the research.

The mental health professional can begin the process of preparing the bariatric patient for the changes in the relationship between food and body image expectations. Although ongoing mental health support is critical, the PSE is a time to work with the bariatric patient at the beginning. Hence, they feel more ready for unique challenges to overall mental health, emotional eating, and body image issues. The PSE also allows mental health professionals to identify those who deal with binge eating disorders and give them tools for changing the relationship with food and referrals or follow-up care specific to binge eating disorders.

**Cross-Addiction**

Bariatric patients also face challenges with alcohol use disorder (West et al., 2023). Patients who dealt with using food as an unhealthy coping skill no longer have the ability to utilize food in the same way. Patients also have a higher sensitivity to alcohol after having bariatric surgery. Patients also seek to utilize alcohol in social situations when food is not available to use socially any longer. The research shows that brief interventions can result in reducing alcohol use disorder. Patients overall can be prepared for the unique challenges of alcohol use disorder and their susceptibility to it during the PSE.

## Follow-Up Care

The ASMBS (2022b) discussed that every patient's follow-up care after surgery is essential. Patients who follow up with a multidisciplinary team after surgery have better long-term outcomes. Follow-up care has shown promising research to help patients with the difficulties of lifestyle change after surgery. Patients who utilize follow-up care will work to understand their new relationship with food. The PSE is an opportunity for mental health professionals to discuss the importance of follow-up care. A plan for individual follow-up care should be addressed before receiving bariatric surgery. Starting the process of discussing follow-up care allows for a mental health professional to discuss certain aspects of handling the new relationship with food and when it is a good idea to seek follow-up help.

## Problem Statement

Currently, a bariatric patient does not have a standard of care during the PSE. Without a standard of care, the effectiveness of the PSE is limited (Sahar & Riazi, 2021). The PSE could play a role in preparing a bariatric patient for lifestyle change, mental health, body image, and strategies for handling environmental difficulties in making a lifestyle change. The research indicates that patients experience depression and anxiety and sometimes struggle with negative body image both before and after surgery (Liisa et al., 2022; Sahar & Riazi, 2021). The PSE could also increase the symptoms depending on how it was conducted in patients (Sahar & Riazi, 2021). For some individuals who deal with emotional eating, food can be used as an emotional coping skill. Often, patients are not prepared to handle the unique lifestyle changes, and environmental factors can lead to

weight regain (Liisa et al., 2022). Weight re-gain can then lead to emotional and psychological issues such as depression, anxiety, and negative body image. The researchers also found that post-bariatric patients deal with overconsuming alcohol due to the emotional process of bariatric surgery. The lack of standard of care is identified to make the process of the PSE seem like an inconvenience or annoyance for the bariatric patient population. The patient often feels the PSE is just something to complete that is necessary for surgery and not a valuable tool to help them with lifestyle change, emotional eating, or preparation for life after surgery (Sahar & Riazi, 2021). Creating a valuable standard of care for the patient may benefit them by helping them prepare, assess mental health, assess emotional eating, and discuss strategies for long-term success. Collaboration with the patient population is also important to improve the PSE and direct it toward a patient-centered approach to care (Sahar & Riazi, 2021).

The PSE is currently being utilized primarily to relay to the surgical team the patient's psychosocial functioning and contraindications for surgery. Mental health professionals who do PSE have an opportunity to contribute more to the long-lasting lifestyle change of the patient population. However, future studies need to be conducted to address strategies for adherence to complex lifestyle changes required in a bariatric patient (Sarwer & Heinberg, 2020). Research has also identified the importance of compliance with lifestyle change to create the long-term success of bariatric surgery (Masood et al., 2019). However, this research focused on post-bariatric interventions. Mental health professionals have a unique opportunity to address some of these identified

problems before surgery. Patients can have a valuable process they no longer see as an inconvenience.

## Purpose of the Study

The study aimed to understand the lived experiences of 12-36-month post-bariatric patients during their PSE. The study collaborated with post-bariatric patients to gain a perspective of their behavioral/mental health interventions to address long-lasting lifestyle change and learn how they feel the PSE would benefit future bariatric patients. The PSE is often a bad experience for patients and is viewed as an unhelpful hurdle during the rest of the process before surgery (Sahar & Riazi, 2021). The PSE could guide a patient to understand long-lasting lifestyle changes better and better prepare a patient for mental health challenges such as body image, anxiety, and depression (Sarwer & Heinberg, 2020). But research shows that patients have difficulty with adherence to lifestyle change in the long term (Ariel-Donges et al., 2020; Assakran et al., 2020). Patients can struggle with lifestyle changes over the years after the surgical process. The PSE is an opportunity to discuss strategies to help these patients navigate barriers that may occur during their lifetime.

### Gap in the Literature

Currently, there is a gap in the literature that focuses on the patient perspective regarding ways the PSE prepared them for bariatric lifestyle change, managing mental health post-surgical, including body image and strategies for emotional and disordered eating. This study attempted to address this gap through a collaborative process with post-bariatric patients. There is a need for a patient perspective in the literature on the

ways the PSE prepares a patient for emotional distress, coping strategies for barriers, and negative experiences post-surgery (Sahar & Riazi, 2021). The process focuses on ruling out candidates for surgery rather than discussing strategies and support for successful lifestyle changes post-surgery. Collaboration with bariatric patients to understand better ways the process could be improved will be valuable to future patients.

Another concern is the gap in the literature. El Ansari and Elhag (2021) completed a scoping review and found a lack of literature on behavioral interventions regarding the lifestyle changes needed for sufficient weight loss and dealing with weight regain after surgery. They found a gap and a need to understand better what behavioral interventions could help patients with lifestyle changes for sufficient weight loss and when those interventions are best implemented. The researchers stated that understanding the lifestyle changes and barriers to behavioral change could help implement interventions. The review found that binge eating disorder before surgery is a predictor of insufficient weight loss outcomes. The PSE could be a valuable time to work with a patient on strategies to overcome barriers that create inadequate weight loss and weight regain.

Further, McGarrity et al. (2022) noted a gap in the literature on interventions to improve resilience focused on increasing adaptive coping skills, discussing social supports, and discussing strategies for barriers. The researcher states that future research in interventions to enhance resilience could benefit patients. This research attempts to address the gap by collaborating with post-bariatric patients on how their experiences in the PSE addressed coping strategies for positive outcomes.

Other areas for further study are pre-surgical indicators of non-adherence to lifestyle changes (Bianciardi et al., 2021). Bianciardi et al. (2021) found that emotional disorders, eating disorders, and a lack of emotional awareness (Alexithymia) were indicators of non-adherence. The researchers identified the lack of literature on pre-surgical interventions to train patients for the post-operative lifestyle changes required. This current study collaborated with patients to better understand their experiences with the PSE and receive feedback on how they were prepared for the lifestyle change and ways to improve the PSE for post-operative guidance to increase self-efficacy, improve coping skills, and improve strategies for mental health and emotional eating management.

**Why the Study is Needed**

This study is needed to give a patient perspective of lived experiences with the PSE and to gain an understanding from the patient's viewpoint if they felt the PSE prepared them for the bariatric lifestyle change post-surgical, managing mental health post-surgical, and provided strategies for any emotional or disordered eating. The study created a collaboration with the patient population in hopes of providing direction for providers who give the PSE on possible improvements with the process.

## Research Questions

Overall Research Question (RQ): What is the lived experience of post-bariatric patients with the PSE process?

RQ 1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery?

RQ 2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery?

RQ 3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes?

## Conceptual Framework

This study focused on the patient perspective of the PSE prior to bariatric surgery. The study specifically addressed ways the PSE process addressed mental health and eating disorder-related barriers, lifestyle change barriers, and a collaborative approach to the patient perspective of improvements to the PSE process. The literature points out that the current PSE process often has a negative viewpoint from the patient's perspective. The literature has stated that the PSE could be an opportunity to prepare the patient better for barriers.

This study used Rosentok's health belief model (HBM) and Bandura's self-efficacy theory. The HBM is used to understand why a positive health intervention is or is not utilized by a patient (Glanz et al., 2015; Rosenstock, 1974). The HBM looks at different factors on whether a health intervention is applied, such as perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Kebede et al., 2023). This study gathered a perception of post-bariatric patients' experiences with how their individual PSE addressed perceived barriers, cues to action, and self-efficacy. Ariel-Donges et al. (2020) found that individual patients ran into specific barriers, such as adopting the nutrition regimen, finding time for planning meals, and the way they received support. A personal approach is essential because of the

unique barriers that face each bariatric patient. Understanding how previous patients were prepared for managing these circumstances can help adopt an improved PSE process.

Bandura's self-efficacy theory states that a person is more likely to succeed in adopting behavior changes if they have confidence in their abilities to manage social barriers and feel in control of the situation utilizing cognitive, emotional, and social skills (Bandura, 1977; Pyykkö et al., 2023). The PSE process allows a mental health professional to begin discussing strategies and approaches to the demanding lifestyle changes required by the surgery. Implementing this process with the PSE can increase self-efficacy in making those changes. When a patient obtains a better understanding of their situation and changes that need to be made for that situation, self-efficacy can be increased, enhancing long-term results (Dahlberg et al., 2022).

With the difficulties of adhering to the strict behavior change after surgery, it is beneficial to look at the HBM to understand better why a health behavior was or was not followed. Patients have unique circumstances that create barriers to the lifestyle changes necessary for bariatric surgery, such as planning meals and following nutrition plans (Ariel-Donges et al., 2020). A personal approach is essential because of the unique barriers that face each bariatric patient. The focus on the perception of the way a patient's self-efficacy was addressed during the PSE will help understand how previous patients were prepared for managing these circumstances and can help adopt an improved PSE process. Pyykkö (2023) reiterated that an improvement in the feelings of a patient's competence with the bariatric lifestyle changes could improve adherence and better goal achievement.

The fundamental concepts of this conceptual framework regarding this study focus on the elements of perceived barriers, cues to action, and self-efficacy. The literature pointed out that higher self-efficacy and strategies for managing perceived barriers increased adherence to adopting a lifestyle change. The post-operative viewpoint of patients 12-36 months post-op will provide a picture of how the PSE addressed perceived barriers, addressed strategies for those barriers, and enhanced self-efficacy. The lived experiences of these post-bariatric patients with PSE could provide valuable information to providers that conduct the PSE.

The interview questions designed for this study directly focused on understanding each patient's experiences with the PSE and how the PSE addressed self-efficacy and barriers to lifestyle change. The interview questions were semistructured, open-ended questions. The questions allowed the interviewee to provide more details on whether they felt prepared for the barriers of lifestyle change and what unique experiences they may not have felt prepared for. The interview questions aimed to show each patient's perspective regarding whether/how the PSE improved self-efficacy.

## Nature of the Study

This study was an interpretative phenomenological analysis study (IPA). The IPA study focused on the lived experiences of post-bariatric patients with the PSE. Utilizing the phenomenological approach in this study can assist mental health professionals who evaluate and provide behavior change interventions to bariatric patients. The study allowed a collaborative approach to learn from the perspective of bariatric patients. (Neubauer et al., 2019). Sarwer and Heinberg (2020) discuss in their research the

importance of collaboration to enhance the PSE and improve the mental health professional's role in the behavior changes of the patient required post-surgery. Utilizing the phenomenological approach is the appropriate way to understand the bariatric population's lived experiences. IPA allows the researcher to develop an analytical view of the population's experiences of an event (Percy et al., 2015; Smith et al., 2022).

Social constructivism states that the researcher gains knowledge because of the participants' perceptions and reflections on the research study, highlighting the importance of collaboration between mental health professionals and bariatric patients. (Bryman, 2016; Smith et al., 2022). Semistructured interviews were completed with each participant. After conducting the interviews, they were coded and analyzed, identifying themes. The IPA analysis used the seven-step approach presented by Smith et al. (2022). In this study, IPA presents the collaborative experience of post-bariatric patients in discussing the PSE to understand their experiences and give a direction for improvement of the process.

I sought to recruit 12-16 participants to reach data saturation. I needed access to post-bariatric patients 12-36 months post-surgery to obtain these participants. Facebook bariatric support groups were used to obtain the participants. Once the desired number of participants was identified, semistructured interviews were conducted over Zoom. Key concepts that focus on the lived experiences of the PSE process of the post-bariatric patients were identified.

## Definition of Terms

*Anxiety:* Anxiety is defined as being a nervous disorder that is characterized by a state of excessive uneasiness and apprehension, typically with compulsive or behavioral panic attacks (American Psychiatric Association, 2023a).

*Bariatric surgery:* These operations aim to modify the stomach and intestines to treat obesity and related diseases. The operations may make the stomach smaller and also bypass a portion of the intestine. This results in less food intake and changes how the body absorbs food for energy, resulting in decreased hunger and increased fullness. These procedures improve the body's ability to achieve a healthy weight (ASMBS, 2022a).

*Depression:* The American Psychological Association (2023b) defines depression as a mental health disorder characterized by a persistent depressed mood or loss of interest in activities, causing significant impairment in everyday life.

*Emotional eating:* Occurs when an individual utilizes food intake as a response to negative or positive emotions. Negative emotions of depression, anxiety, and loneliness can encourage food intake to lessen the intensity of those emotions (Manchón et al., 2021).

*Pre-surgical evaluation (PSE):* The ASMBS provides recommendations for the PSE process. It is encouraged to have a bariatric-specific behavioral health clinician with the knowledge that covers the lifestyle change and long-term care involved after bariatric surgery (ASMBS, 2022a).

## Assumptions

Based on the literature and my own experiences, I assumed the patients would have varying experiences related to the PSE process. Varying experiences will help with the literature findings that there is no standard of care during a PSE process. It was assumed that interviewing patients 12-36 months post-surgical would provide them with adequate lived experiences to answer the questions being asked. The topic of bariatric surgery and the experiences related to mental health may be sensitive to some participants. I planned to use semistructured interviews to help improve comfort with any sensitive topics discussed in the interview. I assumed the questions being asked in the interview would be understood by the participants; however, if they needed clarification, I provided a better understanding. I also assumed some of the patients interviewed have struggled with the rigorous behavior changes that bariatric surgery requires. Understanding the lived experiences of post-bariatric patients with the PSE process can help clinicians provide an improved PSE process in the future.

## Scope and Delimitations

The scope of the study includes bariatric patients who have had surgery in the last 1 year to 36 months. Limiting the timeframe to no longer than 36 months was necessary because the participants needed to recall the experience they had with the PSE. A significant amount of bariatric research focuses on post-surgical counseling and behavioral change. Post-surgical follow-up and counseling are essential to long-term lifestyle change but are not the focus of this study. This study focused on the PSE to gain an elevated understanding of that experience and how that experience may affect

behavior changes and mental health struggles a patient may experience 12-36 months post-surgery.

## Limitations

Some possible limitations are my therapeutic role as a licensed mental health counselor providing bariatric-specific counseling in a bariatric program and access to the specific bariatric population. I have 5 years of experience as a bariatric counselor. I discussed this openly with the interviewees and focused on the information limiting my personal experiences to play any role in the interviews. Subjects were selected outside of my practice as a bariatric counselor. Self-reported data in a semistructured interview may also create a limitation. Some of the interventions of the PSE the patients experienced could be difficult to recall 12-36 months post-op. Participants may also exaggerate mental health outcomes pre- and post-surgical. The semistructured questions allowed prompt clarification or asking for more information. The interview style allowed the interviewee to expand on specific mental health challenges and barriers to making behavior changes.

## Significance

This IPA study used a collaborative approach with post-bariatric patients to enhance the PSE. If the PSE is improved, mental health professionals could play a more significant role in preparing the bariatric surgical population for the challenging lifestyle change required to make lasting changes. Currently, much scholarly literature focuses on the post-bariatric intervention of behavioral change, mental health, body image, and emotional eating. This study was conducted to understand better how the PSE process

prepares a patient for behavior changes, mental health, body image, and emotional eating after surgery. Understanding the new role food plays in their lives is a significant indicator of creating long-term lifestyle changes in the population (Bianciardi et al., 2021). Developing a process to improve this perception about emotional eating, mental health challenges, lifestyle change, and body image is crucial to the long-term lifestyle change. Mental health clinicians can play a significant role in the preparation process and, with a better understanding of the lived experiences, provide crucial PSEs and direction for future bariatric patients.

The study also allowed for a collaboration between a mental health professional and post-bariatric patients to assist in establishing a PSE that better prepares the patient for the difficult lifestyle change. Sahar and Riazi (2021) discussed the importance of collaboration in the process of developing the PSE. Their study began the process, but they stated the importance of further emphasizing the collaboration between the providers and mental health providers of the PSE to create a better patient-centered approach.

## Summary

Due to the lack of a standard of care for the PSE and negative experiences with the PSE, it is vital to collaborate with post-surgical patients to understand how the PSE can be improved. Most of the current research focuses on post-surgical interventions; however, the pre-surgical process provides an opportunity for mental health professionals to discuss managing future barriers to lifestyle change and prepare patients for any possible mental health circumstances that I arrive at. The conceptual framework of the HBM and self-efficacy provided the direction of this study. Understanding how the PSE

addresses perceived barriers, provides guidance for managing perceived barriers, and enhances self-efficacy through a patient's lived experiences could provide valuable information to providers conducting the PSE for bariatric patients.

