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Samone Marion

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Walden University
2018

Abstract

A Qualitative Study of Factors Related to Weight Regain Following Roux-en-Y Surgery.

by

Samone Marion

MA, University of Phoenix, 2013

BS, University of Phoenix, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

General Research Psychology

Walden University

February 2018

Abstract

During the past decade, obesity has become a worldwide epidemic, and bariatric surgery has been used to treat obesity. Previous researchers have addressed the success of the Roux-en-Y bariatric (RYGB) surgery within 12 months or later of the surgical procedure; however, a lack of research exists regarding participant success in maintaining their post-surgery weight loss long term. The current qualitative, phenomenological study was based on the conceptual framework of social learning and examined the beliefs, experiences and perceptions of women who underwent RYGB weight loss surgery but did not maintain their ideal weight during the 1st year and later following surgery. Participants included women at least 18 years of age who had undergone RYGB surgery 12 months or later prior to the study and who had regained 20–40% of their weight. Semistructured interviews with 8 recipients were conducted to gain an understanding of the experiences that hindered the maintenance of participants' long-term weight loss goals. Convenience Sampling was used to analyze the experiences of women post-surgery. Results suggest that important factors were commitment to change, the effects of body change and social support. These factors were based on sub-textual themes of eating habits, quality of life, lifestyle change, mentality, misconceptions of surgery, weight loss, excess skin, social support, and weight regain. This study contributes insight into weight gain and weight loss maintenance following bariatric RYGB surgery, and is useful for medical and weight loss professionals, bariatric patients, and community members. Stakeholders increased understanding of weight gain and weight loss maintenance following RYGB surgery.

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Dedication

I want to first, and foremost thank "God" for allowing me the chance to embark upon this journey. You allowed me to remain focused, stay motivated and gave me the extra push to persevere when I was tired and at a loss for words, you made my dreams possible and reachable. Dr. Elbert and Ada M. Cowling and Willie D and June Maxine Coleman Sr. (My Parents), thank you for teaching me to reach for the stars. Although the journey sometimes seems confusing your biblical teachings, smiles and life experiences motivated to me complete the mission. To my wife Pamela June Coleman, you are a jewel. You made continuous sacrifices by encouraging me to stay on task, even though it took time from our lives and family. You always kept busy by reading, playing cognitive games, picked up the slack around the house, cooked dinner and many nights left me up typing and reading. I love you so much and thank-you for supporting me through this journey. Elberaette Cowling, my "BIG" sister (the Matriarch) of my family, you stepped in and spoke up when family members inquired about my missing in action. You stood up for me and told them she's at home completing the most important step in her life, not all are privileged "The completion of the book" I love you and thank-you for your support. Jevestine Coleman, my sister, and my friend. You always made me feel special and told me you were proud of me. My sister's Gena W, Kim W, and Tanya Gillard and my brother Keith Underwood thank-you for your support it meant the entire world to me.

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Chapter 1: Introduction to the Study

Introduction

Obesity impacts individuals from every cultural background, age group, gender, and socioeconomic group. It has become one of the leading causes of illness and premature death in the United States and surrounding countries (Flegal, Carroll, Ogden, & Curtin, 2010). Previous studies have shown that weight-loss surgery is the optimal treatment for obesity and combatting preexisting medical issues; however, patients have reported difficulty in maintaining the weight loss long-term (Wysoker, 2005). The psychological effects resulting from the difficulty in maintaining weight loss long-term include low self-esteem, weight-related depression, anxiety, social isolation, and eating disorders (Huberman, 2008). In addition to the physical and psychological effects, obesity significantly affects an individual's quality of life in the area of employment. The employer pays a higher cost in health care from time off work because of preexisting medical issues related to obesity (Bachman, 2007). The consequences of obesity cause health care professionals to search for effective treatments for weight loss because many of the current diet programs and behavior treatments promote short-term weight loss where individuals regain what they lost or surpass their original weight (Huberman, 2008). Weight loss surgery (WLS) patients often fail to lose, fail to maintain, and regain weight due to cognitive and behavioral adherence difficulties. This lack of behavioral adherence plays a significant role in weight maintenance following surgery (McVay et al., 2012). Psychological screening for WLS patients pre- and postsurgery may help

identify barriers attributed to the overall treatment for overcoming obesity and weight-related comorbidities (Canetti, Berry, & Elizur, 2009).

Background of the Study

Bariatric surgery is a relatively new treatment for the severely obese individual. These surgeries have increasingly been used for individuals who have not had success with nonsurgical interventions, which sometimes result in modest weight loss followed by increased weight gain (Sheets et al., 2015). Bariatric surgery results in massive weight loss and may resolve or improve preexisting medical morbidities. The surgery is recommended for adults with a body mass index (BMI) of 35 or higher with severe obesity-related conditions (NIH, 1991). According to Buchwald and Oien (2009), gastric banding (GB), Roux-en-Y (RYGB), sleeve gastrostomy, and biliopancreatic diversion with or without the switch are the most common procedures for weight loss (Sheets et al., 2015).

The definition of "successful" weight loss can differ following each procedure. The rate of weight loss can range from 20–30% of a person's total weight (Devlin, Goldfein, Flancbaum, Bessler, & Eisenstadt, 2004). Many who undergo RYGB surgery equate it to having a second chance on life and being reborn into a newly created body (Bocchieri, Meana, & Fisher, 2007). As a result of the body altering changes made by surgical procedures, patients must learn to dress, eat, drink, and walk all over again (Ogden & Clementi, 2010; Thorsby, 2008). Weight-loss respondents even have slowly adapted themselves back into society learning new people, embracing old friends, mentors, employers, and potential mates.

After losing a significant amount of weight, many weight loss respondents celebrate their new life by saying “happy reborn day” (Boccieri, Meana, & Fisher, 2007; Throsby, 2008). Weight-loss surgery recipients are often unsure of their acceptance by family, peers, and themselves, so they begin to increase their independence by eating and drinking with the small-restructured pouches. The recipients begin the process of embracing their new identity and new life.

Byrne, Cooper, and Fairburn (2003) provided information on weight management and relapse related to obesity. The key factors in relapse reported by respondents included feeling that the weight loss failed to achieve their ideal weight goals. In addition, respondents reported dissatisfaction with the weight loss they achieved, resulting in the tendency to evaluate self-worth in relation to body weight and shape (Byrne et al., 2003). Psychological findings included a lack of vigilance for weight control, black and white thinking style, and the inclination to use eating to regulate mood (Byrne et al., 2003).

Chaar (2013) and Hamilton (2008) discussed the correlated factors for individuals who did not lose weight after weight-loss surgery. The key factors included anatomical, physiologic, body image, and depression factors, which played a role in participants’ acceptance of a new self-image. Researchers have found that after weight loss, individuals often exhibit poor coping skills and low self-esteem related to the effects of their new body and lifestyle changes (Chaar, 2013; Hamilton 2008).

Davin and Taylor (2009) provided a comprehensive review of obesity, including behavioral, psychological, and pharmacology considerations for treatment. Key treatment

factors include identification of the psychological and social influences that may assist in predicting successful treatment long-term. Mental health providers are needed in the plan to address the obese individuals psychosocial, physical, psychological factors and social basis factors by providing a comprehensive assessment to ensure proper treatment is warranted (Davin & Taylor, 2009).

Additionally, Gunstad, Strain, and Devlin (2010) analyzed the improvement of memory function 12 weeks after bariatric surgery. Weight-loss surgery respondents exhibited high rates of preoperative cognitive impairments in attention, executive function, memory, and language related to obesity, and memory function improved following surgery (Gunstad et al., 2010).

Myers (2005) studied psychological management after bariatric surgery, and provided a guide for mental health professionals and bariatric treatment. The case study and postsurgery reports showed that patients experienced anxiety, weight gain, hunger, and the desire to binge (Myers, 2005). Cognitive behavior therapy is helpful in resolving issues of negative thoughts and stimulus control, and in aiding reconceptualization (Myers, 2005). McVay and Friedman (2012) also studied the benefits of cognitive behavioral group therapy for bariatric surgery patients and found that it can assist people with the preparation for surgery and with postsurgery lifestyle changes.

Researchers have identified the stigma of obesity and the key negative consequences of this stigma (Ogden & Clementi, 2010). Ogden and Clementi (2010) conducted a qualitative analysis to explore how people experience their obesity and to examine the effect of this on their motivation to lose weight. Worrell and Trevino (2007)

also assessed how body image and appearance affect the psychosocial functioning of women, which may result in depression, heightened anxiety, and low self-esteem (Worrell & Trevino, 2007).

Weineland, Arvidsson, Kakoulidis, and Dahl (2011) studied the benefits of acceptance and commitment therapy for bariatric surgery patients in relation to emotional eating, body dissatisfaction, and quality of life. The randomized study included face-to-face interviews, support via the Internet, and treatment for eating disorders, body dissatisfaction, and quality of life relating to thoughts and feelings. The researchers compared the results with a group that received standardized treatment by the bariatric team and found the effects of weight-loss surgery can be improved when emotional eating behavior is also treated (Weineland et al., 2011).

There are several studies pertaining to the follow-up of weight-loss surgery respondents who participated in treatment trials (Byrne et al., 2003; Zalesin et al., 2010). In these studies, participants have reported that their weight-loss relapses were related to weight-related behavior, personal stressors, and poor coping and problem-solving skills (Byrne et al., 2003; Zalesin et al., 2010). The critical factors were lifestyle and psychosocial modifications needed by the respondents to adapt to the new physical and cognitive changes (Byrne et al., 2003; Zalesin et al., 2010).

Gap in Literature

Bariatric RYGB surgery is a jumpstart for initiating weight loss for extremely obese individuals. However, surgery alone does little to assist obese women with maintaining lifestyle behaviors to promote long-term health (Terre, 2010). Among most

bariatric surgery patients, psychiatric diagnoses, such as anxiety and mood disorders, remain after surgery, and these diagnoses have ramifications for postoperative psychopathology (Zalesin et al., 2010). Stegemann (2016) found that when patient issues are addressed early, significant weight regain can be prevented. According to Natvik, Gjengedal, and Råheim (2013), future researchers should focus on the individual needs of patients to promote long term weight loss after bariatric RYGB surgery. Additionally, patients need to receive proper information to reinforce coping skills that will enable them to maintain a healthy psychopathology postbariatric RYGB surgery (Natvik et al., 2013). As such, I examined the effects of self-efficacy and body image (excess skin) on women postbariatric RYGB surgery (Terre, 2010).

Why the Study Was Needed

Bariatric RYGB surgery is one of the most effective treatments for obesity. However, many individuals who receive bariatric RYGB surgery fail to maintain their weight-loss goals. Some researchers have explored why respondents struggle with keeping the weight off, but the root cause of why most female respondents regain weight is still unclear. Thus, exploring the relationship between self-efficacy and body image of women after weight loss will help weight-loss professionals understand the motivational drive behind weight gain and maintenance long-term.

Statement of the Problem

Bariatric medical professionals have noted that bariatric surgery is the best long-term solution for morbidly obese individuals with a BMI of 40 or higher (Chaar, 2013; Zalesin et al., 2010). Although the RYGB surgery has proven to promote weight loss as

designed, researchers have found that 12 months and more after the procedure, 20–40% of WLS patients began to regain weight postsurgery (Weineland et al., 2011).

Researchers and weight-loss experts have consistently found that females who have undergone surgery and received pharmacological and behavioral treatments, nonetheless begin to regain weight over time. Byrne et al. (2003) reported that half of the bariatric patients relapse and regain weight the first year following treatment. Weight gain continues 3–4 years postsurgery, often exceeding their pretreatment weight because of poor coping and problem-solving skills (Chaar, 2013). The reality is that bariatric surgery assists with losing massive amounts of weight, but the excess skin left behind proves to be a new challenge that individuals are not prepared to cope with (Darvin & Taylor, 2009). What is not known is whether the relationship between self-efficacy and body image contributes to women being unable to maintain their postsurgery weight loss.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the lived experiences and perceptions of women who regained weight during the first year and beyond following RYGB surgery. Specifically, I engaged participants in an exploration of their perceived self-efficacy and body image, and of how their coping skills, eating habits, social support, self-efficacy, and locus of control influence their ability to maintain their weight loss within 1 year following RYGB surgery. The study was formative in nature, as limited information and resources exist on the issues associated with weight gain following bariatric surgery.

Zalesin et al. (2010) noted several studies pertaining to the follow-up on WLS patients who had participated in treatment trials, which showed that their relapse was correlated with weight-related behavior, personal stressors, and poor coping and problem solving skills (Byrne et al., 2003). One of the misconceptions about bariatric surgery is that it is "quick fix" to the obesity problem (Lee et al., 2004). Misconceptions about the surgery and lack of information on maladaptive behavior, depression, socioeconomic status, culture and ethnicity, and family influences create problems for the WLS respondents and those considering surgery as an option (Myers, 2005). Gaining an understanding of the adjustments may potentially improve the long-term success rate of WLS recipients.

Researchers have conducted ethnographic research to identify, examine, and understand the possible triggers that prevent WLS recipients from maintaining their ideal weight goal (Gunstad et al., 2010). Behavioral and cognitive findings indicate that cognitive function could play a role in how successful a patient is in losing weight after bariatric surgery (Gunstad et al., 2010). According to Gross (1980), holistic self-care management study participants stated that the major influence on behavior is thoughts, feelings, and situations that play a fundamental role in self-care behavior. Moreover, social learning theory (SLT) focuses on inner forces in the forms of need, drives, and impulses often operating below the level of consciousness (Bandura, 1966). Closely viewing the weight loss recipients environment may provide awareness of the psychosocial stages of the recipients development. Evidence has shown that impulses,

feelings, environment, and behavior play a role in the success rate of WLS postsurgery long-term (McVay et al., 2012).

Research Questions

To facilitate an exploration of the perceptions and experiences of women who have regained weight following RYGB surgery, I queried participants regarding their experiences immediately after surgery and for up to 1 year or more following surgery. The overarching research question guiding this study was: How do the experiences and perceptions of women who have undergone RYGB surgery influence their ability to maintain weight loss management? To explore this question, I developed the following research questions:

RQ1: What is the experience of post-RYGB clients with coping skills related to weight loss and weight gain following RYGB surgery?

RQ2: What is the experience of post-RYGB recipients with eating habits and how do they contribute to the success or failure in maintaining ideal weight following surgery?

RQ3: What does RYGB surgery mean to post-RYGB recipients related to body image?

RQ4: What does social support mean to post-RYGB clients?

RQ5: What is the influence of perceived self-efficacy on maintaining weight loss goals post-RYGB surgery?

RQ6: How do participant perceptions of locus of control influence their perceived responsibility for maintaining weight-loss goals?

Nature of the Study

In this qualitative phenomenological study, I explored the lived experiences of women who had not maintained their weight loss during the first year following RYGB surgery. The study involves an examination of participant experiences and perceptions regarding the RYGB surgery, body image, and self-efficacy. By gaining an understanding of the indicators of maladaptive adjustments and the negative psychosocial effects, this research provided new insights into possible reasons why recipients may fail to maintain a healthy weight loss long-term. I selected a qualitative methodology for the study to facilitate an in-depth exploration that was not constrained by quantified measures of participant experiences (see Merriam, 2009). Quantitative methods pertain to statistical analysis of quantifiable variables (Mustafa, 2011), making this method inappropriate for the study. Following Braun and Clarke's (2013) recommendations, I used a qualitative phenomenological approach and conducted interviews with participants to gain insight into their experiences and perceptions related to the phenomenon of interest. A qualitative methodology is best suited for studies when the researcher intends to examine a phenomenon inductively and situated in its unique context (Tracy, 2013).

Framework

The theoretical framework for this study was Bandura's (1966) SLT. Bandura (1969) suggested that thoughts, feelings, and situations play a fundamental role in behavior. I focused on participants lived experiences with thinking patterns and behaviors regarding self-efficacy and body image after WLS. As Bandura (1986) has noted, the

SLT focuses on inner forces in the forms of needs, drives, and impulses often operating below the level of consciousness.

The process of introspection opens the door to self-discovery and new insights that are an essential part the process. In the case of the weight loss recipients, the self-discovery process can help them identify self-defeating beliefs and self-esteem patterns, and help them self-analyze their current situation (Bandura, 1986). The downward spiral of relapse after bariatric surgery is associated with limited coping and problem-solving skills, binge eating, and depression, along with body image and appearance difficulties (Hamilton, 2008). In the case of relapse and weight regain, it is likely that maladaptive behaviors are driven by inner thoughts and self-perceptions (Baer & Sherman, 1964; Bandura, 1969; Hamilton, 2008; Perez et al., 2002; Worrell & Trevino, 2007).