Chapter 2 will provide an in-depth review of the literature. The review will address bariatric surgery, obesity, PSEs, lifestyle changes, and mental health related to bariatric surgery. Chapter 2 will also include a more in-depth review of the conceptual frameworks that are a part of this research and the literature search strategy.

# Chapter 2: Literature Review

The purpose of this qualitative IPA study was to explore the experiences of post-bariatric patients 12-36 months post-op of the PSE they went through to provide a collaboration to improve the process. The exploration of this study focused on the bariatric patients' mental health, emotional eating, body image, and behavioral lifestyle changes both before and after surgery and the way the PSE explored this specific phenomenon. The literature review highlights the research on what is known about the PSE, mental health, emotional eating, body image, and behavioral lifestyle changes of the bariatric population. Behavioral specialists who create a better understanding through collaborating with post-bariatric patients of the PSE process could enhance their role in the patient's post-surgical results. The PSE process could be a critical step for a bariatric patient and not just something the patient sees as an annoyance to get through.

## Literature Search Strategy

The Walden University online library was utilized to search for current peer-reviewed articles ranging from 2018 to 2023 to complete the literature searches. The databases used were SAGE Premier, PsychARTICLES, MEDLINE, Science Direct, and Allied Health Source. Additional references were utilized from the ASMBS and the Centers for Disease Control (CDC). Multiple keywords were utilized to locate articles for this literature review. The keywords used were *bariatric surgery, pre-surgical evaluation, mental health and bariatric surgery, eating disorders and bariatric surgery, obesity, body image, cognitive behavior therapy, weight regain, bariatric lifestyle change, health belief model,* and *bariatric lifestyle change biopsychosocial model.*

The only exception to the desired range of article searches (2018-2023) was in the conceptual framework section of the literature review. I utilized articles from Glanz et al. (2015) and Rosenstock (1974) to highlight the HBM and from Glanz et al. and Bandura (1977, 1997) to discuss the self-efficacy theory.

## Conceptual Framework

For this study, the conceptual framework was the HBM and self-efficacy theory. The HBM states that an individual is more likely to make a health behavior change if the perceived benefits of a health change outweigh the perceived barriers of making a behavior change. The model considers the importance of understanding unique personal barriers such as environmental, social, and personal obstacles. The model also examines the importance of self-efficacy and cues to action (Glanz et al., 2015; Saghafi-Asl et al., 2020). The self-efficacy theory states that if someone believes they can accomplish a change, they are more likely to succeed in their goals. (Bandura, 1977; Tay et al., 2023).

### Health Belief Model

The HBM was an appropriate conceptual framework due to the focus on perceived barriers to creating action in accepting a health behavior change. The barriers and beliefs about the benefits of making a behavior change and the barriers that a person faces directly determine if a behavior change is made (Glanz et al., 2015; Rosenstock, 1974). Bariatric patients face unique barriers and challenges to making changes after surgery. The HBM was initially used in the 1950s by Hochbaum, Rosenstock, and Kegels to understand why people did not participate in prevention and diagnosis programs. The

HBM was then utilized in other research to understand the connection between health behavior, health services, and action to adopt a healthy behavior change.

The HBM started with five constructs. The constructs are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action. In 1988, self-efficacy was also added as a construct on the suggestion of Rosenstock. The constructs state that if perceived benefits based on the severity of the condition are more significant than perceived barriers, then a cue to action to implement a behavior change will occur. The construct of self-efficacy related to the health behavior model states that if a person feels more confident in their ability to overcome perceived barriers, they will be more likely to maintain a health behavior change (Glanz et al., 2015).

Similar studies have used the HBM to examine weight management. Saghafi-Asl et al. (2020) used the HBM as an approach to weight management in college students. They found that the HBM, specifically self-efficacy, was influential in adhering to healthy behaviors such as good nutrition and exercise. The researchers stated that building self-efficacy would benefit weight loss and management programs, which demonstrates the importance of utilizing self-efficacy in the PSE. The PSE is an opportunity for mental health providers to implement building self-efficacy with the bariatric population.

Kebede et al. (2023) also sought to understand ways the constructs of the HBM contributed to weight management in participants in a weight management program. The research found the importance of perceived barriers and action of the weight management behavior change. The researchers identified that the HBM construct, specifically the

participants' ability to manage perceived barriers and their self-efficacy of making behavior changes, was a significant factor in adopting positive health behaviors.

**Self-Efficacy**

The self-efficacy theory from Bandura (1977) was not originally developed to look at strategies for weight management or bariatric surgery specifically. The self-efficacy theory, however, focuses on an individual's belief in their abilities to adopt a positive behavior change. Self-efficacy is connected with the HBM; however, initially, it was developed to understand not only the initial action of making a health behavior change but also the continued maintenance of that behavior change. The theory focuses on the value of confidence in an individual's behavior, social environment, and motivation (Glanz et al., 2015). According to Bandura, there are specific influences of increasing self-efficacy. These influences are success or failure in the behavior, judging the ability to adopt a behavior when compared to others, support from others encouraging the ability to adopt the behavior, and environmental factors such as psychological and physical challenges.

Researchers have explored self-efficacy among surgical patients in the past. In a qualitative study by Dahlberg et al. (2022), bariatric patients were interviewed for approximately 1 year post-operative. This specific study focused on what affected a patient's self-efficacy in their experiences after surgery. The study found that in patients, post-surgical feeling they had a mastery of the behavior and seeing success towards their goals effectively increased self-efficacy. The research also found that encouragement and feedback from support systems and healthcare providers on making successful

achievements with the behavior change showed increasing self-efficacy. My study focused on the lived experience of post-bariatric patients with their PSE process. The information gathered focused on ways the process prepared them for barriers to making lifestyle changes to increase feelings of self-efficacy.

In a longitudinal study from Pyykkö et al. (2023), the researchers looked at self-efficacy in post-operative bariatric behavior adherence. The researchers identified that patients who felt more competent with the health behavior changes had better overall adherence to the bariatric lifestyle. They also found that regarding self-efficacy, the importance of social encouragement and increasing feelings of worthiness improved adaptation of the behavior change. The researchers stated in the clinical implications the possible benefit of the opportunity during the PSE to look at possible interventions. The researchers feel that addressing specific situations, encouraging personal coping skills, giving information, and practicing behavior changes may improve overall self-efficacy. The study from Pyykkö et al. focused on the patients' self-efficacy experiences with pre-operative measurements. The research found that patients with lower self-efficacy before surgery struggled more with the bariatric lifestyle change and weight loss results. The study did not address the potential for enhancing pre-surgical self-efficacy. The research I conducted addressed the patients' experiences with the PSE to determine if a patient felt the PSE addressed strategies for overcoming barriers to the lifestyle changes necessary for a bariatric patient.

## Literature Review Related to Key Variables and/or Concepts

### Obesity

Body Mass Index (BMI) is the tool utilized to define when an individual meets the requirements for obesity. Individuals are obese if their BMI reaches over 30 on the BMI scale, starting from mild 30 to severe at a BMI of over 40. Obesity currently ranks as the fifth leading cause of death in the world. Obesity rates continue to grow yearly, and researchers have identified significant increases in the rates, demonstrating a problem that needs to be addressed. Obesity has been shown to have adverse health outcomes for an individual's organs, leading to reduced quality of life and possible death (Safaei et al., 2021).

Lifestyle factors play a significant role in developing obesity (Safaei et al., 2021). Many environmental factors, such as culture, nutritional education, and stress, can affect an individual's ability to make healthy food choices. Often, someone with obesity feels confused with the nutrition information they have been given or heard from others. Social media and poor education lead to a lack of understanding of sound nutritional choices (Rowe & Alexander, 2022).

Obesity rates can vary across ethnic groups. The most current CDC information identifies that obesity prevalence in the United States is 41.9%, demonstrating over a 10% increase from the last data collected by the CDC. The highest prevalence was found in non-Hispanic black adults at 49.9%; next was Hispanic adults at 45.6%, followed by non-Hispanic white adults at 41.4%, and the lowest in non-Hispanic Asian Adults at 16.1%. Two significant contributing factors to obesity prevalence were found to be

education and socioeconomic status, according to the CDC. The CDC research also showed that obesity rates were higher in non-Hispanic Black males the more their income was. Overall, the more education both men and women had, the less prevalence of obesity was identified (CDC, 2022). Independent of ethnic groups, obesity numbers continue to accelerate in all populations.

Obesity is a progressive and complicated disease, and the causes are multifactorial (Andromalos et al., 2019). Due to the complicated nature of the disease, it requires strategies that require a lifelong management approach. The treatment options for obesity consist of creating behavior changes in diet and exercise, utilizing medications that can assist in improving diet and exercise, and bariatric surgery. Bariatric surgery has also been shown to assist in creating diet changes. Every treatment option for obesity identified by the authors requires the patients to develop a long-lasting lifestyle change. The authors indicate that bariatric surgery has a significant improvement in patients with obesity. However, patients can regain weight and fall into old eating patterns and bad habits. The surgery requires a solid commitment to change, and a patient-centered behavioral approach of the multidisciplinary team is vital.

**Bariatric Surgery**

Weight loss surgeries have been modified and changed over time to become a safe and effective way for people with obesity to lose weight. Early procedures that began in 1954 displayed more complications and were often described as uncomfortable by patients, and over time, surgeons and medical professionals worked to improve the procedures (ASMBS, 2004a). Weight loss surgeries are also commonly referred to as

metabolic surgeries due to effective increases in a patient's metabolism. Today's surgical options provide minimal complications and a faster recovery time. Beyond obesity, metabolic surgery can help patients improve symptoms of diabetes, sleep apnea, high blood pressure, and high cholesterol. The surgical options decrease hunger and more satiation, resulting in weight loss. Vertical sleeve gastrectomy (VSG) is currently the most common bariatric surgery performed (53.8%), followed by the Roux-en-Y Gastric Bypass (RYGB; 23.1%; ASMBS, 2022 a). Due to the commonality of these two procedures, this study will focus on bariatric patients who underwent these two surgeries.

The VSG removes 60-75% of the stomach, leaving a sleeve approximately the size of a banana. Due to stomach removal, an individual cannot consume as much food and has a reduced appetite. The VSG is more common for a few reasons. VSG has less of a problem with malabsorption when compared with other procedures. VSG is a less time-consuming and more straightforward process when compared to other surgery options. However, compared with the RYGB, the downside to VSG is possible increases in reflux and heartburn, and it can be less effective for patients with a higher BMI (ASMBS, 2022a).

The RYGB forms a smaller stomach or a pouch so the patient can consume less food. The RYGB results in a reduction in feeling hunger and the ability to achieve satiation. The RYGB is a popular surgical choice for a few different reasons. The RYGB often results in higher and longer-lasting weight loss. The RYGB has a long history of effectiveness with minimal complications. The RYGB is recommended for bariatric patients with reflux and heartburn and can decrease or even eliminate reflux. Compared

to VSG, the RYGB has malabsorption issues, so vitamin supplementation is needed for the patient's life. The RYGB may create ulcers if patients use NSAIDs. Dumping syndrome can happen when a bariatric patient overconsumes food or the food consumed is not recommended. Some foods that are not recommended are processed sugary foods and processed junk foods. Dumping could also occur if the food consumed is eaten too fast, even if the food is appropriate for bariatric patients. Although dumping can occur in VSG patients, it is more common in patients with RYGB (ASMBS, 2022a).

Clinical practice guidelines co-sponsored by the ASMBS from Mechanick et al. (2019) discussed the benefits of bariatric surgery. The authors found that bariatric surgery significantly benefits treating type 2 diabetes. This helps patients live a higher quality of life with bariatric surgery and saves insurance companies millions of dollars in medical costs over a 10-year period. Another benefit the researchers found was an improvement in both cardiovascular disease and hypertension in patients who underwent bariatric surgery. The authors noted the importance of implementing multidisciplinary teams for managing the care of bariatric patients, including mental health professionals, registered dietitians, and physicians.

**Guidelines for Bariatric Surgery**

A BMI over 35 is the typical guideline for a patient to qualify for bariatric surgery (ASMBS, 2022b). The ASMBS states that non-surgical weight loss interventions for someone over a BMI of 35 are typically ineffective for long-term weight loss results. In the Asian population, however, the BMI guidelines are lower because they carry more

adipose fat in the lower extremities. Because of this difference, the Asian population guideline for bariatric surgery is a BMI over 25.

The ASMBS addresses age in their guidelines for bariatric surgery. There is no age limit when it comes to requirements for surgery. Instead, it is up to the medical team to assess the frailty of the individual. Higher levels of frailty result in more post-operative complications (ASMBS, 2022b). Most patients will be over the age of 18; however, being under the age of 18 has been shown to be safe and effective. This study focused on adult populations because they comprise most bariatric patients.

**Metabolism/Metabolic Syndrome**

Metabolism is the entire chemical process that changes nutrients in the body into energy. The unit of energy measurement from nutrition is the caloric intake a person takes daily. This energy is applied to many bodily functions, such as breathing, regulating body temperature, and building new cells. Many things affect an individual's metabolism, such as lean body mass, age, and activity level (Judge & Dodd., 2020).

Metabolic syndrome is a common issue in the United States. Metabolic syndrome is made up of different health conditions, but if three or more of the conditions exist, Metabolic syndrome is diagnosed. The requirements include high blood pressure, high blood sugar levels, low HDL cholesterol, high LDL cholesterol, and an expanded waistline. Management of metabolic syndrome relies on making behavior changes to improve the symptoms along with pharmaceutical approaches or bariatric surgery (Nilsson et al., 2019).

In a study by Yu Ji et al. (2021), they discussed that bariatric surgery has been shown to vastly improve both metabolic syndrome and diabetes. Bariatric surgery has been shown to, at some points, completely stop metabolic syndrome. Many metabolic syndrome symptoms qualify a patient to undergo the surgery utilizing their health insurance.

**Lifestyle Changes**

Bariatric patients face specific lifestyle changes that are required for success post-surgery. The patients must follow a particular diet, take vitamins and minerals, exercise, and avoid alcohol and smoking. The ASMBS (2022 b) describes these required behavior changes in their guidelines for life after bariatric surgery.

After a patient has had surgery, the nutritional guidelines require a protein goal that falls between 60 and 100 grams daily based on height. The protein goal is a lifestyle change that continues throughout the life of each bariatric patient. A carbohydrate limitation is asked of patients at 50 grams per day post-surgical, with possible increases as a patient enters maintenance. Patients will move through different stages of nutritional consistency after surgery, starting from a liquid diet and moving to more solid foods as they heal (Mechanick et al., 2019). Guillet et al. (2020) state that protein needs for post-bariatric surgery are critical to protecting patients from poor health outcomes. Gasmi et al. (2022) found that patients who do not take vitamins post-bariatric surgery can have anemia, hair loss, and ataxia. Creating a lifestyle change that leads to vitamin compliance is significant for the patient's long-term health.

A post-bariatric patient must maintain a vitamin regimen for the remainder of their life. Not following the vitamin guidelines after surgery can lead to deficiencies due to the change in the body's ability to absorb nutrients. Patients are expected to have education before surgery that explains the importance of vitamin management for the remainder of their lives (Mechanick et al., 2019).

In a study conducted by Dahlberg et al. (2022), they demonstrated the role of self-efficacy in creating an ongoing lifestyle change. The study found that patients who found a way to understand their situation better and manage their thoughts about the many changes that bariatric surgery creates in their lives have improved long-term results. A bariatric patient needs to deal with life situations that create barriers to eating differently, understand how their body is changing, manage negativity from others, and seek social support throughout their life.

Patients undergoing bariatric surgery often express many barriers to making lifestyle changes. Ariel-Donges et al. (2020) completed a study to determine barriers that post-bariatric surgery patients identified as barriers to lifestyle changes required by the bariatric changes. The 66 participants of the study ranged from 1 to 30 months post-op. The study found that the highest identified barrier to adherence was stress at 39.4%, with the need to plan ahead as the second highest at 36.4%. Other barriers identified in the study were the cost of healthy food, time/pressure, being around food I should not eat, the cost of exercise/gym, and burnout. The study's authors point out that the patients identified that they understood the expectations of lifestyle change after bariatric surgery but had difficulty implementing those changes in real-life situations. Assakran et al.

(2020) also completed a study to determine factors that created issues for adherence in post-bariatric patients. This study interviewed 399 participants who had undergone vertical sleeve gastrectomy and gastric bypass. The study did not identify the postoperative length of time for each participant. The authors determined that the most significant barrier to adherence was low self-discipline, followed by a lack of motivation and cost or lack of nutrition options. These two studies highlighted post-bariatric patients' difficulties with long-term adherence to lifestyle changes. The studies emphasize the problem of receiving and applying that information to real-life situations after completing the surgery.

Bariatric patients are often encouraged to attend bariatric-specific support groups. Andreu et al. (2020) found that patients who attended bariatric support groups had better weight loss results in the research's short-term and long-term areas. The researchers found a direct relationship between the number of support group sessions attended and weight loss outcomes in their research participants. The researchers also noted a decrease in attendance in patients at 1 year post-op and another significant decrease in participation at 5 years post-op. The authors of the research feel that support groups are an essential aspect of the long-term lifestyle changes of bariatric patients and should be encouraged in both the pre-surgical and the follow-up and after-care processes.