SLT is useful for explaining the behavioral and cognitive variations related to social context for WLS patients. The theory further provides an explanation of how learning can influence weight-loss surgery patients to overindulge in food as an emotional outlet, giving women a sense of control of emotional stress, well-being, and security. Factors, such as low self-esteem, weight-related depression, eating disorders, bullying, and academic discrimination may be associated with being overweight and morbidly obese (Epstein & Wing, 1987).

Ferster, Nunberger, and Levitt (1962) reported a relationship between genetics, environment, and learned behavior of individuals as the root of the obesity problem. The researchers indicated that the lack of physical exercise, increased calorie intake, and extended leisure time have significant consequences on the individual’s behavior,

resulting in weight gain. Addressing those unhealthy behaviors that cause weight gain can be unlearned and replaced with positive healthier habits that include diet and exercise, self-monitoring, goal setting, modeling, and stimulus control (Ferster, Nunberger, & Levitt, 1962; Shields, 2013; Stuart, 1967). The purpose of social learning is to focus on the environmental changes, cognitive and behavioral strategies, reinforcement control, and relapse prevention (Shields, 2013). Additionally, WLS patients can be taught how to change maladaptive behaviors by replacing the negative behaviors that cause them to fail to maintain their weight loss long-term (Shields, 2013). According to Ng and Lucianetti (2015), high arousal influences performance, and individuals who experience high arousal are more likely to conform to success compared to individuals who exhibit a negative mood, which results in negative performance and beliefs.

Self-Efficacy

Bandura (1997) identified four major sources of self-efficacy: mastery experience, vicarious learning, social persuasion, and overcoming emotional barriers. Learning how to overcome barriers reduces negative emotions that repress a person's growth of self-efficacy. According to Ng and Lucianetti (2015), high arousal influences performance, and individuals who experience high arousal are more likely to conform to success compared to individuals who exhibit a negative mood, which results in negative performance and beliefs. Dark-Freudeman and West (2016) conducted a study on middle-age (40–64) and older adult (65–90) participants. The researchers examined the positive and negative effects on self-efficacy as it related to how one values self as a predictor of his or her psychological well-being. The results of the study showed individuals late in

life were more successful with their hopes than with avoiding their fears (Dark-Freudeman & West, 2016).

Cognitive and Behavioral Changes

SLT holds that cognitive and behavioral techniques are designed to teach WLS patients new skills that equip them to modify triggers, reinforce consequences, and dysfunctional thoughts. As a result, the clinician can highlight the benefits of diet and exercise and address the potential barriers that arise from negative feelings regarding body image (Head & Brookhart, 1977).

Relapse Prevention

Relapse prevention is another approach assocaited with SLT. Perri et al. (1988) investigated various strategies and found that the most effective program was the behavior program that included post-treatment therapy, social supports, and aerobic exercises within an 18-month period (Shields, 2013). The follow-up showed WLS patients achieved and maintained 82% of their weight loss, compared to the other group that maintained only 33% of their weight-loss (Shields, 2013). The program teaches modeling, changes negative behaviors, and replaces those negative behaviors that cause WLS surgery patients to fail at losing weight and maintaining their weight loss long-term (Shields, 2013).

Operational Definitions

I have used the following terms and associated definitions throughout this study.

Bariatric (RYGB) surgery: A surgical procedure that reduces the amount of food by diving the stomach from the top, creating a pouch to hold 1 ounce or 30 milliliters in

volume (equivalent to the size of an egg). The bottom portion of the stomach is connected to the small intestine to aid in the digestion and consumption of food. The process restricts calorie and nutrients, rerouting the flow of food and changing the gut hormone. This suppresses hunger and reverses the mechanisms that induce Type II diabetes (Karmali et al., 2010).

Body image: A mental representation of how an individual creates self, but it may or may not be what another individual actually sees. Body image is subject to various internal distortions, such as past experiences, moods, emotions, and attitudes (McClullough & Hardin, 2013).

Coping skills: A set of defense mechanisms that individuals use to avoid or lessen psychological pain. These learned skills regulate how individuals feel, react, and communicate to others. Those skills can either be adaptive or destructive, which can have an effect on social relationships, make preexisting problems worse or better, and even create new stress-related emotional injury.

Emotional eating: A maladaptive coping mechanism that causes an individual to eat to relieve negative emotions. Emotional eating, over a period of time, will become a learned behavior when dealing with stress (Bennett et al., 2013).

Excess skin: The result of extreme loss of body weight. The areas are frequently seen on the abdomen, arms, thighs, and face. Although the goal of bariatric surgery is to improve self-esteem and weight related-depression, the excess skin may cause discomfort and appearance distress (Smith & Farrants, 2013).

External locus of control: Allows the WLS recipients to place the blame of failing to lose or maintain weight on outside factors such as people, self, or environment. It is the belief of WLS participants who are driven by external locus of control and outside forces; therefore, the individual is justified in avoiding personal accountability for failing to maintain his or her own weight loss goal (Rotter, 1966).

Internal locus of control: As it relates to weight loss, internal locus of control is motivated by the internal drive that empowers people to achieve their weight loss goal by following the dietary guidelines and physiologists' and medical professionals' recommendations. As a result, the goal of weight loss is successfully achieved (Rotter, 1966).

Locus of control: Pertains to deep-seated motives that determine an individual's behaviors, which are driven by unconscious impulses from individual past experiences, personality, and one's environment (Rotter, 1966). The SLT model focuses on the four main components of behavior: potential, expectancy, reinforcement value, and psychological situation. Rotter (1966) noted individuals engage in various behaviors depending on the situation, and behavior that has the highest potential is the behavior an individual will exhibit.

Self-efficacy: The belief that an individual has the capability to set a plan to accomplish a given task or situation successfully, and this influences how a person believes, behaves, and feels (Bandura, 2006). Individuals who have a strong sense of self-efficacy view opposition as a task that must be mastered and it is quick to recover from

setbacks. Individuals with decreased self-efficacy lack the ability to challenge themselves, lack confidence, and avoid difficult situations (Bandura, 2006).

Self-esteem: The reflection of an individual's appraisal of him or herself. It is the evaluation of how a person believes, feels, and thinks about the self. Self-esteem is a significant social psychological construct that motivates individuals to achieve a goal. Low self-esteem is evident in obese individuals who devalue self and believe they lack willpower, self-control, competence, and self-discipline (Bandura, 1986).

Weight gain: The increase in fat deposits surpassing the BMI of 18.5–24.9. The deposits are associated with increased food intake, pre-existing medical conditions, and lack of physical exercise (Ogden, Carroll, Curtin, Lamb, & Flegal, 2010).

Assumptions

I assumed participants in the study provided candid and honest responses during their one-on-one interviews. To facilitate this open exchange of information, I constructed an environment that encouraged an honest dialogue by selecting a comfortable, private location to conduct interviews. I assumed that women who participated in the study met the inclusion criteria. To ensure that the inclusion criteria was met, interested potential participants were screened to ensure they had undergone RYGB surgery within the previous year and that they had not maintained their weight loss following the surgery. I also assumed the qualitative phenomenological design was the best suited methodological approach for the study. Because I was concerned with accessing participants' lived experiences and perceptions free of the influence of my own preconceptions, the phenomenological approach was the best methodology for this study.

Scope and Delimitation

The scope of the study included female participants who failed to maintain their weight within 1 year following RYGB surgery. I focused on these individuals' perspectives and lived experiences related to RYGB surgery and body image. No other populations were studied, and the findings are not transferable to other populations because of the in-depth focus on women who have had RYGB surgery. Participants were at least 18 years of age. The insights gained from this research may only be applicable to women who share the same characteristics. Because phenomenological research is designed to facilitate rich documentation of participants' lived experiences and perspectives, the research is not intended for transferability to other populations.

Limitations

Because I retrospectively explored women's experiences within the year following their RYGB surgery, the study was limited by my ability to accurately access memories and recollections. For instance, participants may not have been able to recall the specific events, thoughts, and feelings that contributed to their behavior or performance. External factors such as relationship, health, and employment may have influenced their behavior and ability to maintain long-term weight loss; however, these factors were not considered within the scope of this study. This limitation was acceptable because I opted to adjust the scope of the study to render it feasible given my resource constraints. The study was further limited by my position as an instrument of data collection, analysis, and reporting. This position left the study vulnerable to the influence of my own biases and preconceptions regarding the findings. To mitigate my influence on

the study, I used journaling to document, consider, and set aside personal biases. This process ensured I acknowledged my personal biases prior to data analysis and reporting. I also used member checking to confirm the validity and veracity of the findings.

Significance of the Study

Permanent weight loss is one primary goal of obesity treatment and remains the ideal solution for obesity. Obesity is an epidemic in the 21st century, and research has shown that 20–40% of weight loss recipients begin to regain weight within 12 months of surgery (Weineland et al., 2011). This study contributes to the existing body of research and provides insight into the application of the conceptual concept of the SLT and the constructs of self-efficacy and locus of control. I investigated the lived experiences of women 12 months or later after RYGB surgery. I focused specifically on the relationship between self-efficacy and body image and how they may influence individuals' abilities to maintain their weight-loss goal long-term. My findings regarding the reasons for weight gain may encourage weight-loss clinicians not just to analyze noncompliance and programs, but also to explore the areas of self-efficacy, body image, and locus of control. The literature has shown the problems for bariatric clinicians, but the research is limited on programs or interventions that address the problems encountered by postsurgery recipients (Phipps, 2011).

Weight-loss clinicians have discussed the physical indicators of bariatric success, which include weight loss and improved BMI measurements, but limited information exists on psychosocial and body image adjustments following surgery (Bauchowitz, 2005; Davin & Taylor, 2009; Grimaldi & Van Etten, 2010). My goal in this study was to

identify the beliefs and challenges of women post-RYGB surgery and to understand the process that may influence their beliefs and social interactions that will lead to weight loss success. In turn, the results will influence the areas of self-efficacy to assist patients in embracing their new lifestyle, body image, and weight-loss goal long-term.

Summary

Weight-loss surgery is an effective treatment for losing massive amounts of weight and reducing preexisting medical issues associated with obesity; but weight can be regained for various reasons. In this study, I examined the psychological, psychosocial, and physiological effects of individuals 12 or more months following RYGB surgery. In conducting this research, I hoped to gain an understanding of how thoughts, emotions, personality, and drive contribute to weight gain. New discoveries regarding awareness in cognition, behavior, environment, and how they all work together will assist health care professionals in understanding the importance of internal processes and learning.

Chapter 2 includes a review of the extant literature on the physical, psychological, and social factors that contribute to women failing to achieve or maintain their weight loss goal 12-months or more post-RYGB surgery long-term as well as the conceptual framework for the study. Further, I will explore the literature that supports the methodology for the present study. In Chapter 3, I will outline the methodological approach for this study. In Chapter 4, I will present the results derived from the data, and Chapter 5 will close this study with a discussion of the findings and recommendations for future research.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to understand the psychological aspects of women who did not achieve their ideal weight in addition to maintaining their weight goal 12 months or more after RYGB surgery. Understanding the relationship may help women who have undergone RYGB focus on the outcome predictors and gain a better understanding of the possible psychological implications following surgery.

This chapter includes an analysis of existing literature on noncompliance with weight-loss programs, cognitive and behavioral adherence, and nonadherence to psychosocial and body image adjustments postsurgery. The theoretical framework was based on evidence that physiological, cognitive, behavioral, and social forces can influence one's ability to achieve their ideal loss goal and maintain weight loss long-term (Phipps, 2011).

In this RYGB study, I analyzed the participants' significant statements. This process involved generating meanings, identifying the essence of their specific experiences, and understanding individuals' descriptions of their experiences (Moustakas, 1994). I used qualitative research and semistructured interviews to provide an explanation of the cognitive and behavioral adherence and nonadherence following surgery.

I obtained the literature for this study using Walden University library resources, Google Scholar, and PubMed, SAGE Premier, and PsycArticles databases. I used the following keywords to locate pertinent literature: *obesity, self-esteem, coping skills, emotional eating, weight gain, weight loss, excess skin*, *body image, locus of control,* and

self-efficacy. I collected other research by reading relevant articles and cross-examining the reference lists of those items.

Social Learning Theory

Some of the problems contributing to obesity are psychological, psychosocial, and body image factors that can be explained using the SLT. The SLT is useful for considering how thoughts, feelings, and situations play a role in patterns and behavior. Some examples are depression, low self-esteem, poor eating habits, and problem-solving skills (Hamilton, 2008). The SLT was also useful for examining individuals' self-defeating beliefs and analyzing their current situation and patterns of low self-esteem in this study on the issues of weight loss and maintenance (see Bandura, 1986).

The SLT is a key in understanding the relationship between obesity and the driving forces that motivate or deter change required for long-term weight loss maintenance. I used it to develop the research questions to identify key psychological, psychosocial, and body image factors that may play a direct role in a person failing to achieve and maintain long-term weight loss. The following literature relates to the problem of obesity and the factors associated with a lack of long-term weight-loss achievement and maintenance.

Development of Obesity

Karasu (2016) stated that obesity has been considered a disease for decades. It causes metabolic imbalance, inflammation, brown fat, and a blood-brain barrier that stems from an infectious origin. Obesity is controversial because the disease has been known and seen as a sin, a crime against society, and a self-inflicted disability that can

result in the failure to regulate energy (Karasu, 2016). Also, obesity can be caused by inappropriate adaptation to the environment, hereditary disorders, psychological and behavioral disorders that cause individuals to overeat and lead to poor self-relations and addiction.

McCullough and Hardin (2013) explained that obesity continues to be a puzzling disease because of the diverse ways it has been conceptualized. Most researchers define the cause as an energy imbalance, such as a disparity between calorie intake and outtake. This can be a result of genetic predispositions of some individuals that cause them to be more susceptible to weight gain than others (Karasu, 2016). In previous studies on obesity, researchers have focused only on the psychological aspect, which entails the etiological basis of eating disorders and obesity with a combination of environment, psychosocial, and biological attributes, such as depression and eating disorders (Collins & Bentz, 2009).

Biomedical Paradigm

The biomedical model was established to provide an explanation of how diseases manifest. Using the biomedical framework model views of health help to complete the absence of the disease, pain, or defect. The model is focused on the physical threats to a healthy life, and researchers use it to analyze the causes of a given disease and strategies for recovery. The biomedical model is used to find a solution to biological and genetic malfunctions and determine the best plan of action that will resolve the problem (McCloud, 2014).

Medical scholars have focused on obesity from a preventive standpoint as an illness that needs to be treated. Obesity is recognized prehistorically, but more recent interpretations of the disease have pertained to the science behind obesity (Bray, 1990). Obesity is not a recent discovery, and had been studied by the ancient Greek physician Hippocrates. Hippocrates (1967) studied four concepts: black and yellow bile, blood, and phlegm. He understood that excessive weight shortened a person's life span. In the 16th and 17th centuries, obesity was considered a life-threatening condition (Bray, 1990). This view of obesity was carried through centuries and accepted as an energy discrepancy that differed in stages. The clinical characteristics of obesity evolved through experimental evidence (Karasu, 2016). This disease was blamed on involuntary genetic factors, environmental influences, physiological disturbances, irresponsibility, and not holding people accountable for their obesity (Chang & Christakis, 2002).

Obesity is widely considered a disease because of the severe implications it has on both the patient and society (Martin, 2013). The act of diagnosing the disease is linked to an individual's social system, may be used to enforce social norms, and is defined as defiance with the individual by using their obesity as a tool to release them from certain obligations, or even some advantages and legal privileges (Rosenberg, 2002). Erueti et al. (2012) stated that medical professionals should caution themselves regarding an individual's condition. A lack of empathy may lead to unnecessary treatments or none at all, resulting in the patient's possible refusal to comply with the recommendation because of the heightened perceptions (Young, Norman, & Humphreys, 2008). The treatment process involves medical professionals, crusaders, and experts that call attention to the

obesity problem by circulating the resources to other interest groups, supporters, moralizers, and administrators (Monaghan et al., 2010).

Heshka and Allison (2001) explained that there is no sign or symptoms predicting when individuals will develop obesity-related problems other than excess fat. Some obese individuals are metabolically benign and may not be at risk for obesity-related health problems such as Type 2 diabetes. Heshka and Allison noted that the root of obesity is a relatively small increase in average weight that has a disproportionate effect on the the individual (McKay, 2013).