In a study by Istfan et al. (2021), the researchers found that weight regaining in post-bariatric surgery patients is a clinical problem. Currently, there is a limited method of evaluation to identify when weight regain becomes an issue for a patient. Ongoing follow-up care is essential to the long-term lifestyle change so that behavioral and

nutrition professionals can identify and address weight regain. A quality PSE process with the right direction can help a patient with the lifestyle changes needed to reduce future weight regain. The authors feel that adequately understanding the necessary lifestyle changes is essential to ongoing success in the patient's weight loss.

In a study by Billing-Bullen et al. (2022), the researchers examined enablers and barriers to weight regain in patients after surgery. The authors identify a significant problem of bariatric patients post-operatively returning to unhealthy habits they once had regarding food and lack of exercise. In a focus group, the study asked post-bariatric patients to identify the barriers and enablers to regaining weight after surgery. The researchers found specific themes in the patients interviewed. The patients identified long-term barriers as time, stress, cultural and social issues, lack of knowledge of the difficulties related to lifestyle change, lack of self-control, emotional eating, depression, and anxiety. The researchers found the importance of ongoing support groups post-surgery to help manage the barriers identified by the patients. However, the research should have discussed the PSE and preparation they received before surgery with the patient population. The patients in the study had a theme about a need for knowledge of the challenges of changing eating behaviors and managing a new healthy lifestyle. A study investigating how the patient population could be better prepared in the PSE and preparation could help multidisciplinary teams direct the path to lifestyle changes.

A study by Liisa et al. (2022) found that some patients had difficulty with lifestyle change and problems with handling weight regain post-operatively. The study identified managing difficult life situations as a significant contributor to weight regain. The

patients who dealt with regain stated emotional and environmental issues associated with the weight regain. The study emphasized the importance of post-care follow-up. Still, it needed to identify the importance that PSE and preparation for the lifestyle change can play in preparing a patient for the extensive changes after surgery, along with follow-up care options.

Both research from Atwood et al. (2021) and Bianciardi et al. (2021) discussed motivation theory's role in long-term lifestyle changes. The authors indicate that finding a way to create motivation within the patients will help them understand the reasons for making a drastic lifestyle change. Gillison et al. (2019) discuss that motivation theory encourages a person to achieve a specific goal. Specifically, the authors discuss the motivation theory of self-determination. Self-determination theory is based on the intrinsic motivation of participating in the behavior to gain knowledge, growth, and power. Patients can be motivated to examine the basis of food's power and the development of nutrition knowledge.

In a study by Ariel-Donges et al. (2020), they discuss that patients with the knowledge and feeling that they have a sense of control related to the program's behavioral changes had better post-surgical adherence. The study looks at ways to implement this in a post-surgical program utilizing health behavior professionals. The limitations to the research and the importance of possible future studies suggest that strategies to increase self-determination using self-determination theory could improve internal motivations, a sense of knowledge, and power over making lifestyle changes. One of the barriers to motivation was difficulties in planning and creating a long-term

structure. Identifying this barrier related to self-determination would suggest that discussing it before surgery in a behavioral change program could improve the patient's ability to enhance knowledge, power, and internal motivation. Implementing better strategies to increase motivation has been shown to create better long-term adherence to behavior changes for bariatric patients. Alternatively, a lack of motivation before and after surgery could lead to many difficulties in making behavior changes.

**Pre-Surgical Evaluation**

The ASMBS provides recommendations for the PSE process. It is encouraged to have a bariatric-specific behavioral health clinician with the knowledge that covers the lifestyle change and long-term care involved after bariatric surgery. The ASMBS states that the pre-surgical psychosocial assessment is an opportunity for a bariatric patient to build rapport with the bariatric behavioral specialist. Having both pre-surgical and post-surgical care is essential for better outcomes after surgery (ASMBS, 2022b). Sarwer and Heinberg (2020) also found that mental health professionals significantly promote the lifestyle change necessary for bariatric patients post-surgical. The PSE can be ideal for a prospective bariatric patient to understand contributing factors such as environment and behaviors that develop obesity. Bariatric behavioral health clinicians can discuss eating behaviors, coping strategies, realistic expectations, and barriers to making change.

The clinical guidelines presented by Mechanick et al. (2019) stated the identified requirements of all patients undergoing bariatric surgery in the ASMBS Clinical Practice Guidelines during the pre-surgical process. A qualified licensed behavioral health professional with specialized training in obesity and eating disorders must assess the

patient. In the assessment, all behavioral factors of environmental and risk factors such as suicide will be evaluated. The licensed individual must address suspected psychiatric illness or substance abuse issues before surgery. The guidelines strongly encourage evaluating the patient's ability to make the necessary behavior changes before surgery. The guidelines state that patients need an evaluation of their current nutrition and understanding of nutrition. Patients with malabsorption issues will require more extensive nutrition guidance before surgery. The guidelines do not specifically identify practices to address the ability to make behavior changes or how to prepare each patient for the necessary behavioral changes. The guidelines do not address input from past patients to better understand ways the licensed professionals could have better prepared them for the behavior changes needed for a lifestyle change. Collaboration with the patient population could provide valuable information to enhance the effectiveness of the PSE.

The research from Sahar and Riazi (2021) found that bariatric patients often discussed the PSE process as a negative experience. The authors stated that it had been concerned that the pre-surgical process is often seen as just something to check off their list with no benefits. The research from Sahar and Riazi found no purpose, standard of care, or recommendation for the roles of the multi-disciplinary bariatric team in a bariatric program. Sarwer and Heinberg (2020) identified that the bariatric patient population can deal with mental health issues, substance abuse, body image, and emotional eating within difficult long-term lifestyle changes. They feel that mental health professionals have a significant role in providing interventions for the lifestyle changes required. Behavioral and mental health professionals who provide interventions and the

PSE have an opportunity to promote strategies that will help the patient population with the challenges of life changes.

In a cohort study by Morgan et al. (2020), they also found a significant role in mental health and the outcomes of bariatric patients. The findings show that when mental health professionals work with bariatric patients, post-op adherence to difficult lifestyle changes is enhanced. The researchers found the importance of a multi-disciplinary team of mental health professionals and nutritional counseling to improve compliance before bariatric surgery. The researchers also highlight how important future studies are that compare and better understand the PSE and its role in creating this behavior change. They note the importance of developing a post-operative strategy with the patient during the PSE. Griauzde et al. (2018) found that patients' post-surgery can deal with psychosocial difficulties. Some psychosocial challenges include dealing with the perceptions of otherwise and adjusting to not using food as an emotional coping skill. The research that interviewed post-bariatric patients found that all the patients had undergone an evaluation, but they did not feel it was a good or personal experience. The research from Griauzde et al. focused on patients' issues with making lifestyle changes. However, the researchers mentioned that the patients could have been better prepared for the psychosocial difficulties they identified during the interview. A more personalized PSE may benefit patients by enhancing adherence to challenging lifestyle changes post-surgery.

In a study by Masood et al. (2019), the researchers conducted a study to understand why patients regain weight after surgery. The research sought to identify what

factors contribute to weight regain within the bariatric population. The study found the importance of limiting weight regain in following up with post-surgical nutrition and mental health counseling. The researchers discussed that continued dietary and lifestyle changes were connected to working with behavioral change professionals. Although this study focused on post-bariatric follow-up care, they found that long-term behavior changes are complex and need behavioral specialists' intervention. A study that focuses on how the PSE process could contribute to developing strategies to combat old habits, such as emotional eating, and prepare them for lifestyle change could benefit this patient population.

A group study of 57 bariatric surgery participants from Subramaniam et al. (2018) focused on predictors of successful bariatric surgery outcomes. The study focused on how anxiety and depression play a role in eating behaviors. The study utilized the Hospital Anxiety and Depression Scale and the Dutch Eating and Behavior Questionnaire as predictor measurements. Higher levels of anxiety and depression are possible predictors of weight regain after surgery. This demonstrates the importance of utilizing the PSE to discuss mental health in the patient population. The study looked at the role emotional eating plays in lower outcomes post-surgery. The PSE can present strategies for managing emotional eating in the patient population. If the emotional eating is identified before surgery, it can be discussed, and a plan of action could be taken.

A review of nutrition care in bariatric surgery was completed by Andromalos et al. (2019). The authors noted that the review had findings that demonstrated the importance of a multidisciplinary team in the pre-surgical process of the bariatric patient.

The authors state that the registered dietician has a distinct role in preparing the patient for the surgical process. The registered dietician is responsible for educating the patient about changes in eating patterns, the importance of necessary nutrition, the habits related to eating and discussing overcoming barriers to each patient's nutritional challenges. The authors completing the review discussed the issues with evidence-based recommendations, specifically about changing behaviors of the patients related to nutrition expectations. The authors note the importance of understanding registered dieticians' role in assisting behavior change post-operatively in the patient population. The review does not discuss how the registered dietitian can assist patients with preparing for behavior change before bariatric surgery during the pre-operative process.

A quantitative study by Atwood et al. (2021) was also used to gain a better understanding of predicting successful patient outcomes. The study used the Bariatric Interprofessional Psychosocial Assessment of Suitability Scale to help predict successful outcomes. The researchers found that utilizing this assessment was a predictor of possible long-term weight regain, emotional eating, and binge eating disorders. However, the research findings did not find a significant prediction of adherence. The research did find a benefit to pre-surgical assessment to understand better long-term weight regain habits. If certain behaviors can be identified in the PSE, strategies could be worked on with the bariatric individual before surgery. The Bariatric Interprofessional Psychosocial Assessment of Suitability Scale in this study was shown to be a good tool for identifying behaviors that may create long-term behavior changes. If assessment and strategy

building were combined to present lifestyle change interventions, the bariatric patient could be better prepared to undergo the changes.

Additionally, the researchers highlighted the importance of future studies to examine how assessment may be significant in long-term lifestyle change outcomes. The researchers feel that more resources applied to the assessment may better benefit the bariatric patient population. The researchers also noted that patients often need to utilize better follow-up care after bariatric surgery. In this study, the patients that participated in the research were those that utilized the follow-up care. Post-surgery patients could experience weight regain and not reach out to behavioral/mental health professionals for post-operative care. The lack of follow-up care presents an opportunity to address the importance during the initial assessment and PSE.

In a research study from Bianciardi et al. (2021), they found that poor attitudes, difficulties in understanding emotions, and emotionally disordered eating were significant contributors to a lack of adherence to lifestyle changes post-surgery. The researchers found that both the pre-surgical process and post-surgical follow-up play a role in providing direction to the challenges of lifestyle change for the bariatric patient. In the future, the researchers feel the PSE and post-surgical interventions should be more personal to the bariatric patient to address their specific challenges related to emotional eating and patient attitudes. The researchers highlight that future studies that address patient attitudes and disordered emotional eating could benefit this patient population.

In a qualitative study by Griauzde et al. (2018), they also found that the role of mental health professionals in the bariatric population is crucial. The study of 77 post-

bariatric patients focused on what psychosocial experiences contributed to their psychosocial outcomes. Three major themes were identified in the research study: change in perception of self, change in perception by others, and relationship changes. The categories demonstrated mixed results in the study, some showing improvements while others noted that outcomes worsened after surgery. The main finding of the research was that bariatric patients face unique, difficult challenges. Things like how patients perceive their sense of self and social connection with food play a role in psychosocial experiences. The study demonstrates the importance of preparation before surgery due to the unique psychosocial difficulties. Mental health professionals completing the PSE should be aware of these unique challenges the bariatric patient faces after surgery. The PSE allows for adequate preparation.

In a study by Rutledge et al. (2020), they propose the importance of revising the psychological evaluation process, emphasizing the importance of using a patient-centered approach. The authors identify the importance of assessing each individual patient's goals for how they view a successful bariatric experience and outcome. Having the patient's input on the goals they want to accomplish can help with the clinical implementation of lifestyle change. Håkansson Eklund et al. (2019) discussed what it means to have a patient-centered approach in healthcare. A patient-centered approach is utilized to understand the unique situation of each patient. It is crucial that a patient participates in the healthcare they receive. The patient-centered approach attempts to accomplish five essential elements: (a) establish the reasons for the visit and the patient's concerns, (b) a holistic approach to understanding the patient's world, (c) find a common area about the

problem and management of the problem, (d) raise preventative health approaches, and (e) build a strong rapport between the patient and health care professionals.

**Emotional Eating**

Emotional eating occurs when an individual utilizes food when experiencing an emotion. Often, research focuses on negative emotions for emotional eating. Wong et al. (2020) stated that emotional eating is also a response to disordered eating patterns. These patterns include a loss of control with overeating, binge eating disorder, and food cravings. The researchers found that these disordered eating patterns made behavioral interventions difficult and weight regain an issue after weight loss was accomplished. Patients who once had bariatric surgery were found to have a strong relationship with emotional eating. This research indicates the importance of discussing and working with bariatric patients to establish strategies for managing emotional eating patterns. The PSE could be an opportunity to begin the process of discussing emotional eating.

Research presented by Lattimore (2020) discussed that emotional eating could be a response to both negative and positive emotions. A process to improve weight loss is to work with an individual to reduce emotional eating. An individual with emotional eating has the wrong cues around eating and a higher response to eating when high levels of emotions occur. Utilizing interventions to improve cues could help with interventions for weight loss. The research demonstrates that individuals who do not have emotional eating cues have a 10% increase in weight reduction with behavioral interventions. The study from Lattimore demonstrated that utilizing a mindfulness treatment before weight loss improved overall effectiveness. The mindfulness interventions in the study targeted

understanding internal and external emotional triggers to reduce becoming reactive when it comes to emotional eating. This study demonstrates the possibility of utilizing the PSE to discuss mindfulness and emotional regulation strategies before surgery.

Behavioral weight loss treatments are enhanced when emotional eating is attempted to be controlled (Annesi, 2021). In the study, the researcher found that utilizing physical activity and other forms of emotional regulation significantly improved weight loss interventions. The study suggests that utilizing an approach that targets coping skills, including physical activity before or alongside a weight loss intervention, will improve overall results. The mental health professionals have an opportunity during the PSE process to discuss strategies for emotional regulation and coping skills to enhance weight loss surgery results.

In a research study by Hindle et al. (2020), they discussed that patients who deal with emotional eating before surgery are more likely to have reduced success in weight loss and a higher possibility of weight regain. The researchers state that reduced emotional eating led to a significant improvement in 12-month weight loss results. The researchers conclude that utilizing psychoeducation and other strategies to address emotional eating in the presurgical process could significantly benefit the patient population. This research shows the importance of utilizing the PSE process to address emotional eating and discuss strategies for emotional regulation.

In a research study by Liisa et al. (2022), they found that patients often regained weight due to emotional eating post-surgery. The patients in the research study stated they went back to using food as an unhealthy coping skill. Often, patients were aware of

what they were doing but had difficulty stopping the behavior. Better strategies discussed before surgery about emotional eating, coping skills, and triggers could improve the relapse to these habits.

**Mental Health in Bariatric Surgery**

In research presented by Ribeiro et al. (2018), they found a significant improvement in patients 1 to 23 months post-op related to anxiety, depression, and binge eating disorder. The study measured symptoms pre-operatively and post-operatively to determine improvements post-bariatric, making it significant for measuring mental health outcomes. One hundred nine patients completed evaluations during the PSE before surgery and then completed the evaluations 23 months after surgery. Improvements in assessing for depression, anxiety, and binge eating were found in the study. The study noted that some patients struggled with the changes after surgery and had negative measurements. This research study only completed assessments before and after surgery with no pre- or post-surgical counseling.

In a review of the literature from Morledge and Paries (2020), they found that mental health issues in the bariatric population are a current area of investigation due to the high prevalence of mental health issues within the bariatric surgery population. The review indicates that depression is the most common mental health problem of those seeking bariatric surgery. The review suggests that depression symptoms are improved; however, some research previously shows that it is possible that after 1-3 years after surgery, the improvement of symptoms begins to lessen (Mitchell et al., 2014). Additionally, the review found that due to difficulties in both pre- and post-surgery, the

patients identified anxiety about their relationships with others and body image. The review states that due to the unique mental health challenges, there is an essential need for a valuable PSE process. The review states that the process currently has little validity in the outcomes of bariatric individuals. In the review, it is noted that a more standardized approach that utilizes interventions both pre-and post-surgical to manage the patient's mental health better.

In a research study completed by Ristanto and Caltabiano (2019), they identified that bariatric patients who seek surgery typically have a lower overall quality of life and deal with mental health-related issues due to their weight and physical well-being. The researchers found a significant increase in the overall mental well-being of bariatric patients with more counseling sessions. The research demonstrates the importance of identifying specific counseling interventions to help patients with their overall mental well-being and quality of life. The research found that even a minimal amount of counseling sessions before surgery contributed to the better mental well-being of the individuals seeking bariatric surgery. The findings indicate that counseling sessions should be a part of the treatment process, and future studies should seek to understand the most beneficial counseling interventions for the population.