Researchers and public health officials consider obesity an epidemic because of its high prevalence in the population and the increase in its occurrence during the past several decades (Mitchell, Catenacci, Wyatt, & Hill, 2011). Karasu (2016) reported that Rosenberg and Grob (1993), the Council of the Obesity Society (2008), and the American Medical Association (2013) all seem to share the idea that obesity is responsible for a multitude of medical, psychological, and psychosocial effects. Researchers have suggested that obesity results from a chosen lifestyle exemplified by overeating and lack of exercise. Although it has a a multitude of causes, of obesity can be explained. The notion that obesity as a disease, however, is still controversial.

Biopsychosocial Paradigm

The biopsychosocial model is focused on three essential components: biological, psychological, and social etiologies (Engel, 1980). In addition to the biological, genetic, and physiological factor of the human body, the biopsychosocial framework includes psychological conditions, and cultural and economic backgrounds. The interaction of all

three factors helps in understanding human health, illness, and how health care delivery play a significant part in multidimensional treatment (Engel, 1980).

Biopsychosocial Factors of Obesity

According to Porter et al. (2012), 36% of adults and 17% of children and adolescents are obese. The Centers for Disease Control and Prevention (2009) reported that among the African American population, the number of adults who are obese has risen more than 51% compared to Caucasian adults. During the past few decades, obesity among African American adolescents had increased from 13% to 24%, compared with 11% to 18% for all other ethnicities (Porter et al., 2012).

In a recent longitudinal study,

One of the most commonly faced experiences of overweight children and youth is the stigma about their weight (Puhl & Latner, 2007). Teasing is linked with weight-related stigmas and poor psychological well-being among children and adolescents. This stigma causes the youth to become stagnant and refrain from exercise and other activities (Hayden-Wade et al., 2005).

Self-Esteem

Self-esteem is an overall subjective emotional evaluation of one's self-worth. It is the judgment or attitude toward the self that encompasses beliefs and emotions such as pride, despair, triumph, and shame (Hewitt, 2009). Self-esteem is how one evaluates oneself positively or negatively (Smith & Mackie, 2007). It is an attractive psychological construct that researchers conceptualize as an important, influential predictor in

outcomes, such as achievement, happiness, criminal behavior, and self-defeating behavior (Greenberg, 2008).

Maslow (1987) noted that self-esteem is fourth on the needs pyramid. He defined self-esteem in two different ways: (a) a need for respect from other individuals in the forms of admiration, success, and recognition; and (b) a need for self-respect in the forms of love and belonging, inner self-confidence, and achievement (Maslow, 1987). Without the fulfillment of self-esteem, the individual will seek it and lack growth, never reaching levels of self-actualization (Maslow, 1987).

Self-Efficacy

According to Bandura and Adams (1977), the SLT changes in the defensive behavior by different methods of treatment deriving from the cognitive mechanism. The psychological procedures serve as a way of creating and strengthening an individual's personal effectiveness. When you incorporate self-efficacy, it is the choice of activities and behavior settings, the effort they expend, and how long the individual will persist at the task. The longer the individual persists in the subjectively threatening activity eventually will eliminate the inhibitions by a corrective experience. However, those who avoid fear and refuse to face their obstacles will retain their self-deliberating expectations and defensive behavior (Bandura & Adams, 1977; Konttinen, Haukkala, Sarlio-Lahteenkorva, & Silventoinen, 2008).

Locus of Control

Locus of control is the perception about the main causes of events that affect people's lives. Some individuals believe in destiny and others believe the reasons are

from outside forces. Rotter (1966) bridged behavioral and cognitive psychology viewing behavior as guided by rewards and punishments, and by these actions, individuals develop a belief system about their causes and actions. Individuals who possess internal locus of control believe they are responsible for their outcomes, destiny, and often excel in vocational and educational realms. One the other hand, those who possess external locus of control blame their success and failure on environmental or situational factors rather than internal; they often believe they are a victim of their own circumstances (Buckman & Saltzer, 1978; Konttinen, H., Haukkala, A., Sarlio-Lahteenkorva, S., & Silventoinen, K. 2008).

Body Image

Body image is a psychological factor associated with weight-related teasing, depression, and self-esteem (Porter et al., 2012). Weight-related teasing can affect an adolescent's body image, causing the individual to dislike his or her body, leading her or him to develop low self-esteem and more severe consequences, such as depression and suicidal ideation (Eisenberg et al., 2003). Researchers have explored ethnic differences among African American youth; African American adolescents reported more minimum impairments in psychosocial functioning than any other racial or ethnic group (Fallon et al., 2005).

Researchers found teasing to be similar across racial and ethnic groups; however, teasing bothered Caucasian adolescent females more than African American adolescent females (Van den-Berg et al., 2008). A large body of research shows ethnic differences with body image; for example, African Americans embrace their large body frames and

are more satisfied with their bodies than European American women are during late adolescence and adulthood (Henriques, Calhoun, & Cann, 1996).

Gabe and Hyde (2006) suggested that although African American women may not share the same body shape issues as Caucasian women, it does not mean that they are not dissatisfied with their bodies. Research has shown that obese African American adolescents have been given limited attention regarding how they perceive their bodies, psychosocial functioning, and the effects of weight-related teasing. Setiloane (2004) analyzed the reasons for overweight adolescents. The data used in the study were from the National Health and Nutritional Examination Survey, which indicated 22% of adolescents were overweight (Setiloane, 2004). Although the findings seem to be similar in adults, the problem of adolescent obesity is most prominent in minority groups. Schneider (2000) noted half of the African American youth population and more than one-third of Latino children are obese.

The results of Setiloane's (2004) study demonstrated both African American and Latino youth were more likely to be obese and at risk of becoming overweight compared to Caucasian and Asian youth. The study showed the children had physiological effects related to obesity, and the psychosocial area of the research was also well documented. The adolescents exhibited concerns about their height and weight, and feared becoming obese, along with the ridicule and prejudice that comes with it (Setiloane, 2004).

Body image is important in the development of youth self-esteem, and it influences behaviors regarding food intake, such as dieting, which can develop into bulimia and anorexia nervosa (Anderson, 1985). Setiloane (2004) provided details

regarding the correlation between high fats, sugar consumption, and the relationship between adolescent female perceptions and actual weight related to their self-esteem and body image. The adolescent girls in the study were unhappy with their bodies and wanted to lose weight.

The results showed out of 5,817 individuals ages 14–19 and 61, 83% wanted to lose weight and 6% were females who considered themselves overweight (Seltiloane, 2004). Self-esteem was found to be inconsistent as other studies reported no relationship between self-esteem and body image, and some researchers showed an inverse relationship between body image and self-esteem (Seltiloane, 2004). Although the results of these studies provided details regarding food intake, body image, and self-esteem, limited information exists on the psychosocial effects of being overweight in African American adolescents (Seliloane, 2004).

Psychological Factors of Obesity

Depression is one of the most common mental health problems in the world associated with the tendency for weight gain and obesity and is considered an important factor for metabolic syndrome (Goldbachelor & Matthew, 2007). Bariatric surgery patients have a higher rate of visceral obesity and higher BMI than those without depression (Kahl et al., 2005).

Consequences of Obesity and Eating Disorders

The World Health Organization reported obesity is one of the leading public health problems and is increasing all over the world (Matini, Jolfaei, Pazouki, Pishgahroudsari, & Ehtesham, 2014). It is estimated that one-third of all adults in

developed countries suffer from obesity, and this number is expected to increase up to 20% by the year of 2020 (Matini et al., 2014). If morbid obesity rates rise as well, it would increase the mortality rate and increase the risk of medical conditions, psychiatric disorders, and poor quality of life associated with obesity (Health, 2009).

The side effects of obesity include cardiac disease, hypertension, Type 2 diabetes, liver and joint diseases, certain cancers, and mental and social health problems. Obesity is the cause of 2.8 million deaths each year (Matini et al., 2014).

Depression and Obesity

Researchers found that depression is associated with the tendency for weight gain and obesity, leading to a high factor for metabolic syndrome in women (Goldbachher & Matthew, 2007). Patients with depression have a higher rate of visceral obesity and higher BMI than those without depression (Lin, Liang, Liao, & Tsay, 2014). Obesity and depression are major health issues worldwide and are related to lifestyle changes, followed by depression that occur as early as early adulthood (Bornstein, Schuppenies, Wong, & Licinio, 2006). Depression is also associated with the occurrence of excess body weight and metabolic syndrome in participants. Based on the findings, medical professionals should be aware of the high rate of depression among young adult women and potential health risks related to depression (Lin et al., 2014).

Matini et al. (2014) stated several studies have shown that obesity is associated with mental illness and social isolation, which can lead to inactivity and make individuals susceptible to various mental disorders and increased weight gain (Gallagher et al., 2000). For patients with a BMI higher than 35, bariatric surgery can be an optimal

treatment plan for weight loss. The candidates chosen for the procedure must be severely obese and suffer from pre-existing medical conditions, such as sleep apnea, coronary artery disease, hypertension, or Type 2 diabetes (Matini et al., 2014). Matini et al. (2014) noted psychological problems caused by obesity include: (a) emotional eating to cope with personal problems; (b) bulimia, as a symptom of depression; (c) food addictions; (d) agitation regarding food and smell; and (e) stress that triggers overeating. Stress, depression, and mental disorders are all associated with overeating, which, in turn, affects the quality of life and self-esteem of those who suffer from obesity (van Hout & van Heck, 2009).

Van Hout & van Heck (2009) found obese women with a higher socioeconomic status are at an increased risk of depression than women with a lower status. These factors can also influence quality of life and self-esteem. Kalarchian et al. (2007) also found BMI was linked to depression, eating disorders, and anxiety, which affects an individual's quality of life. The findings also illustrated a decline in eating disorders 6 months after bariatric surgery. Although WLS improves the patient's body image and quality of life, it does not affect the mental components, such as depression and anxiety, that need attention and treatment in patients struggling with obesity (Matini et al., 2014).

Bariatric Surgical Treatment for Obesity

The problem of obesity has reached an all-time high in the United States and worldwide (Müller, Mitchell, Sondag, & de Zwaan, 2013). Bariatric surgery procedures have been noted to be the best treatment for patients with severe obesity and have shown significant improvements in obesity-related disorders (Casazza et al., 2013). However,

psychiatric problems are prevalent in weight-loss surgery patients pre and postsurgery. Müller et al. (2013) stated binge eating disorders are prevalent in 25% of bariatric surgery patients, but this number decreases significantly after surgery. The researchers further mentioned surgical weight-loss patients may develop or redevelop subjective binge eating, loss of control, and even self-induced vomiting for weight loss or shape reasons.

Depression and eating disorders have been associated with increased personal distress (Müller et al., 2013). Depression is a significant cause of deaths in obese individuals. Bariatric surgery patients often exhibit mood disorders in their lifetime, as well as relevant clinical symptoms (Müller et al., 2013). Previous findings indicate depression will begin to decline overtime, and in some cases weight-loss patients may still exhibit bouts of depression just as they did in their presurgical stage (Engel, Mitchell, de Zwaan, & Steffen, 2012).

Impulsive Control Dysfunction and Obesity

Müller et al. (2013) noted impulsive control disorders have been associated with morbidly obese patients (Ertelt et al., 2008). Research shows impulsive control dysfunctions or any other unhealthy behaviors may harm the behaviors of obese patients because of excessive behavioral addictions. Müller et al. found relatively high occurrences of impulsive control dysfunction in both 100 presurgical and postbariatric patients. The results showed 8% of patients exhibited pathological skin picking, 6% exhibited compulsive buying, 5% were diagnosed with intermittent explosive disorders, 2% became addicted to Internet use, 1% became pathological gamblers, and, in some cases, patients would excessively exercise to prevent weight gain (Müller et al., 2011).

Although these issues have become prevalent in bariatric patients pre and postbariatric surgery, the alternatives help the patient to suppress the urge to overeat (Moorhead & Alexander, 2011). Müller et al. (2013) stated longitudinal studies are warranted in the development of impulsive control dysfunction postbariatric surgery, and more research is needed regarding depression, eating disorders, and body image problems pre and postsurgery as they relate to obesity.

Excessive Skin and Psychological Dysfunction After Bariatric Surgery

Bariatric surgery has been identified as the best medical treatment for individuals battling obesity (Ramalho et al., 2014). The results of the surgery promote massive weight loss, resulting in improved psychosocial function, body image, sexual function, and depressive symptoms (de Zwaan et al., 2011). Despite the positive outcomes, 5% to 39% of patients regain weight after bariatric surgery because of the remaining surplus skin that negatively affects psychological and psychosocial well-being postsurgery (Sarwer, Lavery, & Spitzer, 2012). Rapid weight-loss results in loose skin, skin envelopes, and fat deposits primarily located on the upper arms, thighs, and abdomen, which causes a multitude of problems and discomfort. For example, fungal infections, skin abrasions, abdominal and back pain, personal hygiene issues, frequent urination, difficulties in physical activity and dressing, and sexual dysfunction are all caused by excess skin after bariatric surgery (Mitchell et al., 2008). Ramalha et al. (2014) noted women in the study said the hanging skin located in the lower abdominal area (Pannus) interfered with sexual performance.

Ramalho et al. (2014) believed excessive skin negatively influences body image, causes dissatisfaction and embarrassment, and is often associated with reduced quality of life. Baillot, Asselin, Comeau, Méziat-Burdin, and Langlois (2013) stated the literature is scarce regarding details of the physical, social, and psychological consequences of the aesthetic conditions of excess skin, which can have affect the outcomes of postbariatric surgery patients. The associations of the hanging skin, body image, sexual performance, and depressive symptoms in women need to be explored (Ramalho, 2014). In this study, I used the phenomenological approach to access the lived experiences of women who have undergone RYGB surgery within the first year following the procedure. The phenomenological approach is best suited to explore these experiences and perceptions in their natural setting free from manipulation (Moustakas, 1994). Phenomenological researchers use the phenomenological design to gain an understanding of participants' worlds and the meanings they make of their experiences (Finlay, 2012). Phenomenology encompasses gathering rich data that depict the lived experience of participants related to a particular phenomenon (Roberts, 2013). Because I intended to explore and understand the essence of the experience of women who have undergone RYGB surgery and their perceptions regarding body image and self-efficacy, the phenomenological approach was best suited for this study. Examining the experiences of women who failed to maintain weight loss postRYGB surgery through Bandura's self-efficacy model facilitated exploration of the influence of self-defeating thoughts, negative belief systems, past negative experiences, and verbal persuasion regarding the ability to maintain weight loss postRYGB surgery.

Qualitative phenomenological researchers conduct interviews with participants to gain insight into participant experiences and perceptions related to the phenomenon of interest (Braun & Clarke, 2013). A qualitative methodology is best suited for studies in which the researcher intends to examine a phenomenon inductively, situated in its unique context (Tracy, 2013).

Summary

Chapter 2 included a review of the extant literature on the physical, psychological, and social factors that attribute to women failing to achieve or maintain their weight-loss goal 6–12 months post RYGB surgery long-term. I also discussed the conceptual framework for the study. Chapter 3 will outline the methodological approach for this study. The purpose of this qualitative, phenomenological study was to explore the lived experiences of women who failed to achieve and maintain their weight-loss goal post RYGB surgery. I wanted to explore and obtain an understanding of this phenomenon by conducting in-depth interviews of their physical, psychological, and psychosocial factors that influenced them to regain weight. The sample size consisted of 10 women who were at least 12 months or more postoperative, and who had started to regain weight post RYGB surgery. Chapter 4 will present the results derived from the data, and Chapter 5 will close this study with a discussion of the findings and recommendations for future research.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to explore the lived experiences and perceptions of women who regained weight during the first year or later following RYGB surgery. The study was formative in nature and designed to assist women who have experienced RYGB surgery by providing insights from postsurgery women who did not maintained their weight-loss goal. This chapter includes the research questions and discussions of the research design and methodology. In the chapter, I detail data collection and analysis methods, issues of trustworthiness, and ethical procedures.

Research Questions

The overarching research question guiding this study was: How do the experiences and perceptions of women who have undergone RYGB surgery relate to body image and influence their ability to maintain weight-loss.? To explore this question in depth, I designed the following research questions:

RQ1: What is the experience of post-RYGB recipients with coping skills related to weight loss and weight gain following RYGB surgery?

RQ2: What is the experience of post-RYGB recipients with eating habits and how do they contribute to the success and failure in maintaining ideal weight following surgery?

RQ3: What does RYGB surgery mean to post-RYGB recipients related to body image?

RQ4: What does social support mean to post-RYGB recipients?

RQ5: What is the influence of perceived self-efficacy on maintaining weight-loss goals post-RYGB surgery?

RQ6: How do participant perceptions of locus of control influence their perceived responsibility for maintaining weight-loss goals?

Research Design and Approach

This qualitative phenomenological study involved an exploration of the lived experiences of women who have not maintained their ideal weight-loss goal 12 months or later following RYGB surgery. My primary focus was their shared experiences, such as self-esteem, emotional eating, and body image perceptions postsurgery. Participants'

behavioral experiences related to self-efficacy, self-esteem, depression, coping, and problem solving skills were explored in relation to their daily life stressors. The goal was to gain a deeper understanding of how coping skills, maladaptive adjustments, and negative psychosocial environmental factors influence participants' mental health, self-esteem, self-efficacy, and locus of control. The themes I developed from this qualitative research may provide new information regarding the reasons why the women did not maintain a healthy weight loss long-term.

Role of the Researcher

My role in the research was that of a participant and observer. A qualitative design was most suitable for this study because it allows me to uncover the meanings of the women's experiences (see APA, 2014). Qualitative research allows the researcher to play an active role in the lives of those being studied by building a rapport to obtain an understanding of the personal meaning and subjective experiences participants ascribe to

the phenomenon of interest. This experience allowed me to become immersed in the data to learn more about the phenomenon studied. Because the goal was immersion in the data, I engaged in bracketing during the research process. I discussed and documented my personal experiences of RYGB surgery. This process enabled me to set my own biases and preconceptions aside and solely focus of the experiences of the women in the study.

Participants in the study included community members, past bariatric clients, and coworkers who may recognize me as a counselor and a person who has previously undergone RYGB. I acknowledged these roles and the potential influence that participants assign to these roles. I ensured participants that there was no pressure to participate and participation was strictly voluntary. I addressed any inquiries from participants regarding my experiences prior to the interview as a means of building rapport. I strove to maintain the focus of interviews on participants and their experiences during the interviews. Knox et al. (1997) noted that self-disclosure early in the therapy session positively influenced the relationship between the therapist and the client by unveiling imperfections of the therapist; however, disclosing too much may have grave consequences on the results of the study (Audet & Everall, 2010).

Ethical Concerns

I recognized that I may have preconceived biases, beliefs, and assumptions about the reasons women are unable to maintain weight-loss after RYGB surgery. Bracketing reduces biases and allows the researcher to view experiences of the participants with fresh eyes (Moustakas, 1994). I described my own experiences with the phenomenon and

examined my assumptions prior to listening to the experiences of the women included in the study. Participants were bariatric recipients chosen from Facebook weight loss and weight gain blogs, Detroit newspapers, and the Walden University participant portal. I informed participants of the study's purpose and participants' rights using an informed consent form. I scheduled interviews with participants who consented to participate.

Methodology

IRB: 04-13-17-0396080.

Participants

The participants for this research study were 10 women recruited through convenience sampling. Women selected for participation had issues in maintaining their ideal weight-loss goal 12 months or more after RYGB surgery at the time of the study. The sample included women 18 years of age and over of diverse racial or ethnic backgrounds, and with various educational levels. I asked participants to provide demographic information at the beginning of the interview, recorded the information, and have reported it in the results chapter of this dissertation. Participants were recruited from the community (Detroit area), Facebook weight gain and weight loss blogs, and the Walden University participant pool. The sample size of 10 participants was based on research indicating that thematic saturation is achieved at 8 participants in qualitative research (see Guest, Bunce, & Johnson, 2006).

Procedures

Phenomenological research requires a series of procedures to satisfy the requirements of an organized, disciplined, and systematic study (Moutaskas, 1994). I used the following methods for recruiting and informing the participants, collecting data, and validating the results of the study:

1. Contact the administrator(s) of the online weight blogs, Walden University participant pool, and community support groups via telephone or e-mail. I developed a letter for distribution to the professional association contacted for recruitment (see Appendix A).
2. Send an informative letter detailing the nature of the study to the three entities requesting the assistance of female participants (see Appendix B).
3. Ask the administrator(s) to distribute the letter to the members to encourage participation.
4. Receive direct responses from members desiring to participate.
5. Selected the individuals based on the inclusion criteria.
6. Contact individuals for a face-to-face interview. The interviews took place in a mutually agreed upon location.
7. Before the interview, require each individual to read and sign an informed consent form describing the study; the consent form included a clause that allows the participants to leave that study at any time.

8. Conduct face-to-face interviews with participants using a semistructured interview protocol (see Appendix C). I requested permission from participants to record the interviews prior to beginning each interview.
9. Transcribe audio recordings of the interviews and examined transcriptions according to pre-established data analysis steps.

Data Collection

I used a semistructured interview for this phenomenological study to obtain in-depth descriptions of shared experiences with postsurgery weight gain patients in their own words, and from their personal perspective (see Creswell, 2013). The objective of these questions was to elicit participants' perceptions regarding (a) their experiences following RYGB surgery, (b) their thoughts and emotional state after weight loss and weight gain, and (c) their perceptions and attitudes regarding their body after massive weight loss.

Building rapport is a necessary strategy to establish an effective relationship for collecting data. The rapport between researcher and participants should include active listening, showing empathy, and understanding, which leads to active sharing. Too much or too little communication from the researcher may distort what is disclosed during the interviewing process (Ward, 2012). I began the interview with introductions and an icebreaker activity. I set a neutral and comfortable tone and environment for the interview to enrich the interviewing process (see Ward, 2012).

I assumed there was a core or a shared understanding about weight gain and the lack of weight maintenance among participants, who each had individual awareness of

their experiences (see Moutaskas, 1994). Throughout the interview, I provided prompts to the participant (e.g., “Tell me how you to changed your habits,” or “Tell me about your emotional experiences”), in the form of interview questions, which elicited responses related to the essence of their experiences with maintaining their weight-loss goals. To set aside my own feelings and mitigate the potential for these feelings to influence data collection and analysis, I discussed my thoughts and feelings through the interview and analysis process with my peers and committee. During the interview process, I kept a journal, audiotapes, and reflective notes with the time and dates of interviews. These reflective notes included what I heard, saw, and experienced while reflecting on my own thoughts during the interview process.

I matched the reflective notes, journal, and audiotapes with the data (see Creswell, 2013). I engaged my committee members and peers in discussion regarding new ideas and insights throughout the data analysis process. I kept participants’ information confidential by assigning pseudonyms to participants. All data collected are in a locked cabinet in in my office, and all audio recordings are stored on my personal password-protected computer. The data will remain stored for a period of 5 years.

Data Analysis

I analyzed the data using Moustakas’ (1994) approach for thematic analysis. The first step of the analysis was to listen to the tapes of the interviews. The second step was to transcribe the digital audio recordings verbatim. The third step comprised breaking down how participants experience the phenomenon. I used NVivo Version 10 to assist in analyzing and organizing my data. The fourth stage involved examination of the

participant statements for the relevancy to the research questions. The fifth stage allowed for development of meaning units, clustering them into categories, and developing themes from the categories. The sixth stage included constructing both structural and textual descriptions of the phenomenon, which provide an overall of the essence of participants' experience.

Issues of Trust Worthiness

Verification of Findings

The finding in this research were verified for fidelity and veracity in relation to participant data. Lincoln and Guba (1985) stated the concepts of validity and reliability are directly based on measures related to the issues of trustworthiness within qualitative inquiry. Lincoln and Guba's framework of trustworthiness consisted of credibility, triangulation, frequent debriefing, peer scrutiny, thick description of the phenomenon, member checks, negative case analysis, and clarification of researcher's bias. This research study involved iterative questioning, triangulation, clarification of the research bias, and a thick description of the phenomenon.

Iterative Questioning

The use of iterative questioning was appropriate because it provided an opportunity to clarify responses and carefully consider their responses to maintain fidelity with their actual experience. I used probing by rephrasing the questions to elicit detail, which allowed for an opportunity to screen for inconsistencies in responses. Any inconsistencies were probed further for clarification.

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Triangulation was appropriate for use within this study because it involved the collection of various types of information. Within the study, I triangulated the findings using a journal, interview transcripts, and reflective notes from the interviews. I examined and analyzed these sources to allow for compensation on the shortcomings from any individual data source. This information was used to build coherent justifications and shed more light on the individuals' behavior under scrutiny (Patton, 2002).

Frequent Debriefing

Frequent debriefing is a necessary tool between the researcher and colleagues. Through debriefing discussions, the vision of the researcher's ideas may be enhanced as different experiences and perceptions are revealed. I participated in debriefing sessions with my chairperson, Dr. Jay Greiner, and mentor, Dr. Francine Sims, when my chair was unavailable as an alternate. Through these collaborative debriefing sessions, Dr. Greiner and Dr. Sims drew attention to discrepancies within the study. The debriefing meetings provided the opportunity to use the chairperson and mentor as a sounding board, test new developing ideas, and help the researcher to become aware of their own biases, as suggested by Shenton (2004).

Thick Description

Thick description is important for promoting credibility in research. As explained by Lincoln and Guba (1985), it helps to convey the actual situations investigated and the

contexts surrounding the experiences of the participants. The reporting system defines a series of different typologies and illustrates the conclusions of the findings.

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Member checks are the single most important provision for strengthening credibility (Lincoln & Guba, 1985). The process involves confirming the data collected from the participants in the form of interview transcripts or summaries of the interviews for participants to review for accuracy. Member checks were conducted during and at the completion of the study, by distributing the findings to the participants. This process allowed participants to critically analyze the findings to ensure the findings reflect their feelings, views, and experiences.

Transferability

Transferability refers to the extent that the findings of the study can be applied to different contexts (Merriam, 1998). Using thick description allows readers to glean a conceptualization of the unique conditions that participants experienced and a detailed view of participants' responses within this context. Using transferability facilitates development of a position within the study for readers who believe the findings are transferable to their own experience.

Confirmability

Shenton (2004) posited the concept of confirmability is the qualitative equivalent to the quantitative concern for objectivity. Miles and Huberman (1994) stated the key criterion for confirmability is the extent to which the researcher admits his or her own predispositions. I readily admitted biases and created questions to access the depth of the

participants' experiences as they related to self-efficacy and locus of control, to ensure confirmability. Additionally, I engaged in journaling and reflective note taking to acknowledge these predispositions.

Ethical Procedures

I was the primary researcher for this study and recruited participants using a Facebook weight regain blog, Walden's Participant Pool, community support groups, and referrals from colleagues who provide bariatric counseling before and after weight-loss surgery. However, my colleagues were not informed of the identity of the potential participants and did not have access to the data. Participants in the community may have recognized me as a mental health counselor, and as someone who has undergone RYGB surgery. I interviewed each participant face-to-face in a office that was quiet, warm and comfortable which, allowed the participants to engage verbally about their experience through various post-RYGB questions regarding their experience with RYGB surgery and maintaining my weight-loss goal following the procedure, I briefly shared my experience as a means of building a rapport. However, I refocused the discussion on the participants to ensure the thrust of the interview illuminated the participants' experiences and perceptions.

According to Swift-Dickson et al. (2007), self-disclosure may help in building rapport with participants, remembering that too much may have unintended consequences in qualitative research. It was important for me to recognize that I may have preconceived biases, beliefs, and assumptions about weight loss and reasons for weight regain. I employed bracketing to reduce bias and the influence of my own preconceptions, as

recommended by Moustakas (1994). During bracketing, I did not schedule any bariatric counseling sessions with participants to avoid a conflict of interest. I communicated this information in the informed consent form (see Appendix B).

Chapter Summary

The purpose of the study was to explore the lived experiences and perceptions of women who regained weight during the first year following RYGB surgery using a phenomenological approach. Semistructured interviews were conducted to obtain participants' insight related to self-efficacy, self-esteem, depression, coping, and problem-solving skills in relation to their daily life stressors. A research journal was kept to log the participants' reactions and nonverbal responses. This chapter presented the methods and processes implemented in this phenomenological study. Chapter 4 includes the results from the data analysis.

Chapter 4: Results

Introduction

The purpose of this phenomenological research study was to explore the lived experiences and perceptions of women who regained weight during the first year following RYGB surgery. Specifically, I engaged participants in an exploration of their perceived self-efficacy and body image, and of how their coping skills, eating habits, social support, self-efficacy, and locus of control influenced their ability to maintain their weight loss within 1 year or later following RYGB surgery. Bariatric medical professionals have noted bariatric surgery as the best long-term solution for morbidly obese individuals with a BMI of 40 or higher (Chaar, 2013; Zalesin et al., 2010). Although RYGB surgery has proven to promote weight-loss as designed, researchers have discovered that 6–12 months following surgery, 20–40% of WLS patients began to regain weight postsurgery (Weineland et al., 2011). The overarching research question guiding this study was: How do the experiences and perceptions of women who have undergone RYGB surgery influence their ability to maintain weight-loss? To explore this question in depth, the following research questions guided the research study.

RQ1: What is the experience of post-RYGB recipients with coping skills related to weight loss and weight gain following RYGB surgery?

RQ2: What is the experience of post-RYGB recipients with eating habits and how they contribute to the success and failure in maintaining ideal weight following surgery?

RQ3: What does RYGB surgery mean to post-RYGB recipients related to body image?

RQ4: What does social support mean to post-RYGB recipients?

RQ5: What is the influence of perceived self-efficacy on maintaining weight-loss goals post-RYGB surgery?

RQ6: How do participant perceptions of locus of control influence their perceived responsibility for maintaining weight-loss goals?

This chapter includes detailed information about the research setting and participants' demographic information. Following the demographic data is a brief review of the data collection techniques I used for the research study, which precedes a description of the data analysis techniques used on the interview data. After a review of the evidence of trustworthiness, I present the results prior to a brief chapter summary.

Setting

The in-person interviews took place in a private counseling office where the participants were comfortable with going into detail about their experiences. The participants were from the Detroit area, and the interviews took 1 hour to complete and were uninterrupted. There was soft nature-sounding music playing during the interviewing sessions.

Demographics

After recruiting participants from my community (Detroit area) and Facebook weight gain and weight loss blogs, I screened the participants to ensure they met the criteria for the research study. The inclusion criteria were (a) being a woman, (b) having issues maintaining their ideal weight-loss goal 12 months or later after RYGB surgery, and (c) being 18 and over. I intended to recruit 10 participants in total; however, after

months of recruitment, only eight participants met the inclusion criteria and were willing to participate in the research study. Despite not having the intended number of participants, I was confident that I could acheive thematic saturation with eight participants, given the findings of other qualitative researchers (see Guest et al., 2006). Table 1 outlines the participants' demographic information.

Table 1

Participant Demographic Information

Participant	Age	Weight before Surgery	Current weight	Goal weight
1	39	427	289	250
2	49	264	184	175–180
3	49	390	290	190
4	42	265	165	145–155
5	45	351	248	175
6	62	325	198	150
7	43	401	258	200
8	35	275	183	147

Data Collection

I used a semistructured interview protocol (see Appendix D) for this phenomenological study to obtain in-depth descriptions of shared experiences with postsurgery weight gain in participants' own words, and from their personal perspectives (see Creswell, 2013). The objective of these questions was to elicit participants' perceptions regarding (a) their experiences following RYGB surgery, (b) their thoughts

and emotional state after weight loss and weight gain, and (c) their perceptions and attitudes regarding their body after massive weight loss. After scheduling the interviews with each participant, I met with each to conduct the interviews. Prior to the start of the interview, I provided each participant with a copy of the informed consent form and reviewed the document with them. Each participant had the opportunity to ask me any questions about their participation in the research study. After gaining their consent in the form of their signature, I began the interview with an audio recording device. The audio recording device was checked prior to beginning the interview to ensure the device was working correctly to mitigate any malfunctions.

During the interview, I built rapport with each participant as a necessary strategy to establish an effective relationship for collecting data. By doing so, I employed active listening, showing empathy and understanding, which led to active sharing. I began the interview with introductions and an icebreaker activity. I set a neutral and comfortable tone and environment for the interview because a relaxed and trusting environment enriches the interviewing process (Ward, 2012).