A research study by Castaneda et al. (2019) found an increased depression and suicide risk level in patients post-surgical. The researchers found that through talking to patients, they had unrealistic expectations and did not handle the extreme life changes well. The researchers also theorized that the differences in absorption post-surgery increased depression. Conceição et al. (2020) found increased depression and eating

disorder symptoms in patients who did not have a solid social support system. The study found that patients who do not have a support system struggle with increasing mental health symptoms such as depression.

A study from Billing-Bullen et al. (2022) found that mental health was identified as an enabler theme in their research of interviewing post-bariatric patients concerning barriers and enablers of weight regain. The patients interviewed identified that the dramatic lifestyle change created a feeling of depression. The unhealthy relationship with food and utilizing food as a coping skill created a drastic change post-surgery that patients felt unprepared for. Some patients stated that it is an ongoing mind game that never goes away, creating a mental health struggle with depression and anxiety post-surgically.

A longitudinal study over 10 years conducted by Morgan et al. (2020) sought to find that there was an increase in patients utilizing mental health services after bariatric surgery. The researchers found that post-bariatric patients did utilize more mental health services after having surgery for depression, anxiety, and possible eating disorders. The study found that weight loss alone did not improve patients' mental health after surgery. The authors point to the significance that mental health can play in the overall success of bariatric patients in creating the lifestyle changes asked of the patient.

A literature review completed by Cheroutre et al. (2020) sought to determine the utilization of cognitive behavior therapy (CBT) in issues that arise in patients who have undergone bariatric surgery. A mental health professional utilizes CBT to increase awareness and challenge negative thought patterns around specific subjects—patients in

the reviewed programs attended either group or individual CBT sessions. The researchers stated that although bariatric surgery is a highly effective obesity treatment, long-term risks of weight regain, depression, and unhappiness with body image are prevalent in post-surgical patients. The researchers found that therapeutic work completed both pre- and post-surgical on body image, motivation, and eating behavior demonstrated a better outcome for patients participating in those CBT programs. The authors found that CBT is becoming increasingly popular in preparing patients for bariatric surgery. The authors feel that more studies should be completed to determine if CBT is more effective pre- or post-surgical.

**Eating Disorders in Bariatric Surgery**

A research study by Cassin et al. (2020) found that binge eating and food addiction symptoms are improved post-bariatric surgery. However, the study highlighted the importance of behavior modification for managing food addiction and binge eating disorders. The study found that patients in the long term have problems with binge eating and food addiction management. Old eating patterns can resurface the longer a patient is out from surgery. Varns et al. (2018) conducted a study that showed elevated depression around body image in patients' post-bariatric surgery. The researchers found that before surgery, patients have unrealistic expectations of body changes that will occur before bariatric surgery. The findings demonstrate the importance of working with patients before surgery to better understand realistic body image after weight loss.

In a qualitative study by Billing-Bullen et al. (2022), they found a theme of eating disorders in the patients they interviewed post-operatively. Bariatric surgery can help

manage binge eating disorder; however, those who struggled before surgery with binge eating have demonstrated more susceptibility to weight regain. The patients found they lacked self-control over the lifestyle changes required after having bariatric surgery. The researchers also found that patients identified struggles in seeing themselves differently and not noticing weight loss when others close to them have noticed body changes. The research shows some identification of body dysmorphia post-surgical for some of the patients who were interviewed.

Research from Sarwer et al. (2019) similarly found that patients who demonstrate binge eating behaviors before surgery have an increased chance of weight regain post-surgery. The researchers stated that impulsive behaviors such as binge eating, and emotional eating make the transition of strict nutrition changes harder to cope with. The patients often identify food as a learned coping skill for stress and complex life events. Even with the restriction of surgery, a patient can find ways to continue engaging in these impulsive behaviors.

Research completed by Ivezaj et al. (2022) identified an increase in post-bariatric patients with Night Eating Syndrome (NES). NES is defined as eating upon awakening in the nighttime and consuming a large number of calories in a short amount of time. Participants who also suffered from depression and other eating disorders before surgery had elevated NES post-surgery. The research found that patients experience Loss of Control Eating (LOC) post-surgery, often starting at six months post-op. The study emphasizes the importance of evaluating LOC and NES during follow-ups with mental health and nutrition specialists.

Food addiction and its contribution to obesity have had increasing research in recent years. Food addiction is described as an addictive-like behavior where a person will overconsume food even though it creates adverse consequences with frequent attempts to stop or decrease the behavior. Food addiction derives from the substance use diagnosis criteria in the DSM-5 (Çelebi et al., 2023). The study completed by Çelebi et al. (2023) utilized the Yale Food Addiction Scale to assess pre-surgery patients in a bariatric program at Marmara University School of Medicine in Turkey. The study found that out of the 140 participants, 47% met the Yale Food Addiction Scale criteria for food addiction. The study found that many patients presented with LOC related to their food consumption. The researchers point out that LOC and food addiction have been identified as indicators of poor outcomes associated with establishing and maintaining the lifestyle changes necessary for bariatric patients. Out of the patients who met the Yale Food Addiction Scale criteria for food addiction, the researchers found that impulsive behavior was a common personality trait.

**Cross-Addiction**

Literature findings show an elevated risk of bariatric patients with alcohol use disorder. Research shows that many post-bariatric patients seek services for problems with alcohol use after surgery. One of the identified issues with alcohol usage is the way bariatric surgery affects absorption rates. Alcohol is absorbed differently, leading to faster intoxication. Research also indicates a social aspect of increasing alcohol after surgery. Some patients have stated that they have issues with being different in social situations, leading to more drinking in these social situations. It is crucial to discuss the

way alcohol may affect a post-bariatric patient before having bariatric surgery (Ivezaj et al., 2019).

In a research study from West et al. (2023), they identify that obesity and alcohol use disorder have neuropsychological characteristics in common. It appears that post-bariatric patients seek out substance and alcohol use recovery programs at an elevated rate. The researchers found some contributing factors are ongoing mental health difficulties, the inability to utilize food as a coping mechanism after surgery, and the increased sensitivity to alcohol. The authors found that screening and utilizing a brief intervention can be utilized to reduce alcohol use disorder. During the PSE, however, mental health professionals can take the opportunity to utilize some brief intervention strategies to prepare the bariatric patient for this unique challenge.

In a qualitative study by Liisa et al. (2022), they found in their research that one of the long-term effects found in the bariatric patient population was overconsumption of alcohol. The patients in the study reported that they utilized alcohol as a coping skill post-surgery. The patients stated they felt the need for social interaction, and sometimes that included heavy drinking. The issue with the possible overconsumption of alcohol indicates the possibility of assessing this and discussing it at the PSE.

**Bariatric Surgery Follow-Up**

A review completed by Bryant et al. (2020) found that overall calorie intake is reduced in post-bariatric surgery patients, making adequate nutrition choices even more important. The review focused specifically on how the weight loss surgery affected eating behaviors and psychological aspects of food choices. The review found four

significant factors in making healthy nutrition choices. Emotional eating and difficulty managing the emotional response led to unhealthy choices and wanting to snack late in the evening. Emotional and physical well-being can lead patients to make unhealthy choices due to environmental factors. Some patients identified still feeling hungry and making poor choices while discussing a lack of restraint when choosing adequate types of nutrition. The review specifically discussed those who had the most success after surgery and held a better understanding of how their relationship post-surgery has changed. The review stated that ongoing care is essential for long-term success. However, the review could have indicated how the relationship with food could be discussed in a PSE to prepare the population better.

The ASMBS (2022b) discusses that life after surgery can be difficult for some and that follow-up is integral to the process. The ASMBS guidelines state that obesity is a lifelong disease and that those who have surgery will need regular follow-ups to help with the long-lasting lifestyle changes. The ASMBS recommendations state that follow-ups should be completed every few months after surgery. After 1 year, it is important to follow up with a bariatric specialist annually for life. Andreu et al. (2020) point out that patients who follow with support groups led by professionals have better long-term results. Regular meetings with mental health and nutrition specialist's post-bariatrics can also increase the long-term success of each bariatric patient.

A study was completed by Lundin et al. (2022) to determine patient satisfaction with outcomes and follow-up care in patients one and 5 years after bariatric surgery. The researchers stated that 70-90% of patients are generally satisfied with their results post-

operatively. Patients were given a pre-surgery questionnaire and then completed a questionnaire at 1 year and 5 years post-op. In pre-surgery, 332 patients completed the questionnaire, 258 returned the questionnaire 1 year post-op, and 224 returned the questionnaire 5 years post-op. The results show that at 1 year post-op, the participants were 90% satisfied with both outcomes and follow-up care, with a reduction to 69% at 5-year post-op. The researchers found that patients may need the right long-term weight loss expectations and regain in the 5-year post-op questionnaire results. The researchers hypothesize that more emphasis on realistic weight loss and managing weight regain could have been expanded and discussed more with patients in the pre-surgery process.

A review completed by El Ansari and Elhag (2021) focused on weight regain and what is considered insufficient weight loss in post-bariatric patients. The review examined how common weight regain occurs and whether there are pre-surgical predictors and possible strategies for weight regain in the post-bariatric population. The review found that identifying strategies to discuss weight loss surgery's hormonal, psychological, and behavioral aspects could benefit the patients. The review stated that identifying and addressing some of the predictors of patients that could have weight regain, such as those that deal with a loss of control of eating, mental health issues, and overall non-compliance with the behavior changes required after surgery. The review felt that a better overall knowledge of the required changes presented to the patient might improve the long-term results. The review identified the unique nature of each individual patient. It stated that when a behavior or barrier is identified within a specific patient, tailored interventions should be considered to target the problem behaviors. The review

pointed out that only some studies have addressed the pre-operative predictors and prevention strategies of insufficient weight loss. This review of the research identifies that there is a gap in understanding ways the PSE process could better help the bariatric population.

## Summary

The literature demonstrates that there is no standard of care for the PSE, and patients often have a negative experience with the PSE. During the PSE, mental health professionals have an opportunity to start the process of preparing bariatric patients for the challenging lifestyle changes they will experience and to discuss possible mental health struggles. The ASMBS provides stringent guidelines for nutrition and behaviors that are important to discuss before the surgery.

Collaboration with post-bariatric patients is a valuable way to understand better the role the PSE could provide for future patients (Sahar & Riazi., 2021). Dahlberg et al. (2022) identified the importance of learning to manage barriers to making lifestyle changes. Many factors can play a role in creating the obstacles; self-efficacy and learning ways to address those barriers may play a role in the long-term lifestyle changes needed.

Emotional eating was a significant predictor of results in post-bariatric patients (Hindle et al., 2020). Researchers found that addressing this in the pre-surgical process utilizing psychoeducation and other coping strategy development can assist the patient population with the lifestyle changes required for the best weight loss and maintenance results.

In the review from El Ansari and Elhag (2021), the researchers found significant gaps in understanding the PSE process and ways the patient population can be helped. They found that many problems can exist with the patients, such as maladaptive eating patterns, mental health, and eating disorders that lead to both weight regain and insufficient weight loss. Adherence is an issue that is often found in research. Through collaboration, mental health professionals can learn strategies that can be utilized during the PSE to address this issue better.

The literature points out specifically that patients often have a poor experience with the PSE. The literature also demonstrates that patients often feel unprepared for the lifestyle changes and barriers they face post-surgery. The literature and research aim to address the gap in understanding the lived experiences of post-bariatric surgery patients with the PSE regarding bariatric lifestyle change, managing mental health post-surgical, and strategies for emotional or disordered eating.

This study collected data using semi-structured interviews. The interviews were open-ended, allowing the patients to elaborate on their experiences with the PSE. Open-ended questions gave the patient perspective on how the PSE prepared them for barriers to lifestyle change, strategies for emotional/disordered eating, and mental health issues. Patients were recruited utilizing open bariatric support groups and Zoom video conferencing interviews were conducted.

When creating a PSE and preparation process for bariatric patients, it is essential to understand their personal concerns and their world. Research shows many patients did not feel the pre-surgical process prepared them for the lifestyle change, or they felt

unprepared for the mental struggle in the shift in relationship with food; the patient should have an active voice in how the pre-surgical process and preparation is handled. Gaining this understanding of the patient's viewpoint through a patient-centered approach will build self-efficacy, encourage preventative health measures, and allow for a stronger rapport between bariatric health professionals and their patients.

# Chapter 3: Research Method

This qualitative IPA research aimed to understand the lived experiences of post-operative bariatric patients with their PSE process. Through investigating the lived experiences of patients with their personal PSE process, the research gathered knowledge of their preparation for the demanding lifestyle changes, mental health struggles, and strategies for managing barriers to better understand the process. The study also aimed to collaborate with the patient population to gather knowledge on what they feel could be improved in the PSE process to prepare them for the challenges they experienced. Currently, there is no standard of care for the PSE (Sahar & Riazi, 2021). With no standard of care, many patients report a negative experience with the PSE. Gaining this understanding will give mental health professionals a direction on ways they can play a more important role in the care of bariatric patients during the PSE. In this chapter, I will provide the research design and rationale. This chapter will also detail the role I will play as a researcher, the methodology utilized in the research, data collection instruments, issues of trustworthiness, and ethical procedures in the study.

## Research Design and Rationale

The research questions were designed to understand the phenomenon of the lived experiences of post-bariatric patients with the PSE process:

- Overall Research Question: What is the lived experience of post-bariatric patients with the PSE process?
- RQ 1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery?

- RQ 2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery?
- RQ 3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes?

Through interviews, the study provides a picture of what post-bariatric patients feel are effective pre-surgical mental health evaluation interventions to provide effective lifestyle changes. The study provides a picture of the PSE's ability to address barriers to lifestyle change to promote self-efficacy and enhance action in adapting the bariatric health behaviors. The research could help mental health clinicians change the PSE to improve the experience for future bariatric patients.

This study was a qualitative research design utilizing IPA to gain an understanding of the lived experiences of post-bariatric patients with the PSE process. IPA is a qualitative research approach utilized to understand how people make sense of significant life experiences (Smith et al., 2022). The IPA method aligns with the research question in the study that examines the lived experiences of post-bariatric patients with their PSE regarding barriers to lifestyle change, mental health/eating disorders, and collaboration for improvements to the process. The IPA is often utilized in the study of a complex phenomenon, and open-ended questions are used to address the unique experiences of each individual patient (Creswell & Creswell, 2022).

Literature has shown there is no standard of care for the PSE, and often, patients feel it is a negative experience (Sahar & Riazi., 2021). Semistructured interviews allowed

me better to explore each individual's experience with the PSE and understand how the process could be improved. Utilizing phenomenological analysis, I explored the unique perspectives of these patients 12-36 months post-surgery.

## Role of the Researcher

As the researcher, I collected data from the interview questions, analyzed the data, and presented the lived experience of each post-bariatric participant. The data were collected from post-bariatric patients with whom I have no therapeutic, supervisory, or professional relationship. I am a licensed mental health counselor and a bariatric counselor with my patients. I located participants outside of my practice. I used researchandme.com to recruit participants for this study. There are many open bariatric support groups to recruit post-bariatric patients. I used semistructured interviews to open discussions with the study participants, allowing them to provide their unique experiences.

Phenomenological research does present challenges. My knowledge as a bariatric counselor for 5 years created beliefs and ideas about my patients' experiences, which I had to put on hold to focus on the experiences from the study participants. To manage any bias from my own experiences, I used bracketing. Bracketing is putting aside my judgments, past beliefs, and experiences to have an open mind when conducting interviews (Peterson, 2019). Another strategy I used in reducing bias is consulting with someone outside of the study. Utilizing an individual not involved in the study reduces qualitative bias (Peterson, 2019). I also kept a research journal throughout the study to help self-monitor any research bias (Creswell & Creswell, 2022).

# Methodology

## Participant Selection Logic

This study had a target population that includes both males and females above the age of 21 years old who have had bariatric surgery in the range of 12-36 months post-operative. The sample was chosen specifically to represent the perspective of the phenomenon being researched (Smith et al., 2022). The participant criteria timeframes are to gather patients who can recall their PSE process with enough post-operative experience to discuss an overall experience of their time as a bariatric patient. I planned to recruit 12-16 participants based on reaching data saturation, which is when no additional insights are stated (Creswell & Creswell, 2022). According to Smith et al. (2022), the typical number of participants is six to 10. Due to the lack of standard of care for the PSE process, the participants had unique experiences. Semistructured interviews were used to gain the perspective of the subjects for a phenomenological research design. To remain anonymous, research participants are referred to as A, B, C, etc.

The sampling needed for this study was homogenous purposive sampling to identify the participants. Purposive homogenous sampling is used when specific criteria and characteristics are necessary for the sample. In this study, all bariatric patients will have surgery in a similar time frame (Smith et al., 2022). I used open Facebook bariatric support groups to obtain the post-operative interview participants. Facebook groups are utilized by the patient population. Permission from the Facebook group administrators was obtained to post the flyer included in Appendix B. Those who respond to the flyer received the letter included in Appendix A. After receiving the letter, the participants

who responded were given the demographic questionnaire in Appendix C. The demographic criteria for participants are 21 or older, had bariatric surgery in the past 12-36 months, live in the United States, and are English-speaking. To obtain saturation of the data collection process, I planned to recruit 12-16 post-bariatric patients who have undergone bariatric surgery in the past 12-36 months and meet the demographic criteria.

**Instrumentation**

The data came from semistructured open-ended interview questions. The interviews were conducted one-on-one utilizing the Zoom platform. The interview questions are presented in Appendix D. The Zoom platform allows for recording the interview. Before the interview, each participant was informed that it would be recorded for data collection purposes. The interview questions were developed to understand the lived experiences of post-bariatric patients with the PSE process. The interview questions were designed specifically to answer the research questions. A pilot study was conducted using the research questions to determine if they adequately answer the research questions.

**For Researcher-Developed Instruments**

The interview questions were developed by me as the researcher. The interview questions were designed to address the established research questions in the study. The research questions were developed to gain an understanding of the way the PSE addressed overcoming barriers to making a health-related behavior change, prepared them to increase self-efficacy and manage barriers of making the lifestyle change, and form a collaboration to obtain their opinion on how their experienced PSE would have

better helped them with life after bariatric surgery. Dahlberg et al. (2022) stated in their research the importance of self-efficacy in creating the lifestyle changes that a bariatric patient must establish for long-term success. Barriers to change in the bariatric lifestyle were identified in the research from Ariel-Donges et al. (2020). The researchers discussed that barriers are unique to the individuals, enhancing the importance of understanding the ways patients were prepared for the lifestyle and individual barriers.

The interview questions are presented in Appendix D. A pilot study was completed to determine if the interview questions fully address the research questions in the study. To address content validity, triangulation was utilized in my pilot study and main study. A co-worker who is a registered dietitian and part of the bariatric multi-disciplinary team was utilized to confirm my perceptions of the interviews and reduce researcher bias (Peterson, 2019).

**Procedures of Pilot Studies**

I conducted a pilot study to determine if the proposed interview questions answer the research questions. This pilot study included co-workers and acquaintances who have undergone bariatric surgery. I conducted the pilot study with two post-bariatric patients. One of the patients had undergone gastric bypass, and the other one had undergone vertical sleeve gastrectomy. The participants in the pilot study did not meet the 12-36 months post-surgical time frame that is part of the main study due to the convenience of using co-workers and acquaintances. All other criteria of my original study were met. I was confident that the participants in the pilot study have a recall of the PSE process they experienced. Zoom was utilized to conduct the interviews in both the pilot and main

study. The semi-structured open-ended interview questions for the pilot participants and the primary research remained the same. The pilot study data were recorded through the Zoom software in both the pilot and main study. The data were analyzed using thematic coding in the pilot and main study. The identified themes determined if the proposed interview questions adequately answer the research questions. The Institutional Review Board (IRB) study approval number is 05-15-24-1001034.

**Procedures for Recruitment, Participation, and Data Collection**

A flyer was used for recruitment posted on the Facebook page (Appendix A and B). The flyer stated the purpose of the study, the criteria for the participants, the expectations of the participants, and contact information. Permission from the University IRB was acquired before the flyers were posted on the Facebook groups. Approval from the Facebook group admins was also attained before the flyers were posted. A demographic questionnaire (Appendix C) was sent to the interested participants who contact me to determine if they met the criteria for the study. The flyer in Appendix B demonstrated the purpose of the study, criteria for the study, and contact information.

If a post-operative patient was interested and met the timeframe criteria, they were sent a copy of the interview questions and a consent form to participate in the study. If the participant agreed to continue the study, they were given a private Zoom link to their provided email address. The semi-structured interview was then utilized to give the opportunity to learn about the participant's PSE experiences.

**Data Collection Method**

Semi-structured interviews were conducted one-on-one utilizing Zoom software to interview participants from different bariatric programs and locations. The semi-structured interviews were characterized by open-ended questions to allow for clarification and unique perspectives of the individual's learned experiences (Creswell & Creswell, 2022). The questions were open, avoided assumptions, and avoided leading the participant to a specific answer (Smith et al., 2022). The researcher created the proposed semi-structured interview questions to answer the study's research questions adequately. The semi-structured interview questions the participants were asked can be found in Appendix D.

In this phenomenological research study, I delved into the lived experiences of post-bariatric patients with the phenomenon of the PSE process. One-on-one semi-structured interviews utilizing Zoom software were used to collect information about this phenomenon. I asked the questions in the same manner with every participant and provided the participant with plenty of time to go in-depth when answering the open-ended questions. I used the provided Zoom recordings to record the audio and then transcribe the audio with permission from each interviewed participant. The Zoom interviews took approximately 60 minutes to complete. Thematic coding analysis was used to link keywords, phrases, and quotes about each individual experience with the PSE. The identified themes were utilized to address the specific research questions (Braun & Clarke, 2006; Creswell & Creswell, 2022).

It is important in qualitative research to demonstrate that the data collected aligns with precisely what the participants stated. Member checking was utilized in this study to show the transcriptions of my notes from the interviews to the interviewees to determine if they agree that the themes and experiences of the interview match their interpretation of the data (Creswell & Creswell, 2022). I emailed the transcription of the Zoom interviews to the participants and scheduled follow-up meetings with them if they needed to discuss the transcription. Suppose a participant feels there are inaccuracies in the transcription. In that case, it was discussed with the university chair, and changes were made so the correct transcription was used for data collection.

Participants were informed that they could leave the study anytime if they did not feel comfortable answering questions. This was discussed in the informed consent before the interviews. At the end of the interview, contact information for the researcher and research committee were shared with the participants if any issues or concerns arise during the study. The participants were informed that they could leave the study anytime.

Suppose I am unable to gain the desired number of participants with the 1st attempt. In that case, I would locate other open bariatric Facebook groups to present my flier with permission from the group's administrators. Many open Facebook support groups were available to recruit participants from. The initial semi-structured interviews were adequate to obtain data, and no follow-up interviews were need to be scheduled.

**Data Analysis**

Manual hand-coding was used to develop the themes from each one-on-one semi-structured interview. Keywords, quotes, and metaphors were coded from the interview

process. Thematic coding was used to identify the themes that are developed to address each research question (Creswell & Creswell, 2022). Zoom was utilized to conduct the interview, and the interviews were recorded with the permission of each participant. Handwritten notes were also utilized to assist with the process. The interview questions underwent a pilot study to ensure they answered the research questions.

I completed my data analysis based on the steps from Smith et al. (2022). In the first step, I focused on reading and re-reading the data and making exploratory notes to gain familiarity with the transcript, taking notes of anything of interest. In the second step, I constructed experiential statements that combined the transcript and my thoughts on the transcript to develop experiential statements that related directly to the participant's experiences. In step three, I found connections and conducted the process of mapping the way the interview responses joined to form themes. In step four, personal experiential themes identified in step three were organized into a table to develop an evidence trail so the place in the interview that leads to the theme and keywords from the participants.

Overall Research Question: What is the lived experience of post-bariatric patients with the PSE process?

RQ1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery?

RQ2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery?

RQ3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes?

The goal of the interview was to obtain the lived experiences of the unique PSE process. Due to the PSE not having a standard of care, there are no issues with discrepant cases. The goal was to fully understand the lived experiences of each individual in their personal PSE process.

## Issue of Trustworthiness

My research aimed to minimize bias and ensure the study's trustworthiness. To accomplish this, credibility, transferability, dependability, and conformability were met throughout the research study. These were met through different types of approaches during the research.

### Credibility

I utilized reflexivity to discuss how my experiences as an experienced bariatric counselor conducting PSEs can shape the interviewees' responses about their own PSE (Smith et al., 2022). A strategy that was utilized was keeping a research log to continually monitor my reflections on anything that may affect the data interpretation.

Due to my experiences with providing PSE, bracketing was an essential strategy to ensure credibility. Bracketing ensured I put aside my experiences, judgments, and ideas about the PSE and focus specifically on analyzing my collected data (Peterson, 2019). I was focused on the information provided from everyone's experience without bringing in my own experiences for this research study.

**Transferability**

To ensure transferability in my research study, providing as much detail as possible about how the study was conducted to establish external validity was essential. The strategy for using thick descriptions is to provide a detailed explanation of the process and analysis of the study (Creswell & Creswell, 2022). This allowed for any replication of the study in the future.

**Dependability**

Triangulation was utilized to have another individual as part of the data analysis of the interviews. Using this triangulation approach helped reduce my researcher bias and increase the overall trustworthiness of the study (Peterson, 2019). I utilized a co-worker who is a registered dietitian and participates as a multidisciplinary team member at a bariatric program.

**Confirmability**

Utilizing reflexivity and keeping a research log allowed the research results to be certified by other researchers. The log was detailed and maintained during the duration of the research study. The research log allowed for continued reflection on my personal experiences throughout the research (Creswell & Creswell, 2022).

**Ethical Procedures**

Human participants were recruited through open Facebook bariatric support groups after the IRB approved the data collection methods and flyers to recruit post-bariatric patients. Permission from the Facebook bariatric support groups administration was also asked to approve the data collection and flyers before submission. This study

utilized human participants discussing medical history and potentially sensitive subject matter regarding mental health, eating disorders, and barriers to making behavior changes. Due to the sensitive nature of the discussion, the informed consent reflected that participants may leave the study at any time, including during the interview process.

### *Institutional Permissions*

Before the study began, approval of my proposal was accepted by both the IRB and committee members. The IRB application reflected the procedures, ethical issues, participant information, and the process of collecting data. After approval was obtained from the IRB and Walden University committee, I asked for access from the bariatric Facebook group admins to post the recruitment flyers to recruit the participants.

### *Ethical Issues About Questions and Purpose*

It is important to be clear about what the research study directly explores with the participants. The participants needed precise definitions of terms used in the research study and interview questions. The identified terms of bariatric surgery, anxiety, depression, and emotional eating were presented to the participants. Hence, they clearly understood how the terms were utilized in the study. The participants had a clear discussion that the purpose of the study is to form a collaboration about their experiences with the PSE and what they feel may improve the PSE and preparation process conducted by mental health professionals before surgery.

### *Ethical Issues in Data Collection*

This study utilized human participants discussing medical history and potentially sensitive subject matter regarding mental health, eating disorders, and barriers to making

behavior changes. IRB approval was gained before data collection began. The participants in the research study provided their consent and then conducted a one-on-one interview through Zoom. Recording of the Zoom interview was discussed to ensure the participants consented to be recorded. To maintain confidentiality, the study referred to participants as participants A, B, etc. Transcribed interviews were stored in a locked file cabinet upon the interviewee's consent. All participants were informed of my role as a bariatric counselor who provides PSEs to patients, giving them information on my relationship to the research outcomes. As a Licensed Mental Health Counselor, I was interested in the outcomes of the results related to the lived experiences of post-bariatric patients as it may assist me in my PSEs.

## Summary

A qualitative phenomenological research design was utilized to gain a perspective of the lived experiences of post-bariatric patients with the PSE process they underwent before surgery. This study addressed the literature gap on the collaboration of patients to improve the PSE to better prepare them for the lifestyle changes related to bariatric surgery.

Utilizing semi-structured one-on-one interviews with the post-bariatric patients 12-36 months post-surgery provided much-needed collaboration. The criteria of 12-36 months post-surgical allowed individuals with experience living post-bariatric but also have a good memory of the PSE they experienced. The participants were recruited utilizing open Facebook bariatric support groups and the researchandme.com website to

help recruit the participants. The participants were 12-16 individuals based on reaching data saturation.

The participants were given a copy of the research questions through the email they provided. The participant consented to the research before participating, understanding that the interview would be recorded and transcribed. Participants were informed of my role as a bariatric counselor before the interview. The interviews were transcribed and put into themes of keywords, phrases, and common concepts.

To ensure trustworthiness was met, I utilized reflexivity, bracketing, member checking, and triangulation. These strategies minimized any bias based on my own experiences of conducting the PSE with patients.

Chapter four will demonstrate the data results from the interpretative phenomenological analysis. Chapter four will provide the data needed to answer this study's research questions and discuss recommendations based on the data identified in the study.

# Chapter 4: Findings

The study aimed to understand the lived experiences of 12-36-month post-bariatric patients during their PSE. There remains no standard care procedure during the PSE process despite the possibility of bariatric patients experiencing anxiety, depression, body dysmorphia, emotional eating, and cross-addiction before and after surgery. The findings of this study contribute to the understanding of experiences related to the PSE to understand how its role can improve long-term outcomes. The research questions that guided this study were:

- RQ 1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery?
- RQ 2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery?
- RQ 3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes?

A pilot study was completed to ensure that the interview questions answered the research questions above. The pilot study included two co-workers who had undergone bariatric surgery and were given a PSE. The pilot study determined that the interview questions adequately answered the research questions, and no adjustments to those questions needed to be made. No further adjustments needed to be made to the instruments or data analysis.

The results are presented in this chapter. To provide context to the findings, a description of the sample of 11 12-36-month post-bariatric patients is reported. The participants were interviewed individually for data collection purposes. The data collection method is described in this chapter, followed by a description of the data analysis procedures. The data analysis procedures involved manual thematic coding and Smith et al.'s (2022) IPA. The rigor of the study is shown in the evidence of trustworthiness. The resulting themes from the analysis are presented in the findings section. A summary concludes the chapter.

## Setting

The study was conducted using Zoom. The participants were not required to turn on the camera, but all interviews were audio recorded. The interviews were one-on-one and conducted at a time scheduled by the participants, which allowed the participants to share their experiences in a comfortable and familiar setting of their choosing. There were no personal or organizational disruptions, such as changes in personnel, budget cuts, or traumatic events, that influenced participants or their responses during the study period. The absence of external influencing conditions helped maintain consistency across all interviews and minimized environmental bias.

## Demographics

The sample of this study consisted of 11 12- to 36-month-post-bariatric patients. The plan to recruit 12–16 participants was not met; however, the sample of 11 participants was sufficient to reach data saturation. The process of reaching data saturation is described in the Data Collection and Analysis sections.

All the participants were recruited online via public Facebook bariatric support groups. All the participants were also 21 or older, had bariatric surgery in the past 12-36 months, live in the United States, and are English-speaking. Most of the participants had a history of dieting and weight-related challenges with emotional or stress-related eating rooted in trauma or chronic stress. Some participants had co-morbid conditions including physical health issues and mental health conditions such as anxiety and depression. The participants' profiles, which also served as their experiential statements, are summarized in the following subsections.

**Participant A**

Participant A described dealing with years of fluctuating weight and unsuccessful dieting attempts. The participant viewed bariatric surgery as a tool for lasting change. Preparing for the surgery entailed managing food, vitamins, and logistics. They have a family history of depression, and they were also diagnosed and prescribed antidepressants. However, Participant A reported a positive outlook going into the surgery and felt prepared.

**Participant B**

Participant B shared living with a lap band for 16 years before pursuing additional surgical intervention. Participant B did not elaborate much on emotional or psychological aspects of PSE and the surgery.

**Participant C**

Participant C shared a complex relationship with food due to adverse childhood experiences and health challenges like chemotherapy. The participant referenced

disordered eating patterns such as nighttime eating and a loss of control under stress. Participant C perceived that the exploration of eating habits was limited in the PSE.

**Participant D**

Participant D identified themselves as a stress and emotional eater shaped by significant childhood trauma. Participant D shared that this link between early life adversity and eating behaviors was acknowledged during the evaluation. However, Participant D also stated that the issues were not deeply explored during the PSE.

**Participant E**

Participant E faced serious physical and cognitive health concerns such as transient ischemic attack and multiple comorbidities prior to the surgery. Participant E sought surgery as a potentially life-saving intervention. Participant E described body image dissonance and identity conflict, specifically, feeling young and vital in mind, but disconnected from their external appearance.

**Participant F**

Participant F was already engaged in psychiatric care for anxiety and depression prior to their surgery. The participant faced challenges when the PSE evaluators did not accept the credentials of their psychiatrist.

**Participant G**

Participant G experienced anxiety from the evaluation process itself. The participant noted the fear of the unknown and apprehension about possible outcomes. Participant G shared how the PSE can provoke stress.

**Participant H**

Post-surgery complications led Participant H to hospitalization. The issue triggered Participant H's depression. However, with strong support from family, they managed to recover emotionally and physically.

**Participant I**

Participant I has a history of situational depression and anxiety. Participant I has also not been in recent therapy or on medication. However, they were not concerned about the issue of emotional eating that was discussed during the PSE, as Participant I shared that they did not identify with being an emotional eater. Their main concern was how mental health might impact surgical eligibility.

**Participant J**

Participant J underwent bariatric surgery on January 2, 2024. Their pre-surgical life involved an intense work schedule, juggling three jobs, and frequently resorting to binge eating, particularly while commuting in between jobs. They used to often snack on a known candy bar. The participants' experience with the mental health evaluation process was marked by superficiality. Participant J had the impression that the mental health component was inadequate for addressing their deeper behavioral patterns around food and stress.

**Participant K**

Participant K had surgery on May 12, 2023 after an extended and emotionally charged journey through the mental health clearance process. They initially began mental health services in June 2021 within their insurance network, but their experience with a

clinician led to a denial of clearance for surgery. Participant K explained that they felt rushed through the clinical requirements. The clinician fixated on K's traumatic childhood history of abuse, which Participant K stated that they were not comfortable with. The second surgeon conducted a more conversational assessment that led to Participant K's clearance for surgery.