During each interview, I probed participants for further information to gather detailed and rich data to analyze. I took notes during each interview to capture meaningful topics that were discussed. After each interview was completed, I thanked each participant for their time and participation, along with providing a thank-you gift of $20 dollars. I maintained a reflective journal during the data collection process that included my thoughts, feelings, and perceptions regarding what I heard, saw, and experienced during the interview. I also reflected on the data collection process as a

whole and provided my thoughts and attitudes pertaining to how the interviews were going. To mitigate potential researcher bias, I reached out to my peers and committee during the data collection and analysis phases of this research study to discuss my thoughts and feelings.

Data Analysis

I used Moustakas's (1994) 10-step modified van Kaam data analysis plan for this research study. Before beginning this process, I listened carefully to the audio recordings of each interview to prepare for transcription. By listening carefully and repeatedly, I made sure no details were missed during the transcription. After each interview was transcribed, I again listened to the interview while following along with the transcribed interview. I ensured all details were preserved and properly typed into the transcribed interview. If I found mistakes in the transcript, I corrected those mistakes and continued.

After completing the transcripts, I sent each transcript to the respective participant's email address to conduct a transcript review, which is also known as a member check of the transcribed interview. During this process, participants were invited to make corrections to their transcrbed interview and provide additional details that could help further explain their thoughts and feelings about the phenomenon. All the participants returned the member checks. After I received the member checked interview transcripts, I uploaded the transcripts into the computer-assisted qualitative data analysis software NVivo 11. NVivo 11 is a tool that qualitative researchers use to organize and manage the robust qualitative data. After the transcripts were uploaded to NVivo 11, I began the 10-step phenomenological data analysis plan (see Moustakas, 1994). This

section only includes the first five steps, and the results section includes the remaining steps.

Step 1: Epoché

The first step of Moustakas's (1994) phenomenological data analysis plan was to begin epoché, the process of separating oneself from preconceived notions and judgments about a topic. To complete this process, I had to set aside preconceived thoughts and feelings about the phenomenon to mitigate any bias. During the interview process, I used a reflective journal to outline my thoughts, feelings, attitudes, and perceptions of the interviewing process. I also outlined my thoughts and feelings about each interview to address my preconceived notions about the phenomenon. By doing so, I hoped to approach each interview as unbiased and nonjudgmental as possible to prevent my potential biases from influencing data analysis. Moustakas (1994) described epoché as the state of pure ego in which anything that could potentially interfere with an objective view is eliminated.

Step 2: Obtaining an Understanding of the Data

The process of transcribing the data gave me an opportunity to become familiar with the dataset. During this process, I listened carefully to the audio recordings to become familiar with the data before beginning the transcription process. In doing so, I began to understand participants' perspectives about their experience with bariatric surgery. Familiarizing and understanding that dataset gave me deeper insight into the participants' individual experiences with the phenomenon and helped me understand the phenomenon as whole through the participants' perceptions.

Step 3: Horizonalization

Moustakas (1994) defined horizonalization as a qualitative researcher treating every piece of data as equal and assigning them equal value. During this process, I began the preliminary coding and grouping by outlining each quote relevant to the experience of the phenomenon. After outlining all the excerpts for a participant reporting her lived experience with the phenomenon, I began to preliminarily group the coded data together based on related experience. This occurred by examining the relationships each excerpt had to the phenomenon and grouping together excerpts with similar relationships. Table 2 outlines how preliminary coding and grouping occurred by showing the list of unorganized codes compared to the list of preliminarily grouped codes.

Table 2

Example of Preliminary Coding and Grouping

Preliminary coding	Preliminary grouped codes
(a) disappointed, not depressed (b) would have benefitted from dietary advice (c) not overly concerned with weight (d) no prior advice on what to expect (e) lack of support following surgery (f) regrets falling into bad eating habits (g) would have followed doctor's orders (h) no self-esteem issues after regaining weight (i) beliefs in necessity of support system	Thoughts and Feelings about Regaining Weight: (a) disappointed, not depressed; (b) not overly concerned with weight; (c) regrets falling into bad eating habits; and (d) no self-esteem issues after regaining weight Importance of Support and Advice: (a) would have benefitted from dietary advice, (b) no prior advice on what to expect, (c) lack of support following surgery, (d) would have followed doctors' orders, and (e) beliefs in necessity of support system.

After the preliminary coding and grouping, I began to reduce and eliminate preliminary codes that were not directly related to the phenomenon. This process was useful to identify the invariant constituents of the phenomenon. I asked myself two questions about each excerpt: (a) Does this excerpt tell a necessary aspect of the lived experience as it relates to the phenomenon? and (b) Can this excerpt be reduced to its latent meaning? If the answer was *no* to either of these questions, then the excerpt was eliminated. After reducing and eliminating the unnecessary excerpts from the preliminary coding, I began the fourth step of the phenomenological data analysis plan.

Step 4: Identifying Invariant Constituents

Invariant constituents are the statements that remain after the researcher completes the process of reduction and elimination (Moustakas, 1994). These statements come from a single interview transcript and do not repeat or overlap. During the process of identifying the invariant constituents, I used imaginative variation to the essences and meanings latent within the data. This occurred by looking at each excerpt from various perspectives, points of view, positions, and roles. I was able to outline the potential structural meanings that could underlie the textural meanings. By recognizing which themes and contexts accounted for the phenomenon occurring, I considered the universal structures that lead to the varying perspectives about the phenomenon. Table 3 outlines an example of some invariant constituents.

Table 3

Example of Invariant Constituents

Invariant Constituents
1. "Well, I didn't have a good support system following surgery."
2. "I think I forced myself to drink cherry even if I threw up I didn't care eventually my body just said drink the cherry coke then I started tolerating the coke."
3. "I thought I was going to have this surgery and be skinny."
4. "It is an awesome opportunity for individuals to have a second chance at life."

Step 5: Identifying Themes

After reducing and identifying the invariant constituents, I began the process of creating themes based on the latent meanings of the invariant constituents. I explored the latent meanings of the invariant constituents and grouped together excerpts based on those latent meanings. These groupings formed the basis for the themes that expressed the participants' experience of the phenomenon. After I created the themes, I examined those against the data set to ensure each theme represented a necessary aspect of the participants' experience. I ensured the participants' story was told with respect to the integral meanings conveyed during the interviews.

Evidence of Trustworthiness

Verification of Findings

The research findings were verified for fidelity and veracity in relation to participant data. Lincoln and Guba (1985) stated the concepts of validity and reliability were directly based on measures related to the issues of trustworthiness within qualitative inquiry. Lincoln and Guba's framework of trustworthiness consisted of credibility, triangulation, frequent debriefing, peer scrutiny, thick description of the phenomenon, member checks, negative case analysis, and clarification of researcher's bias. This research study employed iterative questioning, triangulation, clarification of the research bias, and a thick description of the phenomenon.

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Results

Step 6: Individual Textural Description

Following the creation of themes for each participant, I began to construct an individual textural description for each participant. In the individual textural descriptions, words were taken from the transcript verbatim to clearly communicate the participant's experience.

Participant 1. Participant 1's interview transcripts were analyzed based on the first five steps outlined in the data analysis section of this chapter. The textural description for Participant 1 is organized by themes and subthemes. Table 4 presents each theme, supported by text.

Table 4

Textural Themes for Participant 1

Themes	Subthemes	Textural Aspects of Themes

Weight loss management	1. Excess skin 2. Regaining weight 3. Support	1.a. Emotional response 2.a. Disappointment 3.a. Support from medical staff 3.b. Belief in necessity of support system
Lifestyle	1. Eating 2. Mentality and behavior	1.a. Eating unhealthy foods 1.b. Mental change in eating habits 2.a. Looking to the future 2.b. Second chance at life

Weight loss management. For this theme, three subthemes emerged from Participant 1's data: (a) excess skin, (b) regaining weight, and (c) support. These subthemes helped explain the thoughts and feelings about managing her weight loss, such as dealing with her concern about her excess skin and how she felt about regaining weight after the surgery. Her emotional responses to these experiences were conveyed during her interview.

Excess skin. Participant 1 discussed her experience with excess skin following RYGB surgery. She explained how, even though she felt she had succeeded in losing weight, she was still seen as overweight. She felt that her body was "smaller" and no longer had the "big belly" that people often looked "directly at." She was unhappy with her excess skin, which she referred to as a "sack of potatoes." She thought she would be happy if she could get rid of her excess skin. She stated:

> I found a lady; I don't know how I found her. I don't know if it was in passing or what. I called this lady and told her look I got this belly and I need this cut off.

Either you gonna bill my insurance or I am going to have to put it on layaway. Something has got to happen. It's got to go.

Regaining weight. She spoke about emotions she experienced upon regaining weight, which primarily related to disappointment. Participant 1 shared she never had issues with self-esteem, stating, "At 427 pounds you could not tell me I wasn't Beyonce." However, when she began to regain weight, she was "not happy." She explained that regaining weight was "disappointing," but it did not harm her self-esteem to the point of "being sad and crying." She did share her feelings that she could lose additional weight.

Support. According to Participant 1, there was not adequate support from medical staff before or after RYGB surgery. She said, "I wish somebody had told me what to expect." After surgery, she explained, a "good support system" is necessary. She felt that if there had been support provided, she "probably would have followed the doctor's orders." It was Participant 1's personal responsibility for not joining support groups, though she noted she should have. She felt that support was necessary to a successful experience. She wondered if having a support system would have "changed [her] perspective" on the outcome. Her husband did not want her to have the surgery, which she attributed to "his own insecurities." The two of them practiced poor eating habits, which she described as eating "like two fat pigs." The lack of support she received from her husband carried from before the surgery to after, as she shared "I don't have that [support] now."

Lifestyle. Two subthemes fell under the theme of Lifestyle: (a) eating and (b) mentality and behavior. These subthemes highlighted the changes in lifestyle she either was required to make or she made of her own volition.

Eating. Participant 1 spoke about how eating habits contributed to maintaining her ideal weight. She felt that because she had already lost so much weight, she was able to maintain by just eating smaller. She said, "In my mind, I wasn't gonna [*sic*] be 427 pounds again." To her, it did not matter what she ate because she was "really small." As a result, she ate and drank things she knew she should not such as "pop" and "chocolate donuts." Though she knew her body would not react well, she forced herself to eat and drink things that were bad for her. She described how pregnancy made her crave "Cherry coke." At first, her body did not accept the Coke, but she did not care if she threw up from it. Eventually her body "started tolerating the coke" and she was able to continue drinking it.

Participant 1 noted a mental change in eating habits was required to maintain her ideal weight. She acknowledged that the decision to have the surgery was a "life changing decision" that a person must be "prepared for." She recognized others' poor eating habits because of her mentality shift. She said:

> Let me use my friend, for example. She had the sleeve, she is a "BIG" girl. She still [is] a "BIG" girl, you know why? Because we go out and eat and she eats no different. How she stuffs all that food in her mouth and down her throat is beyond me. I can't do it…Just because you are a "BIG" girl or a big person you have to mentally change the way you eat… We go out to eat she orders six different

> plates around her and I'm sitting there with my little saucer of food. Hell, I should be eating off one of her plates.

Participant 1 made various changes to her eating habits, including trying to "cut down on the pop." She explained that she had gone about a week without having any pop, which was "awesome" for her, but she had not seen a "major difference" yet. Pretzels were her snack of choice, but she felt that if she could "be delivered" from them she would be on better track to change her eating.

Mentality and behavior. Participant 1 explained her response to RYGB surgery in terms of her mentality and behavior changes. She was "excited" about the outcome of the surgery and shared that she was "looking [forward] to losing weight." I was looking forward to not being 427 pounds." Participant 1 did not feel she executed appropriate "self-control" after the surgery. She shared, "You will throw up if you eat the wrong thing," and explained that she did not "put forth the effort" to maintaining a healthy diet and life. She saw the surgery as an opportunity "for individuals to have a second chance at life," but suggested that only people who are dedicated should pursue it. "You have to work at it. I did not do that," she said. People should only opt for the surgery after they have "tried everything to lose weight" and are willing to put in effort after the fact (Participant 1).

Participant 2. I analyzed Participant 2's interview transcripts and identified the themes that emerged from the data. Participant 2's textural description was based on the themes and subthemes identified. Table 5 outlines these themes, subthemes, and their textural aspects.

Table 5

Textural Themes for Participant 2

Themes	Subthemes	Textural aspects
Committed to change	1. Achieving goals	1.a. Daily responsibilities
	2. Mentality	1.b. Committed to exercise
	3. Dietary changes	2.a. Determined to continue progress
	4. Quality of life	2.b. Being in the right mindset
		3.a. Conscious eating
		4.a. Body image
		4.b. Personal responsibility
Support	1. Personal	1.a. Concern from peers
	2. Professional	1.b. Encouragement
		2.a. Dietitian
		2.b. Following doctor's orders

Committed to Change. Four subthemes were under the theme Committed to Change: (a) achieving goals, (b) mentality, (c) dietary changes, and (d) quality of life. These subthemes were identified as the many ways Participant 2 was committed to the change that bariatric surgery brought to her life. Although, she knew what her commitment was she spiraled back and forth with emotional eating with junk food, she gained 20-25lbs; she was able to take charge and commit to change her habits,

Achieving goals. Participant 2 spoke about her daily responsibilities after RYGB surgery. She said, "I weigh myself daily. Just to see if I'm at my weight." She paid attention to her daily dietary and exercise requirements as well. She explained:

> I've been exercising. I am doing the things they taught me to do. I work out, I eat right, I drink my water; I drink my protein. I don't miss my protein because my body has to have that eight grams of protein a day. When I get in the morning, I make my smoothie in "Big" cup. I mark it, so that halfway, halfway, and halfway. I do my eight grams of protein before 6pm.

Mentality. She felt coping with weight maintenance after surgery had a lot to do with mentality and dedication. It was important for her to drink protein drinks "two to three times a day" and take "vitamins." Participant 2 also noted she was "working out" three times a week to maintain her weight. Prior to her surgery, her doctors advised that she lose "five pounds." She explained that they did not give her a "higher goal" because she had already begun working out. The doctor was required to "show the board" that Participant 2 was "dedicated" to the process to gain "approval for the surgery."

Participant 2 felt that it was important to "follow the plan" to maintain her weight-loss progress. She described this commitment as being "dedicated to your pouch" and making sure the surgeon's advice is followed. She shared that a change in "mental thinking" was required to properly follow the plan and maintain weight loss.

Participant 2 additionally noted she was not willing to return to her old self, which exemplified the importance of being in the right mindset. Her refusal to go "backwards" was a shift in her mindset, and she noted she had to tell herself "every day" that she refused to go back. To achieve this, a complete lifestyle change was required to maintain her new weight. She stated:

> I am more aware of the procedure and I know it's just a surgery that helps you lose weight, but I also know it is something I have to do mentally and physically to keep the weight off so, I had to change everything and be dedicated to it.

She understood her responsibility in the process, explaining, "I am responsible for me so I make sure I'm doing the things I have to do to keep this weight off."

Dietary changes. Participant 2 described changes she made to her eating habits to maintain her weight. A dietitian provided her with advice regarding her eating. Participant 2 explained the dietitian "put me on track" to change her habits prior to the surgery. Her dietary changes were difficult to adjust to. She spoke about her affinity toward junk food, noting that her new diet required her to "give up a whole lot" of it. It was difficult at first, but she was able to change her mindset because she "really wanted to do" it. With her new mindset, Participant 2 could resist temptation as well. She "[threw] all the junk food away" and refuses to allow "cookies and cakes" in her house.

Her mindset was “different” after the surgery, which allowed her to be more “conscious” of the foods she consumes.

Quality of life. Participant 2 felt that RYGB surgery was important to her quality of life, noting she was “glad” she did it and it had a positive influence on her body image. Because of the surgery, she could “run” which she could not do before. The surgery provided Participant 2 with increased confidence and strength, which she “loves.” She stated the surgery had not affected her self-esteem because she took the responsibility her doctors assigned to her. Before the surgery, she was “concerned” about her self-esteem because of the “sagging skin” that often resulted from RYGB surgery. However, because she “lifted weights” and did “everything” the doctor advised her to, she only had a “little bit” of excess skin. It was her personal responsibility to maintain her weight loss, which she addressed by doing “45 minutes on the elliptical” every day and making sure she drinks plenty of water. She explained she was “doing the things I have to do” to maintain her progress.

Support. The theme Support had two subthemes: personal and professional. She identified the ways she was supported by her peers through online support groups and meeting with her coworkers to run. She talked about how she sought professional support from a dietitian and other health professionals so that she could keep on track with her goal of losing weight.

Personal. Personal support included an online “support group” where members could communicate their experiences. Participant 2 explained that she went on “every day” to read other peoples’ comments and sometimes make her own comments. This

allowed her to "see what other people are going through" and if they shared similar experiences. She noted the group tried to "keep individuals uplifted." At work, her coworkers have a "running group" which contributes to her motivation to exercise. The members of this group "encourage" Participant 2 to continue exercising. Her "competitive" nature gave her the motivation to sign up for marathons and triathlons with her peers. She had to "train" for these events because she did not want her opponents to "out do" her, which kept her in shape.

Professional. Participant 2 had sufficient professional support as well. The "Behavioral Health" clinic she attended allowed her to obtain information she needed from her dietitian. She explained she could call the dietitian and she would direct her to "any supports I may need within the hospital." This helped Participant 2 when she needed to get her eating habits back on track. She additionally noted she could call her surgeon if she needed, who would put her in contact with her nurse. Basically, she could contact the hospital and they would provide her with the contacts or services she needed.

Participant 3. Participant 3's responses were analyzed to find meaningful themes. Table 3 outlined the themes and subthemes that arose in response to the research questions.

Table 6

Textural Themes for Participant 3

Themes	Subthemes	Textural aspects of themes
Weight loss maintenance	1. Activity	1.a. Committed to change
	2. Effect on body image	1.b. Changes in eating habits
		2.a. Positive
		2.b. Negative
Advice for others		Modify behavior
		Exercise
Misconceptions of surgery		Lack of education about surgery
		Minimal support offered
Difficulties after		Lack of support
		Coming to terms with disillusionment
		Life changing event

Weight Loss Maintenance. The theme Weight Loss Maintenance had the subthemes activity and effect on body image.

Activity. Participant 3 felt "exercising and staying active" were important activities in weight-loss maintenance. She described "being stationary" as the main contributor to weigh gain. To keep herself motivated, Participant 3 joined a gym with her cousin, who she called her "accountability partner." Her cousin had the RYGB surgery at the same time, so they held each other accountable for weight-loss maintenance. By holding each other accountable, they were holding themselves responsible for the progress they achieved and maintained.

Participant 3 explained that prior to the surgery she would "go out and get something to eat." After the surgery, she stopped going out. If the food she wanted was not in the home, she wouldn't go out. She added if "someone [is] popping popcorn" at work and she does not have her own snacks, she would eat some.

Effect of body image. The surgery allowed Participant 3 to rediscover who she thought she was "prior to the weight gain." Having lost "150 pounds," Participant 3 was excited for her new life. She described it as having a "new lease on life" where she could do things she "would not normally do." She felt she "became a woman" because of the surgery, as it was the first decision she made without her mother; she described it as "liberating." Her new perspective of her body image made her feel "powerful" compared to the feelings of powerlessness she experienced before. This made her feel "thankful" for the progress she had made.

Participant 3 experienced many negative effects on her body image because of the surgery as well. Most of these were because of her gaining most of the weight she had lost back. She felt “disappointment” and “like a failure” because of her weight gain, though at first she did not notice it. Seeing herself in photos made her extremely upset. She shared she had a photographer “take 17 to 18 pictures” because she was unhappy with her appearance. Excess skin remains an issue for Participant 3. It makes her feel like she “didn’t even attain” anything. Many health issues arose because of the excess skin on her stomach, which she referred to as an “apron.” She described “dark circles” that would appear and how she would “tape myself with [saran] wrap to lift the skin” from her stomach. The sweat produced from her excess skin made her feel like she constantly “smelled” herself. These negative effects made her feel “terrible” about regaining so much weight.

Advice for Others. People considering having the surgery should know that it is not a “magic pill.” There were a “lot of steps” to be followed before the surgery, and many steps after as well. Participant 3 believed it was vital to “adhere to the follow-up” and guidelines to maintain weight loss. She shared it was a “constant battle” and she skipped many steps through the process. Because she knew people in the field, she was able to “circumvent” the steps and go “through the back way.” Going through the process without the necessary steps and knowledge led Participant 3 to struggle with the process. As a result, she advised anyone considering the surgery to “carefully consider each step” and make sure to “modify their behavior” before the surgery so they could adhere to the follow up.

Misconceptions of Surgery. The first theme was Misconceptions of Surgery, which had two textural aspects. These aspects were (a) lack of education about surgery and (b) minimal support offered. Participant 3 spoke about the lack of information she was given prior to surgery. She shared many things she "didn't know," such as the need to actively work to maintain weight loss and her appetite "for potato chips" coming back. She did not know that the surgery would not solve her weight issues for good. The surgery "needs to be communicated as a tool" because it helps people get on track with their weight, but Participant 3 was not informed of this. There was no assistance offered to her prior to the surgery because she went around the traditional steps leading up to RYGB surgery. Participant 3 believed there should be "educational and physical support" provided to patients because exercise is vital to weight-loss maintenance. She did not have a "good support system" and believed that a "better support system" would have assisted her in maintaining her weight. To her, the surgery was life changing, but without "adequate support" it was difficult to reap the benefits it could provide.

Difficulties After. The second theme, Difficulties After, consisted of three textural aspects: (a) lack of support, (b) coming to grips with disillusionment, and (c) life changing event. Two months after Participant 3's surgery, her mother passed away. This contributed to some of the difficulties she faced in maintaining her weight. She did not have the social support necessary to having a successful recovery and noted that "more education and follow-up is needed." Her surgeon had not reached out to her to check in on her progress. If he had tried to reach out, she would have been "influenced to follow-up" because she would be embarrassed not to. One peer support group was available for

people who had the surgery or were preparing to have it, but she did not participate. She shared that she went to the group once and there were "depressed people" who only discussed the things they could not do, which turned her off.

Participant 4. Participant 4 provided responses to the interview questions, which I analyzed in terms of the four research questions. The following description results from the analysis of themes and subthemes identified from the interview transcripts. One theme, Lifestyle Changes*,* applied to two research questions, but the subthemes differ according to the question. Each subtheme has various aspects, discussed in this section. Table 4 outlines the themes, subthemes, and aspects for Participant 4.

Table 7

Textural Themes for Participant 4

Themes	Subthemes	Textural Aspects of Themes

Lifestyle Changes	1. Physical Maintenance of Weight Loss 2. Mentality Towards Weight Loss Maintenance 3. Improving Eating Habits	1.a. Exercise helps maintain weight loss 1.b. Commitment to exercise 2.a. Desire to live better 2.b. Mindset/mentality change 3.a. Portion control 3.b. Dietary awareness 3.c. Healthy snacking
Perceptions and Feelings of Self After Surgery	1. Positive 2. Negative	1.a. Confidence 2.a. Afraid of gaining weight 2.b. Excess skin

Support Systems	1. Medical Staff Support 2. Peer Emotional/Social Support	1.a. Team effort in weight-loss maintenance 1.b. Health provider responsibility 2.a. Positive social interactions 2.b. Differences in surgery experiences

Lifestyle Changes. The theme Lifestyle Changes had three subthemes: (a) physical maintenance of weight loss, (b) mentality toward weight-loss maintenance, and (c) improving eating habits. Each of these subthemes had two textural aspects. The physical maintenance subtheme's aspects included (a) exercise helps maintain weight loss and (b) commitment to exercise. Mentality toward weight-loss maintenance had aspects (a) desire to live better and (b) mindset/mentality change. Improving eating habits had three textural aspects: (a) portion control, (b) dietary awareness, and (c) healthy snacking.

Physical maintenance of weight loss. Participant 4 discussed the importance of physical activity in maintaining weight loss. Some people had the surgery and "just did the weight loss" rather than working out with it. For RYGB surgery to be successful, a "complete life change" was necessary. This included taking care of "your body and

everything else better." Participant 4 shared her exercise techniques, which included "kick-boxing" and "cross-fitting" classes. She also went "ballroom dancing" twice a month with her husband. Exercising was vital to Participant 4's desire to "live better." Seeing the weight-loss progress the surgery provided encouraged her to "want to live a healthier lifestyle."

Mentality toward weight-loss maintenance. Both of Participant 4's parents had diabetes, which persuaded her to make a "conscious choice" to become healthy. Because of this decision, she struggles daily with deciding what she can eat. She explained mentality is the key to having a positive and successful experience with RYGB. The permanence of the decision required potential patients to "want this for yourself" as they would have to live with the outcome. Participant 4 believed the misconception that patients would "stay small" after the surgery without maintenance illustrated the need for a mentality change. She shared how part of her mentality change was being "okay with not eating sweets," even if it was just a small taste.

Improving eating habits. Before having the surgery, Participant 4 would continue eating when she was full "because [the food] was good." She recognized this habit was not conducive to a living a healthy life and changed her eating habits. She admitted that occasionally she would only eat "once a day" to avoid gaining weight back. Instead of eating until the food is gone, she stops eating when she begins to feel full. This allowed her to "stretch" her meals out to last her through a day. Eating "six meals a day" by controlling her portions was noted as one of the most important eating habits. Participant 4 was also aware of the nutritional or dietary value of the food she was eating, sharing

she had to “be aware of sugar intake.” Her meals sometimes consisted of smaller snacks to prevent her from getting full too fast. She drank protein drinks for breakfast and ate snacks, such as “hummus and string cheese,” throughout the day.

Perceptions and Feelings of Self After Surgery. The theme Perceptions of Self and Feelings After Surgery had two subthemes: positive and negative. The textural aspects that describe the overall theme include (a) confidence, (b) afraid of gaining weight back, and (c) excess skin.

Positive. After having RYGB surgery, Participant 4’s first reaction to her weight loss was excitement. Her increased confidence motivated her to work out, which caused her weight to come off “pretty fast.” She felt “fabulous” and “good” about herself, which she had not felt prior to the surgery. It additionally motivated her to stop smoking cigarettes.

Negative. Participant 4 shared significantly more negative feelings about the surgery than positive. Having to adjust to only being able to eat certain thinks like “pureed food” or “baby food” made her negative about the process. It “almost sent [her] into a depression” because she had to eat “nasty” food while everyone around her ate “normal meals.” For a brief period, Participant 4 was depressed and felt like having the surgery was a mistake. She was also worried that her husband would stop being attracted to her because of her weight loss, as he “liked the size” that she was before.

Excess skin after the surgery was a big issue for Participant 4. She described the skin as a “little turkey neck” that was hanging down over her “privates.” Having all the excess skin could “mess with your psyche” because it makes people feel like they were

not actually losing weight. Participant 4 explained, “When you lift up all this skin, you’re small, but you sit here looking like some type of slime.” She had medical issues related to the excess skin as well, developing “boils” under her stomach and “smelling” from the sweat.

Support Systems. The theme Support Systems had two subthemes: medical staff support and peer emotional/social support. Medical staff support had two textural aspects: (a) “team effort” in weight-loss maintenance and (b) health provider responsibility. Peer emotional/social support had three textural aspects: (a) positive social interactions, (b) differences in surgery experiences, and (c) ability to maintain weight loss.

Medical staff support. Participant 4 felt it was a “team effort” between the health provider and patient to maintain weight loss. She was not provided with any advice or plan that helped her know what she should do to maintain her weight. Something should be “lined up” for patients because the surgery is “too drastic” to not be prepared for life afterwards. Participant 4 believed a psychiatrist should be made available because everybody has different reactions to the results of the surgery, including “suicidal thoughts.” Having a counselor available to talk to about the fear of regaining weight was important to Participant 4, but she noted no such service was available. She explained she did not even “know what not to eat and what to eat,” which she believed the health providers should be responsible for.

Peer emotional/social support. After the surgery, Participant 4 dealt with “a lot of emotions” but did not have anyone to talk to about them. She felt having someone who “understood” what she was going through would have helped her deal with her emotions.

Participant 4, stated she felt alone and gained 15-20 back and began searching for additional online support and found a website was available for RYGB patients to use to "chat with other people" who had been through the process, but Participant 4 did not know of any other resources. Her roommate after the surgery was the only person she could communicate with about her progress, but they had different experiences and "really couldn't communicate." When she gained weight back, her husband was supportive and helped her "settle down."

Rather than receiving peer support after the surgery, Participant 4 explained her results had provided support to both herself other people. Her husband considered getting the surgery after seeing her results, and people recognized the progress she had made. She explained her motivation to do things she "never thought [she] wanted" like walking a 5K and riding bikes. When she started to do this, she realized that the surgery had been a "great influence" on herself and others.

Participant 5. Participant 5's responses provided themes that answered the four research questions. Each theme was unique to a specific research question, and some research questions yielded multiple themes. Table 5 provides an outline of the themes and subthemes that emerged for each research question.

Table 8

Textural Themes for Participant 5

Themes	Subthemes	Textural Aspects of Themes
Weight Gain	1. Stress 2. Back on Track	1.a. Falling out of good habits 1.b. Concern for others 2.a. Setting realistic goals
Motivation for Surgery	N/A	Personal responsibility for maintaining weight Responsibility to family
Lifestyle Changes	N/A	Eating right Getting into traps
Feelings	N/A	Nervous
Support	N/A	Support groups Professional support Family support

Weight Gain. The theme Weight Gain had two subthemes: stress and back on track. The first subtheme, stress, had the textural aspects falling out of good habits and

concern for others. The subtheme back on track had the textural aspect of setting realistic goals.

Stress. Regaining weight after the surgery was primarily because outside stress for Participant 5. Her mother had a stroke and "all of her care" became Participant 5's responsibility because she was the oldest of her siblings. Because she was preoccupied with caring for her mother, she ended up neglecting her own health. She did not continue doing what she was "supposed to do" to maintain, but acknowledged that if she had, her results would have been better.

Back on track. Participant 5 planned to "get back on track" in her weight maintenance. She felt she had "realistic goals" but found it difficult to perform some of them because her "joints hurt." To combat this and allow for more progress to be made and maintained, she planned to see a doctor about "pain management."

Motivation for Surgery. The theme Motivation for Surgery, had two textural aspects: (a) personal responsibility for maintaining weight and (b) responsibility to family. Participant 5 was motivated to have RYGB surgery because of her commitment to her family. She explained that her son was her "biggest worry," and wanted to be sure she lived to "see him graduate from high school." To achieve this, Participant 5 had to "make a mindset change" and convince herself that she needed to have the surgery for her son. She shared her son "needed his mom" because she was his "main" role model. Her son was her "number one fan" and he helped hold her accountable for maintaining her weight. She felt she was responsible for maintaining her weight to be present for her son and introduce her daughter to healthy eating habits.

Lifestyle Changes. The theme Lifestyle Changes did not have any subthemes, but yielded two aspects from the text. The first aspect was eating right, and the second was getting into traps. Participant 5 explained how she had to "learn how to eat all over again" after the surgery. She noted the importance of staying on track with "supplements, protein drinks and…pills," but felt it was not always possible. To manage her weight, she exercised, ate healthier, and staying focused on her goal, which was to lose weight. Avoiding things like "cookies, candy, chips, and pop" were key to staying out of a "trap." A mental change was necessary to "adjust" to being able to only eat certain things, which Participant 5 had a difficult time with. She regained weight "gradually" because she developed poor eating habits. As time after the surgery passed, she stopped "preparing food" and "making protein drinks" like she used to. When her mother had a stroke, she began to "stress eat" to cope. This made her realize the importance of eating habits in the maintenance of her ideal weight.

Feelings. The theme, Feelings, did not yield any subthemes. Aspects identified regarding this theme included (a) nervous and (b) positive view of surgery. Before having surgery, Participant 5 was nervous. She was afraid of the "anesthesia" because she was worried about waking up. After waking up and seeing the results of the surgery, she was happy. Participant 5 felt RYGB surgery was "one of the best things" she could have done with respect to weight loss. She explained that it gave her "more energy" and increased her confidence. It was important, however, for patients to "use the tools the doctor gives" to lose weight appropriately, rather than just losing weight.

Support. Participant 5 spoke about how Support helped her after the RYGB surgery. Three aspects of the theme were (a) support groups, (b) professional support, and (c) family support. Participant 5 explained support groups were available to her and other patients, but she had not reached out to any. The support groups she did know to exist were at the hospital where she had her surgery. She noted she did not "know how long you can belong" to the group after surgery. The support groups provided a "dietitian and nutritionist" to patients when they were struggling or had plateaued. Support groups also existed prior to surgery to provide "extra support" to patients. According to Participant 5, "everyone should get involved" in any groups provided by the facility where they had their surgery done. She felt "family are good support systems," but noted that after her mother's stroke, family became less of a resource for support. Her daughter was helping her with responsibilities at home, but she went away to college.