## Data Collection

The data collection method was individual semistructured interviews. All 11 participants were interviewed. The data collection process followed the plan presented in Chapter 3 without variations. Additionally, no unusual circumstances were encountered during data collection. The participants were recruited from public Facebook bariatric support groups. I obtained authorization from the group administrators to post an invitation to the study. The participant recruitment letter contained an introduction to the study, the nature of data collection, the eligibility criteria, and my email address. The eligibility criteria were being 21 or older, had bariatric surgery in the past 12-36 months, live in the United States, and are English-speaking.

Prospective participants reached out to my email address. I replied with more details about the study and the data collection process as well as a screening questionnaire to validate that the participants met the eligibility criteria. Eleven participants who volunteered were considered eligible. The 11 participants were asked to sign an electronic copy of the informed consent form before their chosen interview schedule.

During the interview schedule, I started with a review of the contents of the informed consent form, focusing on the protection of the participants' rights. When the participants were ready, the interview phase began. I used an interview protocol to guide the conversation across all interviews, but the semistructured nature allowed for the flexibility of asking probing questions. The interviews lasted for approximately 30 minutes each. At the end of the interviews, I informed the participants of the member checking process. The process involved an immediate production of a verbatim transcript of the interview recording. The transcription process was completed through the service offered by Otter.ai. A summary of the keywords was also included in the transcript. The participants were asked to review the transcript and the keywords. The reviewed transcripts were then considered ready for analysis.

## Data Analysis

The data analysis procedures were based on Smith et al.'s (2022) IPA that entailed seven steps. The steps were: (a) reading and re-reading the data, (b) exploratory noting, (c) constructing experiential statements, (d) identifying connections and clustering, (e) naming personal experiential themes (PETs), (f) continuing individual case analysis, and (g) developing group experiential themes (GETs). The analysis was completed through a manual, hand-noting and thematic organization in alignment with IPA guidelines.

I read each transcript three times to immerse in the data. The first round of reading did not involve note-taking to prevent distractions from being immersed in the contents of the transcripts. I became familiar with the general information in the data, and my first impression was that the participants talked more about follow-up care and

support and did not find the PSE to be relevant to their experience of bariatric surgery. During the second round of reading, I engaged in exploratory noting. Specifically, I took notes of descriptive, linguistic, and conceptual comments. Descriptive comments were about the contents in reference to the participants' experiences of the PSE. Linguistic comments were about the tone, repetition, and language use, and conceptual comments were about my preliminary interpretations of the participants' meaning-making.

The third round of reading was to scope the transcripts for anything that I may have missed and to distill experiential statements. I focused on the participants' words and then used personal insights of the participants' words to describe their experiences. For example, the following is an excerpt from Participant A's interview:

> I was ready to make a change. I had been up and down on the scales so many times—I mean, I was a Weight Watchers flunky many times. I'd lose 50 pounds and put on 60. You get the point? Yeah. So, I knew how to take it off, but I didn't know how to keep it off. That's why I thought this surgery was a tool—it was going to help me make changes I hadn't been able to make before. I don't remember being very anxious before surgery. I remember we talked about it, but I don't think it came up much afterward. I felt ready—I had my food, my vitamins, everything in order. I told myself, "Yeah, you've got this," and I really felt that. I wouldn't have missed something like that. I spent 10 years on antidepressants back in the 80s. I come from a family of depressives—alcoholic on one side, depressed on the other. So yeah, I'm very aware of those issues.

From the quote, I derived the experiential statement that Participant A approached surgery with practical readiness through preparedness in food and vitamins. Participant A also viewed the surgery as a tool to deal with past failures with dieting. They also identified a gap in psychological support despite disclosing their personal and familial history with mental health issues. These insights were documented to capture how Participant A made sense of their lived experiences.

After compiling experiential statements for each participant, I identified clusters of meaning across the data. These clusters grouped related experiential statements to reveal deeper structures of meaning. For instance, Participant A's statement about the gaps in psychological support during the PSE encompassing the gaps in information, self-learning, and self-research were grouped into the PET *gaps in preparation information*.

Each cluster of experiential statements was refined and labeled as a PET to represent key facets of that participant's lived experience. PETs retained idiographic integrity and were listed in a table for each case, which consolidated the thematic analysis per participant. This process was repeated for each participant's data before conducting cross-case analysis. The iterative and idiographic approach captured each participant's experience as unique. Each PET was then examined to identify shared patterns. The shared patterns resulted in the identification of a broader, overarching insight that reflected convergences in how participants made sense of their experiences with the PSE. For instance, Participant A's PET *gaps in preparation information* was echoed in the statements of Participants F and G, however, another layer was added to the insights, which was that the gaps in support included lacking direction toward new goals, lacking

discussion about emotional eating and body image, and limited discussion on changes in diet. As a result, the cluster of experiential statements led to the development of the GET *lack of assistance in preparation for lifestyle changes after bariatric surgery*. Overall, seven overarching GETs emerged. These themes were organized into a report. The report of the themes is presented in the Results section.

## Evidence of Trustworthiness

The trustworthiness of the study represents the rigor applied to the research procedures. Trustworthiness can be assessed through the establishment of the following criteria: credibility, transferability, confirmability, and dependability (Merriam & Tisdell, 2015). This section contains a description of the evidence of trustworthiness.

### Credibility

Credibility means the degree of confidence in the accuracy and truthfulness of the study's findings (Merriam & Tisdell, 2015). Establishing credibility entailed grounding the findings to the data to minimize bias. Each step in the research procedure was aligned with the study's problem statement, purpose, research questions, and methodological approach. This alignment created a structure that allowed for the themes to emerge within the scope of the study. A reflexivity journal was kept to document the decisions that helped maintain the study's alignment. Furthermore, the use of Smith et al.'s (2022) IPA steps allowed for the themes to emerge from the participants' statements instead of my ideas alone. Data saturation, the point at which no new information emerges from the data, was also reached. Repeated reading of the transcripts allowed me to check that all relevant statements were accounted in the analysis. No new information emerged after the

analysis of the 11's transcript. Data saturation was part of the proposed methodology, though not a methodological requirement of IPA. According to Smith et al., IPA emphasizes depth over breadth and seeks to explore how individuals make sense of their experiences in rich detail. Thus, in addition to data saturation, I also sought idiographic depth to thoroughly examine the meaning of each participant's narrative.

**Transferability**

Transferability meant the degree of applicability of the study findings to other contexts or populations with similar characteristics (Merriam & Tisdell, 2015). The context of the study including the setting, the sample, and the procedures were reported for readers to make their own judgment about the possible application of the findings to another context. The research gap and the rationale for the chosen methodology were also described.

**Confirmability**

Confirmability means the extent of objectivity of the findings (Merriam & Tisdell, 2015). I engaged in reflexive practices to minimize bias. The reflexivity journal allowed for ongoing awareness and mitigation of personal biases. Adherence to Smith et al.'s (2022) IPA steps entailed the inclusion of direct participant quotes that enhanced the transparency in the emergence of the themes.

**Dependability**

Dependability means the extent of consistency and reliability of the research process over time (Merriam & Tisdell, 2015). An audit trail was maintained to document each step of the research process so that future researchers may replicate the conditions of

this study. Materials such as the informed consent form and interview guide are attached in the appendices. The reflexivity journal was also used to document decisions made throughout the study.

## Results

Seven themes emerged from the analysis. The themes were: (a) lack of assistance in preparation for lifestyle changes after bariatric surgery, (b) received some education and assurance from professionals to prepare for lifestyle changes after bariatric surgery, (c) had a discussion of one's support system after bariatric surgery, (d) did not find PSE to be helpful for mental health, (e) had some discussions about the possible mental health impacts of bariatric surgery, (f) need for a personalized and holistic approach to PSE, and (g) need improvements to follow-up care (see Table 1). The themes are described in this section.

**Table 1**

*Group Experiential Theme Summary*

| Theme | GET | Corresponding RQ |
|---|---|---|
| 1 | Lack of assistance in preparation for lifestyle changes after bariatric surgery | RQ1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery? |
| 2 | Received some education and assurance from professionals to prepare for lifestyle changes after bariatric surgery | RQ1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery? |
| 3 | Had a discussion of one's support system after bariatric surgery | RQ2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery? |
| 4 | Did not find PSE to be helpful for mental health | RQ2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery? |
| 5 | Had some discussions about the possible mental health impacts of bariatric surgery | RQ2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery? |
| 6 | Need for a personalized and holistic approach to PSE | RQ3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes? |
| 7 | Need improvements to follow-up care | RQ3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes? |

## Group Experiential Theme 1: Lack of Assistance in Preparation for Lifestyle Changes After Bariatric Surgery

All 11 participants described the experiences of lacking assistance in preparing for the lifestyle changes following bariatric surgery. The participants discussed their experiences of the gaps in the information provided to them before surgery. Participant A hoped that emotional eating had been discussed during preparation instead of discovering it as a challenge after the surgery. Participant A noted, “I don’t remember emotional eating being brought up, and I wish it had been. It might have helped me recognize and

address those behaviors earlier." Participant G similarly articulated that the evaluation process lacked guidance on managing eating behaviors or providing coping strategies: "The person who evaluated me didn't go into strategies for managing eating behaviors. I had to seek out my own resources afterward." Participant F expressed that the discussion about emotional eating was limited. Participant F shared, "We mostly talked about exercise and drinking water to avoid overeating. I don't recall much discussion about emotional eating." Participant J similarly shared, "I felt like I was going in blind. No one really explained how drastically my eating habits would need to change."

As a solution to the gaps in the PSE process, the participants shared that they sought for information for themselves. Participant E shared independently seeking resources for managing eating behaviors. The participant noted accessing online forums, but the information contained mixed advice. Participant E stated, "I had to ask my nutritionist for resources because my evaluator didn't provide any. I also turned to online forums, but sifting through conflicting opinions was challenging." Participant I reported actively asking questions to gain information but also noted that some patients may need additional mental health services before surgery. Participant I elaborated, "Whenever I asked questions, they provided helpful information on behavioral changes. They also identified potential risks like disordered eating and ensured those who needed additional mental health support got it before surgery."

The participants also shared that they learned most of the changes after their own experiences. Participant F noted that their binge eating behavior remained unaddressed, but they recognized their own need to change their habit: "I'm still working on my eating

behaviors. I have a history of restriction and binge eating, and I was already addressing this before surgery." Participant B admitted to continuously being anxious about their diet after the surgery. Participant B expressed, "It was mind-boggling to eat high-calorie foods just to gain a few pounds and keep my BMI in range. I worried about regaining weight while eating frequently for protein intake. It felt like a juggling act." Participant K noted, "Post-surgery, I realized I had no idea how to handle the emotional triggers that led me to overeat in the first place." Overall, the participants reported lacking the support they needed to face the lifestyle changes following their bariatric surgery.

**Group Experiential Theme 2: Received Some Education and Assurance from Professionals to Prepare for Lifestyle Changes After Bariatric Surgery**

Seven of the 11 participants shared that the PSE prepared them for addressing the barriers to lifestyle changes after bariatric surgery through receiving some form of education and reassurance from the healthcare professionals they worked with. The participants particularly noted the support they received from their doctors, dietitian, and mental health professionals. Participants G and H specified that they received education about changing their habits once they undergo bariatric surgery. Participant G cited the education they received on the possible changes in their consumption of food and in their relationships. Participant G described, "He mentioned that, you know, it's a big change. Relationships can change. He mentioned that… some habits can transfer into other habits." Participant J noted their appreciation for structured guidance: "The dietitian provided a clear roadmap of what to expect, which eased my anxiety about the upcoming

changes." Participant H disclosed receiving information about the possibility of struggling with changing their unhealthy eating habits post-surgery. Participant H stated,

> It gave me a little bit of knowledge as to what to look for, for going forward, and knowing that the help and the security of having the help there was going to be there…The struggle is falling back into old habits, which they did discuss with me, and you know beforehand, and it's falling back into old habits and catching myself doing that and a couple days without exercise, and it's like, nope, you got to get back to it.

Some participants articulated how their doctors provided sufficient information and referred them to a dietitian to prepare for the changes in their diet after undergoing bariatric surgery. Participant C stated receiving clarifications on their misunderstandings about post-surgery lifestyle. Participant C shared, "I received clarity on things I wondered about… if I do the surgery, I have to eat differently." Participant B disclosed,

> I guess the clinic and the doctor I used this time was they were outstanding, because they were the same group that I used when I had the band. And they were very, very informative. I had to go to classes. I met with the dietitian, and it was a much, much easier experience for me, and I think it was because they were so hands on.

In relation, some participants shared that they received sufficient learning materials regarding bariatric surgery and the changes after undergoing surgery. Participant G shared that they were provided with educational materials, including webinars, handbooks, and PDFs, that helped prepare for the lifestyle changes. Participant

G stated, “There were webinars, handbooks, and PDFs covering nutrition, eating strategies, and mindful eating. I used them all and did a lot of research beforehand. I felt fully prepared for the surgery and for my new way of living.” Participant I shared that they were introduced to a comprehensive program covering multiple aspects of health and offering structured guidance toward post-surgery success. Participant I articulated,

> The program covered nutrition, exercise, mental health, and physical health. Each professional provided counseling before and after surgery, tailoring their guidance to my goals. They gave me enough information to succeed, just enough to keep me engaged without overwhelming me.

Some participants reported that they received information about avoiding alcohol and other addictive substances. Participant A, however, admitted that they were not sure whether this information was from the PSE or from personal research: “I may be mixing this up with something I read elsewhere, but I don’t recall her specifically mentioning co-addictions. I’ve come across it in many other places, though.” Participant I expressed learning about the need to avoid alcohol and focus on lifelong dietary awareness and supplementation. Participant I shared, “I remember being told no alcohol, and I just figured my focus for the rest of my life would be on proper diet, vitamin intake, and staying mindful about nutrition.” Participant I also stated that the PSE heavily emphasized emotional eating, but it wasn’t personally relevant for them. Participant I elaborated, “They talked a lot about emotional eating in the PSE, but I never identified with that. Before and after surgery, I didn’t tend to overeat or make bad choices, so it wasn’t something that applied to me.” Participant K noted the benefits of receiving

mental health care: “They addressed the psychological aspects, which made me feel more prepared to handle the emotional rollercoaster.”

One participant described feeling confident after experiencing PSE. Participant C revealed feeling reassured by the questions and discussions but noted some disconnect between different parts of the program. Participant C shared, “One positive was realizing that I could do this. Answering the questions, I felt really good and reassured about my responses. The downside was that it felt somewhat disconnected from what I was already receiving at that agency.”

**Group Experiential Theme 3: Had a Discussion of One's Support System After Bariatric Surgery**

All 11 participants shared that the PSE entailed some discussion about people who would support them after undergoing bariatric surgery. The participants specified having support from mental health professionals, healthcare professionals, support groups, and their family. According to the participants, mental health professionals provided support through encouraging them to reach out to the people around them to address their needs as well as through talking about their feelings and the changes that they might experience after the surgery. Participant D described working with a counselor and social worker, and a psychologist who talked about stress, trauma, emotional eating, and coping strategies. Participant D articulated,

> Before surgery, I met with a counselor, who might have been a social worker, who helped me understand the mental stress of surgery. I also saw a psychologist for an assessment. The counselor discussed my childhood trauma, which I was

> reluctant to explore, but she was kind. She also provided coping strategies like journaling, walking, and recognizing emotional eating habits.

Participant H noted that talking to a mental health professional during the PSE helped them feel reassured that support was available. The participant elaborated the support introduced to them to include online resources and programs focused on recognizing depression and staying on track. Participant H shared, “They assured me that I could reach out if needed and provided an online program to recognize signs of depression and revisit previous training sessions.” Participants C and I noted that working with a mental health professional during the PSE allowed them to understand and explore how the people around them could help them through the post-surgery changes to benefit their mental health. Participant I shared,

> We explored different ways to communicate about the surgery, whether to tell no one, a select few, or be completely open. I chose to tell my closest circle for support. They also provided tools to handle negative feedback and motivational strategies.

Two participants described receiving support from healthcare professionals. Participant B noted interacting with a dietitian who discussed various aspects of post-surgery care, including body image and support availability. Participant B stated, “My dietitian covered key topics in class, including body image and the importance of having support. They reassured me that someone would always be available if I needed help.” Participant I expressed feeling reassured after receiving support before, during, and after the surgery. Participant I described, “It was helpful to see people that were there from all

stages of surgery. So there were people that were there at the start to talk about the process."

Four participants discussed having a support group to talk about their mental health struggles in relation to their experiences of bariatric surgery. Participant J shared, "Being part of a support group where others shared their journeys made me feel less alone and more understood." Participants C and H disclosed that they received referrals for support groups. Participant C noted connecting to both in-person and online support groups through their bariatric provider: "My bariatric provider connected me with a support group, including an online forum and monthly meetings." Participant D shared joining a support group before their surgery to prevent unhealthy eating habits post-surgery. Participant D stated, "I quickly joined a support group after PSE to avoid slipping into constant snacking. The hospital had an in-person group, but I joined an online one instead."

Three participants revealed that they relied on the support of their family as they went through the PSE and the bariatric surgery process. Participant A briefly described, "My family has been very supportive." Participant B expressed that their husband's support helped them overcome self-doubt. Participant B articulated, "My husband has always been supportive. He reassures me constantly, saying he'll love me no matter what. I struggled with feeling unworthy of love due to my weight, but his support has been unwavering." Participant K stated that their sister played a role in their journey: "My sister became my accountability partner, reminding me of my goals and cheering me on every step of the way."

**Group Experiential Theme 4: Did Not Find PSE to Be Helpful for Mental Health**

Eight participants revealed that they did not find the PSE to be especially helpful in targeting mental health issues in relation to bariatric surgery. The participants expressed that the PSE was either too clinical, impersonal, or focused primarily on screening for surgical eligibility instead of providing preparations for the experiences and emotions in the process. Several participants reported the perception that they could not find the connection between the PSE and mental health. Participant B shared their expectation that the PSE would include preparations for maintaining their well-being but found the evaluation to be a cognitive exam. The participant described that they were asked to complete memory and numerical exercises rather than discuss emotional health: "I expected the evaluation to focus on emotions, but it felt more like a cognitive exam. They asked about memory and had me complete numerical exercises instead of discussing mental health concerns." Participant D stated that the exam during the PSE felt impersonal. Participant D expected the evaluation to offer insight into eating behaviors but felt it was simply about answering questions: "I thought the evaluation would help me understand my eating behaviors, but it was just about answering a set of questions. It didn't feel very helpful." Additionally, Participant D described the evaluation as lacking depth. Participant D stated, "The evaluation felt superficial. It seemed more concerned with whether I had an eating disorder than addressing my overall emotional well-being."

Some participants noted that the evaluation did not help with the mental health and further worsened their anxiety over the surgery. Participant G shared that they found the evaluation strictly clinical and focused on assessing whether they were mentally fit

for surgery rather than addressing mental health needs. Participant G explained, “The evaluation felt very clinical, like it was just checking if I was mentally stable enough for surgery, not addressing mental health concerns.” Participant G added, “The evaluation itself caused anxiety, and post-surgery, my support system changed. If the right person and environment had been in place, I think mental health support could have helped.” Participant C had similar experiences and added that going into the facility heightened their anxiety. Participant C noted, “My evaluation was at the same facility where I get psychiatric care, but a different person conducted it. I was nervous. Would my mental health history stop me from getting the surgery?”

Participants E, H, and I expressed that the PSE left them confused. Participant H specified, “The questions left me with more questions than answers. I wasn’t sure how they related to my surgery.” Participant F was the only participants who shared that they were already diagnosed and on medication for depression, but they did not recall mental health being discussed in depth during the evaluation.

Participant A disclosed that the PSE left their mental health struggles unaddressed. Participant A opened up about their personal and family’s history of mental health illness, yet no discussions about mental health occurred during the PSE. Participant A described struggling mentally after the surgery. Participant J reported that they were asked about their mental health history, but no steps were taken to address their issues. According to Participant K, the evaluation felt like a checklist: “I expected a more holistic approach, but it felt like they were just ticking boxes without truly understanding my mental state.” Additionally, Participant K did not find any connection between their eating problems

and the evaluation of their childhood trauma: “She was focusing on the fact that I had been abused as a child… I said, look, somebody should have done this 60 years ago… that wasn’t why I ate.”

**Group Experiential Theme 5: Had Some Discussions About the Possible Mental Health Impacts of Bariatric Surgery**

Six participants reported that the PSE involved some form of discussion about mental health. However, the participants described the discussions to be not comprehensive or consistently impactful. The discussions included managing pre-existing mental health conditions, understanding post-surgical mood changes, and general encouragement in emotional expression.

The participants noted that they felt comfortable and truthful in discussing their mental health history during the PSE. Participant G expressed finding the virtual format as comforting and appreciated the non-stressful nature of the interview, though no specifics about mental health content were discussed: “It was over Zoom and very relaxed. They were friendly and made it feel comfortable, not stressful like I expected.” Participant H similarly preferred the online platform for the PSE. Participant H noted some practical advice for emotional coping and was told to expect mood fluctuations. Participant H disclosed the experience to be emotionally validating:

> Most of the evaluation was done privately online. They advised me to keep busy with things like walking, quilting, or crafting when I noticed emotional triggers. They explained mood changes I might face. I ended up experiencing exactly what they described, emotionally and in setbacks.

Other participants specified the areas of the PSE that they found helpful. Participant B engaged in discussions about the pre-surgery materials they read. Participant B articulated, “We had a chat where I had to share what I read and what I got from it. It helped reinforce the materials.” Participant C reflected on discussions about traumatic food associations, concerns about medication stability, and psychiatric coordination to ensure readiness for surgery. Participant C expressed,

> I wanted to ensure surgery wouldn’t interfere with my meds or mental health. I’m diabetic and a cancer survivor, so both physical and mental health stability were major concerns… My psychiatrist coordinated with the surgical team to confirm my medication readiness before proceeding.

Only Participants I and J reported finding the PSE discussion to be fully helpful especially in addressing body image, body dysmorphia, and coping strategies for situational depression. Participant I elaborated,

> Before the evaluation, I worried that past anxiety and depression might disqualify me, though I hadn’t had recent treatment. They focused heavily on body image and dysmorphia. Mine is reversed. I’ve always seen myself as smaller than I was. They helped me feel more confident and gave practical advice on self-esteem… There was strong focus on anxiety and depression. I appreciated the tools they shared: group therapy, pet therapy, exercise, knowing when to seek help.

Participant J described their evaluator as supportive: “She was really good at explaining that mentally, you have to be ready… she was looking at making sure I was mentally able to tackle this major change in my life.” However, Participant J also found the support

lacking and sought the services of a mental health professional: “I decided to do it on my own. I still talk to her post-surgery too… Because if that [underlying issue] doesn’t get dealt with, you’re just going to revert.”

**Group Experiential Theme 6: Need for a Personalized and Holistic Approach to PSE**

Nine participants stated recommended a personalized and holistic approach to PSE. The participants described tailoring healthcare education and support to individual patient needs instead of a one-size-fits-all model. According to the participants, they hoped for better mental health support during the PSE that consists of integrated and comprehensive mental health services. Starting from building comfort and trust, Participant G recounted their experiences of discomfort with unexpected personal questions during the evaluation. Participant G recommended the need for better preparation and transparency to build trust. Participant G shared, “I was comfortable discussing eating behaviors, but questions about my family background caught me off guard. I wasn't prepared for that.” Participant K revealed the reality that not all patients can follow the recommended care and exercises: “They should have been more honest about what would be realistic based on your age and health conditions… I had to do chair yoga. Not everyone can go to the gym.”

Some participants discussed the need for discussions about the explicit connection between the evaluation and expected physical and mental health outcomes of the surgery. Participant D elaborated their perceptions about the importance of proactive strategies for behavior change through the comparison of their experience in an intervention for

quitting smoking and emotional eating. Participant D stated, “When I quit smoking, I had to plan for triggers like drinking. Similarly, with emotional eating, just being told to find another outlet isn't enough; a concrete plan is essential.” Participant H reflected on the delayed realization of the connection between personal history and surgery particularly regarding depression: “Looking back, I wondered why certain personal history questions were relevant to my surgery, but later realized the link to depression.”

Some participants recommended having better support and resources. One participant described the need for better information about support groups. Participant C specified the need for accessible and clear information of where to reach out for connecting with individuals who have had similar experiences. Participant C shared, “If I wanted to join a support group, where would it be? There wasn't enough information provided… Conversations with people who've been there would help, but no recommendations were given.” Three participants described the need for individualized support, especially an individualized care plan to address their unique needs instead of the checkbox approach. Participant E shared, “The evaluation felt like a checkbox exercise, not offering personalized support suggestions. It felt like just getting a permission slip, without making meaningful connections.” Participant D noted the need for deeper conversations about individual eating behaviors. One participant noted the need for better learning resources. Participant F criticized the outdated and confusing educational booklet provided, which implied the need for an updated and clear material: “The booklet covered surgeries they no longer perform and mixed dietary guidelines,

making it confusing." Participant J expressed, "There should be more than one technique because not everyone deals with it the same way."

**Group Experiential Theme 7: Need Improvements to Follow-Up Care**

Six participants focused their recommendations on follow-up care instead of the PSE. The participants described the need for sustained, individualized, and comprehensive post-surgery support systems. According to the participants, they hoped for better support in terms of dealing with the changes in their body. The participants noted the emotional and psychological adjustments they went through after the surgery. Participant G stated being conflicted about the changes in their life following the surgery. Participant G articulated, "I lost weight so fast that I wasn't used to seeing myself thin. People's reactions were all over the place. It affected my mental health too." Participant D disclosed their difficulty in sustaining a healthy eating habit and discussed the need for more emotional support. The participant shared, "The weight just fell off at first, but once my body healed, old habits came back. I'm an emotional eater, and I had to face that without much support." Participant B expressed struggling with body image and felt anxious about their size and hair loss. Participant B shared, "Even after losing weight, I kept buying the same size clothes because I couldn't see the change… I was worried about hair loss after surgery, especially with my thin hair and sister locks."

In search of better follow-up support, the participants revealed the need for better support groups. The participants reported the need for more accessible, inclusive, and effective support groups. Participant E reported that current support groups lacked visibility despite the group being generally beneficial. Participants B and I expressed

their need for deeper engagement with the support group. Participant B specified that the support groups they attended mostly focused on helping new patients, not those adjusting after surgery. Participant B further stated that their other obligations in life hindered them from being committed to the support group: “I was more active in the beginning, but now it’s harder to join regularly because I watch the kids.” Participant B’s suggestion was to have smaller groups for better mutual accountability and understanding: “Having a partner or a small group to chat with would help. That kind of support is the best way forward.” Participant I advocated for a comprehensive, personalized support program. Participant I stated, “People need one-on-one and group therapy, with a plan that fits their needs. Everyone’s triggers are different. It shouldn’t be one-size-fits-all.”

The participants also noted that the follow-up care they experienced had lapses and left some issues unaddressed. The participants described dropped communications, insufficient long-term planning, and difficulties accessing additional procedures due to insurance and poor guidance. Participant A cited poor internet and travel schedule as barriers to consistent group participation: “Zoom groups were held regularly, but bad internet while traveling in the RV made it tough. I ended up using other support groups instead.” The participant also revealed losing touch with their care team after 8 months due to insurance changes and logistical hurdles: “They followed up for about 8 months, but by a year we lost contact. Now it’s been a year and a half. I should’ve had another follow-up.” Participant K also lost touch with their care team and continued to struggle with their weight. Participant K expressed, “After six months of seeing a psychiatrist monthly, there was no continued care. I never really lost the weight, and I’ve been

passing the same four pounds back and forth for months." Participant H reported the need for better information about caring for their post-surgery body including extra skin removal procedures. Participant H revealed, "I didn't know insurance needed proof of issues before covering skin removal."

## Summary

This chapter contained the presentation of the results. The study aimed to understand the lived experiences of 12-36-month post-bariatric patients during their PSE. Eleven males and females above the age of 21 years old who have had bariatric surgery in the range of 12-36 months post-operative were selected as the sample of this study. The participants were interviewed individually, and the interview data were analyzed thematically. The analysis resulted in the emergence of seven themes that answered the RQs. The themes were: a) lack of assistance in preparation for lifestyle changes after bariatric surgery, (b) received some education and assurance from professionals to prepare for lifestyle changes after bariatric surgery, (c) had a discussion of one's support system after bariatric surgery, (d) did not find PSE to be helpful for mental health, (e) had some discussions about the possible mental health impacts of bariatric surgery, (f) need for a personalized and holistic approach to PSE, and (g) need improvements to follow-up care.

The participants shared mixed perceptions about how the PSE prepared them for post-surgical lifestyle changes. The participants mostly reported that the evaluation lacked depth and failed to address issues such as emotional and disordered eating. The lack of preparedness left them feeling unprepared for the behavioral adjustments required

after surgery. According to some participants, they relied on self-directed learning and informal support systems. Some participants shared that they did receive basic education and emotional reassurance through the PSE. The participants reported that they found guidance from healthcare professionals and found structured resources like webinars and handbooks helpful. In cases where the PSE took a more holistic and collaborative approach, the participants expressed feeling more confident and informed about expected outcomes and experiences.

The participants also provided a range of perspectives on the PSE's effectiveness in preparing them for mental health and emotional or disordered eating challenges post-surgery. Several participants acknowledged some level of support discussion through mental health professionals, healthcare providers, support groups, or family. However, the conversations felt superficial. Some participants expressed finding reassurance in knowing support was available and appreciated referrals to resources, yet most participants criticized the PSE for being overly clinical without making meaningful connections between the PSE process and mental health.

Thus, the participants recommended a more personalized and holistic approach to improve the PSE. The participants discussed tailored evaluations and resources to individual experiences and incorporating comprehensive mental health support. Concrete behavioral strategies, similar to those used in other health interventions, were suggested to help manage emotional eating and stress. The participants also revealed the need for updated educational materials and accessible information on support systems. Nonetheless, the participants also focused on recommendations for better follow-up care.

Suggestions included more inclusive and consistent support groups, smaller or peer-based accountability formats, individualized follow-up plans, and improved guidance on long-term needs such as excess skin removal.

The results reported in this chapter will be interpreted through the lenses of the HBM and self-efficacy in the next chapter. The discussion of the findings will include relating the themes to existing literature about the ways the PSE prepares a patient for emotional distress, coping strategies for barriers, and negative experiences post-surgery. The conclusions of the study are also presented in the next chapter.

# Chapter 5: Discussion, Conclusions, and Recommendations

The problem that this study aimed to address was that bariatric patients do not have a standard of care during the PSE. In addition, the PSE is primarily utilized to determine the patient's psychosocial functioning and contraindications for surgery, but mental health professionals who administer the PSE have an opportunity to contribute more to the long-term lifestyle change of the patient. The purpose of this study was to examine the lived experiences of post-bariatric patients with the PSE. Specifically, it provided insight into their behavioral and mental health interventions to learn how the PSE could benefit future bariatric patients. This study provided a much needed understanding of patients' perspectives on whether the PSE prepared them for the possible post-bariatric barriers to lifestyle changes and issues with mental health and emotional/disordered eating. Ultimately, it allowed for collaboration with the patient population with the goal of informing providers of the PSE of potential improvements to the process.

This study utilized a qualitative design as interviews were conducted with each participant. It also utilized IPA because it was the most ideal way to understand the lived experiences of bariatric patients with the PSE. The research questions that guided this study were:

- RQ1: How did post-bariatric patients feel the PSE prepared them for barriers to lifestyle changes after bariatric surgery?
- RQ2: How did post-bariatric patients feel the PSE prepared them for strategies in managing mental health and emotional or disordered eating after surgery?

- RQ3: How do post-bariatric patients feel the PSE could be improved to better prepare future patients for bariatric lifestyle changes?

The sample of this study consisted of 11 post-bariatric patients, which was sufficient to reach data saturation. These participants, who were at least 21 years old, had bariatric surgery in the past 12-36 months, lived in the United States, and spoke English, were recruited online. Data were collected through remote individual semistructured interviews. Qualitative noting was used to determine the themes from the interviews. Data were analyzed based on Smith et al.'s (2022) steps, including (a) reading and re-reading the data, (b) constructing experiential statements, (c) finding connections and conducting mapping, and (d) organizing the themes.

The data analysis resulted in seven GETs. Participants reported that (a) there was a lack of assistance in preparation for lifestyle changes after bariatric surgery, (b) they received some education and assurance from professionals to prepare for lifestyle changes after bariatric surgery, (c) they discussed one's support system after bariatric surgery, (d) they mostly did not find PSE to be helpful for mental health, (e) they had some discussions about the possible mental health impacts of bariatric surgery, (f) there is a need for a personalized and holistic approach to PSE, and (g) there is a need for improvements to follow-up care. These GETs answered the three research questions of this study. Ultimately, participants had mixed feelings about how the PSE prepared them for post-surgical challenges with lifestyle changes and mental health, and they recommended a more personalized and holistic approach to improve the PSE for future patients as well as improvements to follow-up care.

## Interpretation of the Findings

These findings will be interpreted in terms of both empirical and theoretical literature. To provide context on the participants, most had a history of challenges with eating habits due to trauma or chronic stress, and some experienced issues with physical and mental health. As for the PSE, the ASMBS (2022b) provides recommendations, including having a bariatric-specific behavioral health clinician that is knowledgeable about the lifestyle change and long-term care involved after bariatric surgery. However, it has been found that bariatric patients often describe the PSE as a negative experience as it is often seen as just something to check off their list with no benefits, as well as that there is no purpose, standard of care, or recommendation for the roles of the multi-disciplinary team in a bariatric program (Sahar & Riazi, 2021).

### Findings and Empirical Literature

The findings of this study will be compared to those from other studies. Each research question will be related to relevant empirical literature. The GETs that answer each research question will also be discussed in terms of such research.

#### *Research Question 1*

Regarding Research Question 1, participants had mixed feelings about how the PSE prepared them for barriers to lifestyle changes after bariatric surgery. The ASMBS requires several behavior changes in their guidelines for life after surgery, including following a particular diet, taking vitamins and minerals, exercising, and avoiding alcohol and smoking. It has been found that post-surgery nutritional needs protect patients from poor health outcomes (Guillet et al., 2020), but barriers to these lifestyle changes include

stress, the need to plan ahead, the cost of healthy food, time and pressure, being around food they should not eat, the cost of exercise, and burnout (Ariel-Donges et al., 2020). Thus, although post-surgery lifestyle changes are necessary for successful weight loss, they can be difficult to adhere to.