As far as professional support was concerned, Participant 5 did not feel her doctors provided enough. She explained that the doctors followed up in person with patients for "the first two to three years," but then called them thereafter. Participant 5 believed doctors should follow-up with bariatric patients for "at least seven to ten years" to monitor their progress and offer guidance, if needed. More "personal phone calls" from her doctor would have encouraged her to put more effort into her maintenance. Her doctors stopped contact after 1 year regarding her surgery or progress.

Participant 6. The analysis of Participant 6's interview responses resulted in two themes. Because only two themes existed, the theme Life After Bariatric Surgery has

multiple subthemes. Table 9 outlines the themes, subthemes, and textural aspects that emerged from the data.

Table 9

Textural Themes for Participant 6

Themes	Subthemes	Textural Aspects of Themes
Life After Bariatric Surgery	1. Lifestyle Changes	1.a. Personal responsibility
	2. Eating Habits	1.b. Exercise
	3. Support	2.a. Portion control
		2.b. Poor eating habits
		3.a. Professional support
		3.b. Knowledge about barriers
Real World	N/A	Difficulties and challenges

Life After Bariatric Surgery. The theme, Life After Bariatric Surgery, had three subthemes: (a) lifestyle changes, (b) eating habits, and (c) support. The subtheme lifestyle changes had two textural aspects: (a) personal responsibility and (b) exercise. The subtheme eating habits had two textural aspects: (a) portion control and (b) poor eating habits. Textural aspects related to the subtheme of support included (a) professional support and (b) knowledge about barriers.

Lifestyle changes. Participant 6 believed that after surgery, a "mind and life style" change was required. Patients were often "on [their] own" after surgery. Because of this, Participant 6 emphasized the importance of "exercise" in maintaining her weight.

Eating habits. Specific eating habits noted by Participant 6 included being aware of calorie intake and paying attention to portions. She knew that by focusing on these habits, she would have better luck maintaining her weight. For the first few months after the surgery, Participant 6 was “drinking protein drinks” and eating “mashed up food,” such as baby food to help lose weight. As time passed, maintaining her weight became difficult. Dietitians were important in helping patients stay on a healthy eating track. Participant 6’s insomnia caused her to snack “all night” and have cravings “in the middle of the night.” Potato chips were her “down fall” and she had a hard time “resisting” them. Her responsibility of caring for her mother led her to “stress eat,” which contributed to her regaining weight.

Support. Doctors did not inform Participant 6 of the “barriers” she would face after the surgery. She felt support should have been provided prior to surgery so patients knew what to expect as well as had advice regarding weight maintenance. There were no additional follow-ups after the first, which left Participant 6 feeling like she was “on [her] own.” A dietitian was provided in the beginning, but patients were responsible for themselves after the first few months. Participant 6 was a member of a bariatric weight-loss clinic and could go “at any time and participate” in the programs they offered. This clinic provided a “dietitian, physiologists, swimming classes, cooking classes” and other services. Because of the situation with her mother, Participant 6 did not participate in the programs. She noted she had not checked for “online blogs” because she was busy.

Real World. The theme, Real World, consisted of textural aspects relating to difficulties and challenges. Having the surgery and not aligning mindset and lifestyle

results in issues maintaining weight. She explained the need for cosmetic surgery after the RYGB surgery to remove excess skin. After RYGB surgery, Participant 6 saw herself as a "sagging sac" of skin, and felt that she may have been better off without the surgery. Until her father passed away, she was "doing very well" in her weight loss, but then became the "sole care provider" of her mother with dementia. This caused her to experience extreme frustration with her situation and led to her insomnia. Having to devote constant attention to her mother made it "hard to remain focused" on her weight, which "frustrated" her. He explained that prior to taking on her mother's care, she had "some sense of balance" in her life, which was no longer present.

Participant 7. Four themes arose from the analysis of Participant 7's interview transcripts. Textural aspects were identified for each theme and subtheme, as outlined in Table 10.

Table 10

Textural Themes for Participant 7

Themes	Subthemes	Textural Aspects of Themes
Personal Responsibility	N/A	Surgery as a tool
		Motivational tools
		Weight loss goals

Lifestyle Changes	1. Behavior 2. Mentality	1.a. Conscious eating 1.b. Changing diet 2.a. Conditioning mind 2.b. Self-control 2.c. Emotional eating
Results of Surgery	N/A	Life-changing Excess skin Emotional responses
Support	1. Family/Peer Support 2. Professional Support	1.a. Accountability 1.b. Psychological component 2.a. Communication 2.b. Support groups

Personal Responsibility. Participant 7 spoke about Personal Responsibility in coping with weight loss or gain. This theme did not have any subthemes, but three aspects were discussed. The first aspect of this theme was surgery as a tool. The second aspect was motivational tools, and the third aspect was weight-loss goals. Participant 7 believed the patient was responsible for maintaining his or her weight after surgery. She described RYGB surgery as a “tool” provided by the doctors that the patient was responsible for utilizing “in the proper way.” The doctors gave patients “rules,” which

Participant 7 felt were vital to the overall recovery and weight-loss maintenance process. By following the rules, patients would not "have the issues that people have" when they go off track. For Participant 7, setting a "weight-loss goal" helped to maintain her progress. She focused on moving "forward" in her journey rather than falling back into her old habits. Sometimes she put on clothing she kept from when she was heavier, which brought "tears to [her] eyes" and kept her motivated. Self-motivation was an important aspect of personal responsibility. Comparing "side by side pictures" gave Participant 7 the motivation she needed by giving her a "vision" of where she came from and how far she had come. Seeing the "steady progress" encouraged her in her weight-loss maintenance.

Lifestyle Changes. Two subthemes comprised the overarching theme of Lifestyle Changes in response to the second research question. The subtheme behavior had textural aspects (a) conscious eating and (b) changing diet. The mentality subtheme had textural aspects (a) conditioning mind, (b) self-control, and (c) emotional eating.

Behavior. Prior to having RYGB surgery, Participant 7 had diabetes, but paying close attention to her diet had caused the diabetes to subside. To prevent her diabetes from coming back, she stopped eating "fried foods" and began "watching the carbs." She noted some foods she continued eating could be cut out because of the "natural sugars" they have. More important than the physical behaviors she had to change in her eating habits were the mental changes. Participant 7 spoke about the need to "condition" her mind about what she should be eating. This meant that she thinks about what she is going

to eat before eating it. She explained that, once reaching a certain milestone in weight loss, people do not want to return to their previous weight.

Mentality. Participant 7 explained to get through this, it is necessary to "talk yourself through" the mental process. Dealing with reconditioning was sometimes difficult for Participant 7, as she described herself as an "emotional eater." After her surgery, Participant 7 dealt with emotional events that caused her to "want to eat," including her dad having a stroke. She explained that she sometimes wanted to eat foods because of "emotional ties" to them, but began to question "why" she ate it. She felt that to overcome the "psychological" barriers, she had to determine what caused her to become addicted to food. Remaining aware of her mental state was key to maintaining her weight. Although she regained weight she is eager to lose what she gained.

Results of Surgery. The theme Results of Surgery did not have any identified subthemes, but had three textural aspects. These aspects were (a) life-changing, (b) excess skin, and (c) emotional responses.

Participant 7 believed RYGB surgery had "changed [her] life" and was overall a better experience than other weight-loss surgeries she had. She was "happy" with the weight loss she experienced from the surgery, and felt she was "fortunate" to have not regained weight. It seemed that the weight "melted overnight" after the surgery; she described this feeling as "amazing." The surgery was a "lifesaver" that led to significant improvements in her health. She no longer had diabetes or cholesterol issues, and had improved physical abilities. As time passed, however, she stopped losing weight consistently and hit a plateau. This resulted in "frustration" and a desire to find a new

way to lose weight. Participant 7 was able to "jog" after the surgery, which was a drastic improvement from her have a "hard time with walking" prior to the surgery. The only negative result she identified was excess skin, which she described as her "nemesis." She expressed a desire to lose "50 more pounds," but felt that the excess skin on her stomach area weighed that much alone. Dealing with the excess was "the worst part" of the RYGB surgery for Participant 7, as she had lost more than 100 pounds.

Support. The theme Support consisted of two subthemes: family/peer support and professional support. Aspects discussed regarding family/peer support included (a) accountability and (b) psychological component. Professional support included aspects (a) communication and (b) support groups.

***Family/peer support*.** Participant 7 had what she referred to as an "accountability partner" who kept her on track with her diet. This person kept her "grounded" in her new way of life, offering her a piece of fruit when she wanted something sweet. Since this person had also had RYGB surgery, she had a "different type of bond" with Participant 7 than others who provided support. According to Participant 7, having support from somebody who is "going through the process with you" helps immensely in adjusting to life after surgery. Support groups where she could meet people who can share their experiences with RYGB were available and helped her understand what her "body is going through." Attending these support groups allowed patients to "build relationships" that they would not otherwise have, such as that of Participant 7 and her "accountability partner."

She also noted the importance of familial support in life after surgery. Her family provided “dynamic” support that she could rely on in various stages of her recovery. Participant 7 felt she was lucky to have family who could “motivate” her and “pick [her] up” when she lost focus, but noted not everybody is so fortunate.

Professional support. Professional support outside of support groups was limited. Participant 7 felt health providers could “reach out” more after the process to check-in on patients’ progress. Although providers sent out “memos” about support groups, Participant 7 was not active. She explained some people “may not feel comfortable” speaking about their health in a group environment, and suggested more “one-on-one” support was needed. Her primary care physician had been supportive through the process, offering ideas about what she could do to “keep moving” toward her goal, but she only saw the surgeon who performed the surgery “once a year.” She felt the hospital and surgeon had “failed” to provide enough support to patients.

Participant 8. Of the six themes that emerged from the analysis, only one had subthemes. The following textural description is based on the themes and subthemes, and their resulting textural aspects. Table 8 outlines these themes.

Table 11

Textural Themes for Participant 8

Theme	Subthemes	Textural Aspects of Themes

Lifestyle Changes	1. Mentality 2. Eating Habits	1.a. Changing thought process 1.b. Mental preparation 2.a. Eating healthier foods 2.b. Eating smaller meals 2.c. Conscious eating
Personal Responsibility	N/A	Pushing self Setting goals Reminding self of goals daily
Difficulties	N/A	Medical complications Emotional responses Constant struggle
Perception of Surgery and Process	N/A	Second chance at life Would do surgery again
Positive Outcomes	N/A	Increased confidence Improved physical health
Support	N/A	Family support Support groups

***Lifestyle Changes*.** The theme, Lifestyle Changes, had two subthemes: mentality and eating habits. Textural aspects describing mentality included: (a) changing thought process and (b) mental preparation. The subtheme eating habits had three textural aspects: (a) eating healthier foods, (b) eating smaller meals, and (c) conscious eating.

***Mentality*.** Coping with maintaining weight after RYGB surgery was a "mental" process for Participant 8. She had to remind herself that a "lifestyle change" was necessary if she wanted to stay on track. When considering what to eat, Participant 8 would go through a "detox" where she had to "mentally" prepare herself before eating something. Her doctors advised to do this to aid in her mental change and prevent weight gain. Participant 8 suggested it was important to follow doctors' advice because the surgery was "not for fun," but for increasing patients' quality of life. She felt strongly about the commitment she made to her weight-loss progress, sharing she would rather "eat baby food" than regain weight.

***Eating habits*.** To maintain her ideal weight, Participant 8 had to alter her eating habits. She explained that doing this could "help fix the problem that you created," including diabetes and being overweight. Mental preparation was a big part of changing eating habits. Patients had to "be mentally prepared to eat a salad" while their peers were

eating other things. Participant 8 saw people who had RYGB surgery eating “fried foods, bread, and meat all the time,” which she did not agree with. Continuing eating habits like this prevented patients from maintaining weight loss. It was important to Participant 8 to “maintain a healthy lifestyle” by eating right and exercising. She admitted she had been “on a fall back” eating potato chips, but stopped eating them for a week and “lost 10 pounds.” Before the surgery, Participant 8 had been on “Yo-yo” diets where she was told to eat healthier, but she did not change her habits. After the surgery, she began eating “a lot of fruits and vegetables,” which she had not done before, and banned sweets like “cookies and wham wham” from her home. She also started eating “many small meals” throughout the day rather than a few large ones and paid attention to what and “how many times” she ate.

Personal Responsibility. The theme Personal Responsibility covered three aspects discussed in the text: (a) pushing self, (b) setting goals, and (c) reminding self of goals daily. Participant 8 believed adhering to personal responsibilities was vital to coping after RYGB surgery. By setting “goals,” she held herself accountable; she would buy clothes that were smaller than she could fit in and “set a time frame” for when she would wear them. Setting and achieving goals encouraged Participant 8 to maintain her weight loss. As she continued losing weight, she began rewarding herself with something “sugar free.” She did not want to return to her state prior to surgery, when she dealt with high cholesterol, high blood pressure, and diabetes; as a result, she “over exert[ed] and push[ed]” herself to keep the weight off. Participating in “cardio, walking, dancing, and walking dogs” were a few ways Participant 8 remained active. Keeping weight off was a

“constant struggle,” but by comparing before and after photos, she felt she could “do anything.”

Difficulties. The theme Difficulties had three aspects: (a) medical complications, (b) emotional responses, and (c) constant struggle. After RYGB surgery, Participant 8 experienced physical and emotional difficulties. Medical complications, including having her “intestine wrapped around [her] colon, bowel obstruction,” and an appendectomy, set her back in her progress. She had to undergo another surgery to “widen” her airway so she could digest food. Despite experiencing such difficulties, Participant 8 was not negative about the process overall. Gaining weight caused her to become angry with herself, but she noted most of her weight gain was because of pregnancy. This weight gain made her “frustrated.” She did not want to regain all the weight she lost as somebody she knew had done; this man went from 400 pounds down to 100 pounds, then regained back to his presurgery weight. Though Participant 8 was pleased with her new appearance as a whole, she was unhappy with the excess skin that resulted from weight loss. She wore “girdles, cling wrap, [and] waistbands” to minimize the appearance of her excess skin, but saw it as “ugly” and referred to it as “the devil.” Participant 8 believed that, after having the skin removed, she would be a “true winner” because of her progress.

Perceptions of surgery and process. For Participant 8, RYGB surgery gave her a “second chance at life.” She was no longer in pain from the weight on her body, and she had “energy like never before.” Because patients are required to follow strict diets after the surgery, they are unable to “cheat” on their meals and must “adhere to the tools and

plan of the surgery." Having the surgery was a "great decision" and the "best thing" Participant 8's doctor could have recommended for her. As a result, she "would do it again" if necessary.

Positive outcomes. Participant 8 could see the weight "falling off" and gained confidence that she could lose more weight. She had so much success in her weight loss that her doctor "couldn't recognize" her. Her diabetes went away, and her blood pressure and cholesterol returned to normal.

Support. According to Participant 8, there were "a lot of support groups" available. She was not a member of support groups provided by her hospital, but was active on Facebook groups. If she wanted to participate in the hospital support groups, she would contact her counselors and they would set her up with an appointment to provide her with whatever services she needed. Both the Facebook and in-person support groups offered support ranging from "people struggling to individual[s] coupling up to encourage" patients to stick to their plans.

Participant 8's main support resource was her family. Her sister and mother were her "biggest supporters." They checked on her "daily" to make sure she was staying on track and monitoring her glucose, because she was previously diabetic. Family support was key to maintaining progress after RYGB surgery for Participant 8. She felt without them supporting her, she would have "fallen off the wagon" in terms of her progress. Her family was "pushing her" to continue her weight loss, which contributed to her constant motivation. Friends and family understood what Participant 8 was going through, and offered support and encouragement along the way.

Step 7: Individual Structural Descriptions

Structural descriptions elaborate on the emotional aspects of participants' experiences and the potential causes of those emotions. During each interview, participants talked about their feelings from obtaining the surgery, whether they were happy with having gone through the process or if they had doubts about the surgery. I explored the emotional responses conveyed during the interviews.