GET 1 was that all participants reported a lack of assistance in preparation for lifestyle changes after bariatric surgery. Specifically, they stated that there was a gap in information provided before surgery, so they sought information themselves, but they learned mostly by experience after surgery. Furthermore, it has been found that patients can experience mental health issues, substance abuse, body image issues, and emotional eating due to the difficult long-term lifestyle changes, as well as that mental health professionals play a role in providing interventions for these issues (Sarwer & Heinberg, 2020). Thus, post-surgery problems can occur due to lifestyle changes, but this tends to not be addressed in the PSE even though mental health professionals can help with these problems.

GET 2 was that some participants received education and assurance from professionals to prepare for lifestyle changes after bariatric surgery. Specifically, they stated that they received support from their doctors, dietitians, and mental health specialists. Furthermore, it has been found that both the PSE and post-surgical follow-up play a role in addressing the challenges of lifestyle changes for patients (Bianciardi et al., 2021). Thus, although the PSE tends to be a negative experience in terms of lifestyle changes, it is more positive when patients receive help with such issues.

***Research Question 2***

Regarding Research Question 2, participants also had mixed feelings about how the PSE prepared them for strategies in managing mental health and emotional or disordered eating after bariatric surgery. The ASMBS states that the psychological assessment is an opportunity for patients to build relationships with their behavioral specialists and that having both pre-surgical and post-surgical care is necessary for better outcomes after surgery. As for mental health, it has been found that issues such as depression and anxiety can improve in patients from pre- to post-operation (Ribeiro et al., 2018), but weight loss alone does not improve patients' mental health after surgery (Morgan et al., 2020). As for emotional/disordered eating, it has been found that bariatric surgery can help manage binge eating disorder, but patients with a history of this issue are more likely to experience weight regain (Billing-Bullen et al., 2022). Thus, surgery can improve patients' mental health and eating habits to some extent, but problems can still occur.

GET 4 was that many participants reported that the PSE was not very helpful for mental health. Specifically, they stated that the PSE was either too clinical, impersonal, or focused on screening for surgical eligibility. In addition, as for emotional/disordered eating, one participant stated that the PSE was about answering questions rather than helping them understand their eating behaviors. Furthermore, it has been found that post-surgery patients can experience psychosocial difficulties, including dealing with the perceptions of others and adjusting to not using food as an emotional coping skill, as well as that patients do not feel the PSE is a good or personal experience (Griauzde et al.,

2018). Thus, patients can experience issues with mental health and eating habits after surgery, but this tends to not be addressed in the PSE.

GET 5 was that some participants reported having discussions about the possible mental health impacts of bariatric surgery. Specifically, they stated that these discussions involved managing pre-existing mental health conditions, understanding post-surgical mood changes, and encouragement of emotional expression. In addition, as for emotional/disordered eating, one participant stated that the PSE was helpful in addressing body image issues. Furthermore, it has been found that although bariatric surgery is an effective obesity treatment, risks of weight regain, depression, and unhappiness with body image are prevalent in post-surgical patients, but therapeutic work both pre- and post-surgery on body image, motivation, and eating behavior demonstrates better outcomes (Cheroutre et al., 2020). Thus, even though the PSE tends to be a negative experience in terms of mental health and eating habits, it is more positive when patients receive help with such issues.

GET 3 was that all participants reported having discussions about their support systems after bariatric surgery. Specifically, they stated that they received support from mental health professionals, healthcare professionals, support groups, and their family, who helped them with issues related to mental health and eating habits. Furthermore, it has been found that depression and eating disorder symptoms are higher in patients who do not have a solid social support system (Conceição et al., 2020), while encouragement from support systems on achieving a behavior change had a positive effect (Dahlberg et

al., 2022). Thus, support systems are important in preventing post-surgery problems with mental health and eating habits.

***Research Question 3***

Regarding Research Question 3, participants gave multiple recommendations for how the PSE could be improved to better prepare future patients for bariatric lifestyle changes. GET 6 was that some participants saw a need for a personalized and holistic approach to PSE. Specifically, they suggested tailoring healthcare education and support to individual patient needs, having discussions about the connection between the evaluation and physical and mental health outcomes, and having better support and resources. Furthermore, it has been found that interventions should be more personal to the bariatric patient to address their specific challenges (Bianciardi et al., 2021), as well as that a multidisciplinary approach including mental health professionals, nutrition professionals, and physicians is important in creating long-lasting changes (Mechanick et al., 2019). Thus, the PSE has the potential to help patients, and it can be improved by making it more personalized and holistic.

GET 7 was that other participants focused on improvements to follow-up care rather than the PSE. Specifically, they suggested having individualized and comprehensive post-surgery support systems. Furthermore, it has been found that following up with nutrition and mental health counseling is important in limiting weight regain and that working with behavioral change professionals is connected to continued dietary and lifestyle changes (Masood et al., 2019). Thus, post-surgery care has the

potential to help patients, and it can be improved by making it more individualized and comprehensive.

### *Study Significance*

There is a research gap in terms of bariatric patients' perspectives as many studies do not directly work with them. This study helped bridge this gap through collaborating with such patients. In addition, much of the literature focuses on post-surgery interventions for the challenges that bariatric patients can face. This study builds on this research by providing insight into how patients are prepared before surgery for issues related to behavior changes, mental health, body image, and emotional eating after surgery, as well as how this process can be improved.

## Findings and Theoretical Literature

The findings of this study also relate to its conceptual framework. This lens combines the HBM and the self-efficacy theory. Each of these will be discussed in terms of results from this study and others.

### *Health Belief Model*

The HBM states that an individual's beliefs about the benefits of a behavior change and the barriers that they face determine if a behavior change is made (Glanz et al., 2015; Rosenstock, 1974). The constructs of this model include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action, as well as self-efficacy, which was added later. If the perceived benefits based on the severity of the condition outweigh the perceived barriers, then a cue to action to make a behavior change will occur.

This model is relevant to bariatric patients because studies have found that an individual's ability to manage perceived barriers and their self-efficacy in making behavior changes are important in adopting positive health behaviors (Kebede et al., 2023). Specifically, self-efficacy has been found to be significant in adhering to healthy behaviors such as good nutrition and exercise in weight management programs (Saghafi-Asl et al., 2020). This model applies to Research Question 1 on preparation for lifestyle changes after bariatric surgery because improving a patient's ability to overcome barriers can help them successfully adapt to life post-surgery.

### *Self-Efficacy Theory*

Since self-efficacy is a construct of the HBM, it is connected to the self-efficacy theory. This theory states that an individual's belief in their ability to adopt a positive behavior change impacts their success in making the change (Bandura, 1977). Influences on self-efficacy include success or failure in the behavior, judging one's ability to adopt the behavior compared to others, amount of support from others in terms of one's ability to adopt the behavior, and environmental factors such as psychological and physical challenges (Bandura, 1997).

This theory is relevant to bariatric patients because studies have found that patients with lower self-efficacy in making health behavior changes are more likely to struggle with the bariatric lifestyle changes, while patients with higher self-efficacy are more likely to adhere to these changes (Pyykkö et al., 2023). Patients' self-efficacy can be increased by feeling like they have mastered the behavior and seeing success towards their goals (Dahlberg et al., 2022). This theory applies to Research Question 2 on

managing mental health and emotional or disordered eating after surgery because increasing a patient's self-efficacy can lead to better mental health and eating habits. This theory also applies to Research Question 3 on improvements to better prepare future patients for bariatric lifestyle changes because including methods for increasing self-efficacy in the PSE can result in better outcomes post-surgery.

## Limitations of the Study

Although this study contributed valuable information to the field, it did have some limitations. One limitation noted in Chapter 1 is that my role as a bariatric counselor could have resulted in researcher bias, meaning that my background may have influenced the study. Another limitation is that the data was self-reported by participants, which could have resulted in social desirability bias, meaning that participants may have answered questions in ways that they believed to be favorable rather than giving their true opinions. In addition, it may have been difficult for participants to remember their pre-surgical experiences a year or more after they occurred, meaning that their reports may not have been accurate.

Additional limitations were thought of during reflection after the study was conducted. One such limitation is that qualitative research necessitates a small sample size for timely data analysis, meaning that the findings may not be generalizable to the broader population. Another limitation is that phenomenological research may result in subjective perceptions, meaning that the findings may not be factual. An additional limitation is that pre-surgery patients and those less than 1 year post-surgery were excluded, meaning that the findings may not be comparable.

## Recommendations

To reiterate, this study had limitations that were noted before and after the study was conducted. As for the former, there may have been bias from both mine and the participants, and the participants may not have been able to accurately recall their experiences. As for the latter, the study's qualitative and phenomenological design may have made the findings ungeneralizable and subjective, and the results may not be applicable to patients at other time periods. These limitations can be addressed by future research. To do so, it is recommended that:

1. A longitudinal study should be conducted by non-biased researchers. Specifically, it should ask bariatric patients for truthful reports on their current state before surgery, soon after surgery, and 1 year after surgery. This will allow for more accurate results on the effectiveness of the PSE.
2. This new study should also utilize a quantitative methodology and include a large sample size. Specifically, it should widely disseminate a closed-ended survey to collect a substantial amount of numerical data. This will allow for results that are more generalizable and objective.

Several recommendations for future research are also made by the literature reviewed in Chapter 2. First, Dahlberg et al. (2022) stated that future studies should further investigate the experiences of post-bariatric patients to create pre- and post-operative interventions that increase self-efficacy. Second, Ariel-Donges et al. (2020) stated that future research needs to explore strategies to increase self-determination as it could improve internal motivations, sense of knowledge, and power over making lifestyle

changes. Third, Morgan et al. (2020) stated that future studies should compare and better understand the PSE and its role in creating behavior change. Fourth, Atwood et al. (2021) stated that future research needs to examine how assessment may be significant in long-term lifestyle change outcomes. Fifth, Bianciardi et al. (2021) stated that future studies should address patient attitudes and disordered emotional eating to benefit the population. Sixth, Ristanto and Caltabiano (2019) stated that future research needs to determine the most beneficial counseling interventions for the population.

## Implications

This study leads to several implications. These suggestions are based on the research questions and their associated GETs. Actions to accomplish these objectives will be recommended.

### Positive Social Change

If the PSE is improved as suggested by this study, mental health professionals could better prepare bariatric patients for the challenging lifestyle change required for successful outcomes. Such clinicians could use this study to obtain a better understanding of the lived experiences of bariatric patients and enhance the PSE by providing direction for patients (Bianciardi et al., 2021). It is also important to enhance the collaboration between mental health providers and other clinicians to create a more patient-centered approach to the PSE (Sahar & Riazi, 2021).

### Patients Need Better Preparation for Lifestyle Changes After Surgery

The first implication of this study is that the PSE should better prepare bariatric patients for potential barriers to lifestyle changes after surgery. The findings were that

although some participants reported receiving education and assurance from professionals, there was an overall lack of assistance in preparation for lifestyle changes after surgery. This problem should be addressed to prevent post-surgery weight regain. Based on these findings, the following actions are recommended:

1. The PSE should be expanded beyond eligibility for bariatric surgery to include lifestyle changes after surgery. To do so, behavioral health professionals should be trained to educate patients on the possible challenges with the required lifestyle changes and how to overcome them.
2. The PSE should be standardized so that all bariatric patients receive the same high-quality lifestyle change care. To do so, rules for PSE training for behavioral health professionals should be created and disseminated, and sessions should be observed by an expert to ensure compliance.

**Patients Need Better Preparation for Mental Health Issues After Surgery**

The second implication of this study is that the PSE should better prepare bariatric patients for potential mental health issues after surgery. The findings were that although some participants reported having discussions about the mental health impacts of bariatric surgery, more reported that they did not find the PSE to be helpful for mental health. This problem should be addressed to enhance post-surgery mental health outcomes. Based on these findings, the following actions are recommended:

1. The PSE should be expanded beyond eligibility for bariatric surgery to include mental health after surgery. To do so, mental health professionals

should be trained to educate patients on the possible mental health challenges and how to overcome them.

2. The PSE should be standardized so that all bariatric patients receive the same high-quality mental health care. To do so, rules for PSE training for mental health professionals should be created and disseminated, and sessions should be observed by an expert to ensure compliance.

**Both Pre- and Post-Surgery Patient Care Should Be Improved**

The third implication of this study is that both the PSE and follow-up care for bariatric patients should be improved. The findings were that some participants reported a need for a personalized and holistic approach to the PSE while others reported a need for individualized and comprehensive follow-up care. This problem should be addressed to increase the quality of care for patients at all stages of the process. Based on these findings, the following actions are recommended:

1. Both the PSE and follow-up care should be enhanced so that bariatric patients receive the care they need. To do so, professionals should be trained to tailor care to each patient's specific needs, with guidelines for each type of patient to maintain consistency.
2. Mental and physical health professionals should work together to better help bariatric patients. To do so, they should be trained to collaborate with those in fields other than their own, with guidelines for each type of professional to maintain consistency.

## Conclusion

In summary, this study found that bariatric patients had mixed feelings about how the PSE prepared them for issues with lifestyle changes and mental health. As for lifestyle changes, participants reported both that there was a lack of assistance in preparation for life after surgery and that they received some education and assurance from professionals to prepare for life after surgery. As for mental health, participants reported both that they did not find PSE to be helpful and that they had discussions about the possible impacts of surgery and their support systems after surgery. Participants also made several suggestions for improving both pre- and post-bariatric care. As for the PSE, participants reported a need for a personalized and holistic approach. As for follow-up care, participants reported a need for sustained, individualized, and comprehensive support systems.

This study also made several recommendations in terms of future research and implications. As for future research, it should be longitudinal, non-biased, quantitative, and large-scale. As for implications, the PSE should be standardized and provide information on post-surgery lifestyle changes and mental health, and both the PSE and follow-up care should be patient-specific and collaborative. These recommendations should be followed to improve the physical and mental health of bariatric patients.

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# Appendix A: Recruitment Letter

Greetings,

I am a researcher seeking to recruit post-Bariatric patients who had gastric bypass or vertical sleeve gastrectomy (VSG) within the past 12-36 months. The participants will be asked to share their experience with the Pre-Surgical Mental Health Evaluation (PSE) and how it prepared them for mental health and lifestyle change challenges after bariatric surgery was completed. Those who participated in this study will be anonymous, and both males and females over the age of 21 are welcome to participate. Participants must be English-speaking, live within the United States, and understand the consent they are required to sign for participation. The study is only seeking to understand your experiences with your specific PSE process and how it prepared you for challenges related to mental health, eating disorders, and lifestyle changes. If you are interested and meet the requirements, please email me at [redacted].

# Appendix B: Recruitment Flyer

Post-Bariatric Research Study Participants Wanted, 12-36 Months Post-Op

This study about the experiences of post-bariatric patients could help mental health providers better understand the needs of their patients. For this study, you are invited to describe your experiences of your pre-surgical evaluation prior to having bariatric surgery.

About the study:

- One 30–60-minute Zoom interview that will be recorded
- Review a typed transcript of your interview to make corrections if needed by phone or email (10 min)
- Speak with the researcher one more time after the interview to hear the researcher's interpretations and share your feedback (this is called member checking, and it takes 20-30 minutes; phone option available)
- To protect your privacy, the published study will not share any names or details that identify you
- Volunteers must meet these requirements:
- Had bariatric surgery in the past 12-36 months
- Are over the age of 21
- Participated in a pre-surgical mental health evaluation prior to bariatric surgery

This interview is part of the doctoral study for Nathan Wharton a Ph.D. student at Walden University. To confidentially volunteer, contact the researcher.

# Appendix C: Demographic Questionnaire

Please complete this demographic portion of the interview. It would help if you answered each question accurately and honestly. The researcher will not reveal any personal information in the study's results.

1. Please indicate your age (21 years or older):
2. Please indicate your gender (male or female):
3. Have you had a gastric bypass or vertical sleeve gastrectomy in the past 12-36 months?
4. Do you reside in the United States?
5. Do you speak and read the English language?

# Appendix D: Interview Questions

**Experiences of the Pre-Surgical Mental Health Process**

1. Tell me about your thoughts on your pre-surgical mental health evaluation before bariatric surgery.
    1A. What made it a positive experience?
    1B. What made it a negative experience?
    1C. Did you feel comfortable discussing mental health and eating behaviors during the PSE?
2. What was your experience with your PSE process regarding strategies for managing;
    A. emotional eating
    B. body image
    C. anxiety
    D. depression
    E. Discussing changes with support systems
3. What was your experience with your education/instruction about the behavioral changes before weight loss surgery during your PSE?
4. What specific barriers did you face with the behavior changes after surgery?
    A. In what ways did the PSE process prepare you for the barriers you identified?
5. In your experience with the PSE process, were resources for follow-up care discussed with you?
    A. What was the recommendations for follow up mental health?
    B. What was the recommendations for follow up on maintaining lifestyle change?
6. In your experience with the PSE, what would you recommend be included in the PSE process for future patients?
7. What mental health/body image/emotional eating should be discussed in the PSE that was not?