Participant 1. Participant 1 talked about the effect the bariatric surgery had on her life during her interview. She recognized she had bad eating habits prior to her surgery and talked about how the surgery gave her an opportunity to have a second chance at life. Before her surgery, she indulged in unhealthy foods and drinks, because in her mind, she thought she was not going to ever be at heavy as she was. As a result, she indulged herself with sugary sweets and drinks before going into her surgery. She believed the surgery was something that would make her automatically skinny and although she was happy to begin losing weight as a result of the surgery, she came to terms with the fact that the surgery did not necessarily make someone skinny. She stated during the process she really did not follow what the doctors told her. Participant 1's behavior was, everyone was doing it and lost weight, so I did it. Participant 1's attitude was carefree, but she stated she would do it again if given the opportunity. She admitted she did not know what to expect after her surgery and shared she took the easy way by getting the surgery instead of going through the various trials of weight-loss therapies before deciding that bariatric surgery was the only option left. She shared that after losing weight as a result of the surgery, she was able to become pregnant. It was not discussed

whether her ability to get pregnant was affected by the surgery, she only shared that after losing weight, she got pregnant.

It was during her pregnancy when she began to experience setbacks that influenced her eating habits and mentality towards continuing to lose weight. She began craving soda, and even though soda made her throw up, she continued to drink it. Her cravings continued and she fell back into bad eating habits that outlasted her pregnancy. She recognized the need for self-control, but admitted that she did not have any and regretted regaining weight. Although she reported she was not depressed and not emotionally eating, she mentioned she was disappointed in herself for returning to bad eating habits. Despite that, she was not overly concerned with her weight at the time of the interview and approached the manner in a more pragmatic fashion. She recognized that although she would like to continue to lose weight and eat healthier, she did not have a problem with her current weight because she had already made a significant improvement from her previous weight before the surgery.

After having lost a significant amount of weight, she decided to opt for cosmetic surgery to remove the excess skin from her body. Although this procedure is not covered under her insurance plan, she felt the surgery was necessary because she believed people looked directly at the excess skin when she was out in public. To her, getting rid of the excess skin was another step towards becoming a thinner woman and removing what she felt was a connection to her previous self. Participant 1 stated her stomach was like a sack of potatoes and it made her feel self-conscious. When asked about what advice she would give others, she reiterated her belief that surgery should be a last resort for those seeking

to lose weight and have a second chance at life. She mentioned with those goals, a larger need existed to understand that surgery was not automatic skinniness, and patients need to find support during and after the surgery.

For her, she did not have much professional support from the doctor and felt if she had been supported by her doctor, she may have understood what to expect. Even though she understood her life was going to change because of the surgery, she could not have guessed the dramatic changes her body would go through afterwards. As a result, she felt it was mostly on her to find the information and support she needed to overcome the challenges that resulted from the surgery. She went through many changes in addition to the change in eating habits—the most significant change being her mentality. Despite the progress she made to change her eating habits, after she became pregnant, her mentality toward maintaining her weight loss shifted to satisfying her cravings. As a result, her focus changed from being excited about losing weight and being motivated to continue with her weight loss, to accepting that she did not have enough self-control to monitor her cravings for unhealthy foods and drinks. Although she recognized she needed to get back on track, it was not something she was emotionally committed to because she shared how she was not interested in improving or increasing her weight loss. Participant 1 noted she was unaware of her failure to lose weight and follow direction; however, she blamed her reasons on her work schedule and inability to control her cravings of soda and pretzels. She stated the consumption of food was not her problem and she does not eat the portions like before, but blames her weight gain on sodas, potato chips, and pretzels, which are her

worst enemies. Participant 1 stated she enjoys drinking sodas but she has learned to control the amount she intakes daily.

Participant 2. Participant 2 shared her emotional experiences after getting bariatric surgery. For her, she was aware of what the process entailed and recognized the dedication she needed to have to see long-term results of weight loss after her surgery. She knew the surgery was not a permanent solution to weight loss alone, but coupled with healthy eating habits and regular exercise, she could have the long-term weight loss she wanted. She mentioned how committed she was to change her life after her surgery and shared the many ways she did from her eating habits to her mentality towards weight-loss maintenance.

Participant 2 felt it was her personal responsibility to lose the weight and took responsibility for the decisions to make her weight-loss goals a priority. She knew the changes her body would go through as a result of the surgery and gave up junk food to begin eating healthier and smaller meals. She received support from her doctor and a dietitian about making the transition to healthier meals before her surgery so that after she went through the surgery, her body was adjusted to her new diet. Although she admitted she felt a little sad about not being able to enjoy the food she used to, she would rather have increased quality of life than enjoy the unhealthy food that got her in her original position. She combined her new diet with an exercise plan that she felt would help her lose weight and made goals regarding her weight-loss journey.

Participant 2's weight loss had a profound effect on her overall disposition. Although she did not report any major changes in her self-esteem, she did share that she

felt confident about her new body. She had a new lease on life because of her surgery and felt happy about the changes she underwent to lose weight. As a result of the surgery she was able to run, something she had not been able to do prior to the surgery. She sought personal support from an online support group of individuals who went through the same process. To her, it was important to find individuals with shared experiences to obtain the necessary the support she needed to face the dramatic changes her body was going through.

Participant 2 faced some complications after her surgery; she briefly regretted her surgery and her mother passed away a short time after her surgery. She became depressed as a result of her mother's passing and began emotionally eating during that period of time. She recognized she got off track of her diet and exercise goals, and began to make changes to fix those areas. She began eating healthy again and started working out after a period of grieving because she wanted to live a better life. Participant 2 appeared happy with her results and has learned that a person must control what he or she eats to achieve long-lasting weight loss. She stated that no matter what the obstacle is, an individual is responsible for what goes in his or her body and how much exercise that person partakes in to keep the body healthy. She stated that to keep the figure she has now, she must take accountability for her actions and never place the blame on the situation, but rather recognize the power lies in her hands.

Participant 3. Participant 3 talked about her experiences with bariatric surgery and expressed how she originally thought the surgery was going to be a fit-it-all solution to her weight. She admitted she had unrealistic expectations about her surgery and how

the surgery was changing her body. For example, she did not believe she would have any excess skin because of the surgery and she believed her cravings for unhealthy food would just go away. She also believed losing weight would be easy and continue to occur on its own without a major change in her diet. She did not talk to anyone about what to expect and felt she received a lack of education regarding the surgery.

Participant 3 did not realize how important it was to change her diet and struggled with her cravings for unhealthy foods and drinks after her surgery. She was a part of a support group before the surgery but felt it was depressing because individuals were talking about what foods and drinks they could no longer enjoy because of the surgery. She only had the support of her cousin, who had the same surgery as she did. She recognized she needed to change her eating habits, but she did not make many changes. She continued to eat unhealthy food, just in smaller portions.

Participant 3 faced many difficulties after her bariatric surgery, as her mother passed away and she began fertility treatments. The fertility treatments made her gain back approximately half the amount of weight she lost after the surgery. As a result of her mother passing, she began to emotionally eat and fell off track with her weight-loss goals. Her excess skin created medical issues, such as rashes and an unpleasant smell, and made her self-conscious about her appearance. She felt like a failure because she gained weight and started adopting a self-defeated attitude towards her weight-loss goals. She felt disappointed in herself and felt shame regarding how she looked to the point that she did not want pictures of herself posted online. She pitied herself for not remaining on track with her weight-loss goals. Despite these feelings, she shared during her interview that

she was thankful for the weight loss she did maintain because she was able to have more physical mobility. She did not regret having the surgery; instead, she was glad she did it because she felt that she had a new lease on life. She felt more energized and powerful because of the surgery, she shared that she felt like a woman liberated from her previous body. Participant 3 stated that initially, when she was off work she was able to control what she ate, but after she returned to work, she began to place the blame on not having time to properly prepare her meals. She ate what people offered her and fell off track. Participant 3 stated with everything going on with the passing of her mother, infertility drugs, and lack of support caused her to regain weight. During the time of her interview, she was still struggling to maintain her weight and get back on track because of outside forces.

Participant 4. Participant 4 shared her experiences with her bariatric surgery and how she changed because of the surgery. She made many lifestyle changes, such as improving her eating habits, becoming more active, and changing her mindset. She shared how she improved her eating habits with the advice her doctor gave her and made significant improvements to her overall health. She ate smaller but more frequent meals and substituted unhealthy snacks for healthier snacks that kept her full throughout the day. By doing so, she mitigated any overeating she had and approached food in a different way. She no longer felt the compulsion to finish a meal because it was in front of her; she instead made larger meals last longer by saving the leftovers for another designated meal time. Because the surgery changed her stomach, she began controlling her portion sizes so that she could make sure she got the necessary nutrients she needed

without overloading her body with food. She watched calories and became hyperaware of her diet, which helped her control what she put into her body.

Participant 4 talked about how, in addition to her change in eating habits, she also became more physically active. She recognized the importance of exercise for success in maintaining her weight loss. She reported how she always wanted to be more physically active but was unable to before her surgery because of the strain her weight caused on her body. After her surgery, Participant 4 had increased stamina and physical capabilities that allowed her to exercise more frequently. When she noticed weight gain, she exercised more to prevent further weight gain and made a commitment to herself to exercise more to keep her body healthy.

During the process of losing weight, eating healthy, and getting more exercise, Participant 4 noticed a change in her mentality. She recognized the surgery was a permanent decision on her part and she was committed to making the necessary lifestyle changes so that she could live a healthier life. She had a true desire to live a better and healthier lifestyle because she did not want to be unhealthy like her parents. She shared that she had faith in her ability to get through any difficulties she faced after the surgery. She stopped smoking as a part of her transition to a healthier lifestyle and felt positive about the changes she was going through. She said that without her mindset change, she would revert back to her old way of living, which was something she did not want to do. She said the change in mentality was the cornerstone of her ability to make the necessary changes that came along with her surgery.

After her surgery, she experienced some concern regarding how her husband would see her, especially with excess skin. She felt disgusted with herself about the excess skin and felt it created an illusion of not having lost the weight. Her excess skin also created some undesirable medical complications because she got rashes and boils on that skin. Although she wanted to get cosmetic surgery to remove the excess skin, she faced a financial hurdle because it was not covered by her insurance. As a result, she did not get cosmetic surgery. Despite not getting cosmetic surgery, she felt confident as she watched herself lose more and more weight after her surgery. She was excited about her changes and even though she felt slightly depressed about not being able to eat the food she used to enjoy, she recognized giving up unhealthy food was a sacrifice she was willing to make to be healthy. Participant 4 was overly concerned about regaining the weight to the point that she frantically worked out to prevent any further weight gain. She struggled with her fear of gaining back the weight and feeling like the whole process was not worth it, but recognized she needed to stay committed to her plan. For her to maintain her weight loss, she needed to keep eating healthy meals and continue exercising.

Participant 4 admitted she felt alone in the process because her doctors did not offer any support or guidance regarding a weight maintenance plan. She believed counseling and support would have made a difference to her postsurgery but found other sources of support. Her husband was supportive of her along with her friends and family, but she did not find support from other people who went through the experience. As a result, she shared how she felt lonely going through this process without the support of others who shared similar experiences. She believed the lack of support hindered her

belief in her ability to maintain her weight loss. Participant 5 was excited about her progress but stressed how medical professionals failed her. She stated not having the support to assist her with the process of losing weight. However, she understood that the surgery was only a tool to help her lose unwanted weight. Participant 4 said she reached out to others who previously had the surgery for support. She understands it is a daily process to work on her health and change does not happen over night. Although she was pleased with her weight, she takes accountability for maintaining her weight loss. She stated she has more energy than before the surgery.

Participant 5. Participant 5 talked about how her motivation to get bariatric surgery was to be healthy enough to see her son graduate and set an example to her daughter about healthier eating habits. She shared how she had a responsibility to her son and daughter to maintain her weight loss so that they could see their mother live a long and healthy life. She wanted to be there for her children as they grew up and experienced new milestones in their lives, such as graduating from college, getting married, and having children of their own. To her, those were the driving forces that kept her committed to her weight-loss goals, eating habits, and exercise goals. Her family was her biggest support during her transition to life before and after bariatric surgery and shared that she had outside support groups in addition to her family. She did not receive medical support and felt her surgeons should continue to check in with their patients for at least a decade after the surgery to give follow-up advice.

Participant 5 made some lifestyle changes with her eating habits, her exercise routine, and her mentality. She adopted a “you know better” mentality towards unhealthy

food cravings and began to change her diet to reflect her goals for losing weight. Because of the way the surgery changes the body, she began eating smaller and healthier meals throughout the day to prevent overeating. She became more active by walking and getting additional exercise to maintain her weight loss. After her surgery, she reported she felt better about herself and had more energy to enjoy new activities she previously was not able to participate in.

Participant 5 reported that after her surgery, her mother had a stroke, which put her in a caregiver position for her mother. As a result, she began to revert to bad eating habits because she spent most of her time taking care of her mother and neglected to take care of herself. She shared how she began to emotionally eat because of the stress associated with taking care of her mother while she recovered from her stroke. After her mother recovered, she committed to getting back on track with her weight-loss plan. She made realistic goals about changing her diet and incorporating more exercise so that she could begin losing more weight. Participant 5's facial expressions were of disgust, and she placed the blame of her reverting back to old habits on life situations and talked about how her mother having a stroke contributed to internal stress, which made her stress eat and drink liquor to relieve herself. Although she knew that life changes happen with prompting, she blamed her external stressors, which caused her to revert to the old habits that led her to gain weight in the first place.

Participant 6. Participant 6 talked about her life after bariatric surgery and the challenges she faced. After the surgery, she began to make some lifestyle changes regarding her diet, mindset, and participation in support groups. She recognized that she

was a work in progress because although she tried to maintain portion-controlled meals and watch the calories she consumed, she was a night snacker. She said her weakness was snacking on potato chips, which was especially bad when she was stressed or under pressure. She admitted her shortcomings during the interview and understood she was personally responsible for maintaining her weight loss.

She had various sources of support as she transitioned to her new life after surgery. She saw a dietitian who helped her understand what portions she needed to eat and understand how her surgery was going to influence her eating habits. She attended counseling sessions to address any issues that came up as she made the drastic changes in her life. She also sought outside support, got involved in swimming classes, and went to cooking classes so that she could learn new ways to approach making meals that were flavorful but still healthy. Participant 6 did not have any support from her doctor or surgeons after her surgery, which made her feel that her success was all on herself to achieve. She mention she wished she was made aware of the barriers she was going to face after losing all the weight, such as the excess skin. She felt like she was stuck with all the extra skin and did not feel confident in her appearance because of it. She expressed anger, which was displayed in her body language. She became short tempered and said when she reached out to outside supports, they were unavailable because she had no one to care for her mother during support group hours. Participant 6 stated because of her external forces, she began to stress snack because she had no outlet; she ate all night and during the day. She stated because of no support or outlet, it sent her back to eating the things that caused her to gain weight in the first place.

Participant 6 talked about how after her surgery, her father passed away and she then had to take care of her mother with dementia. She became a caretaker for her mother and began to emotionally eat because of the stress and frustration she was feeling. During the time she was a caretaker for her mother, she shared that it was hard to stay focused on her weight-loss goals because of her additional responsibility to her mother. She was not able to maintain her weight loss and found herself struggling to manage her weight in addition to her new responsibilities. Participant 6 says she works every day to get back on track; she understands she is totally responsible for maintaining her weight. Although outside supports has been unavailable, she manages to exercise and seek support from siblings and friends who have undergone the surgery and are maintaining their weight loss postsurgery.

Participant 7. Participant 7 shared her feelings about the surgery, the changes she made in her lifestyle, the support she received, and the personal responsibility she felt to succeed in maintaining her weight loss. To her, the surgery was a lifesaver and well worth it. When she was overweight, she was concerned about the physical toll her extra weight had on her body and was overjoyed to have the surgery. She watched the weight disappear overnight and the problems she had before completely disappear. Before the surgery, she was a diabetic with cholesterol problems, but after the surgery, her body became much healthier and she was no longer a diabetic. Amazed by the results of the surgery, she felt the surgery changed her life and gave her an opportunity to do things she previously was not able to do. When she became stagnant in her weight loss, she began exercising more and eating different meals to facilitate increased weight loss. To her, the

only drawback from the surgery was the excess skin she had, but considering all the benefits of losing the weight, she was comfortable with her decision to get bariatric surgery. Participant 7 was confident in her choice of surgery. She was excited about life, smiled a lot, and said she should have done this a long time ago. She said before surgery, she had low self-esteem and smiled to mask the hurt of not feeling beautiful.

Participant 7 took personal responsibility for her weight loss and followed the advice she received from the doctor. She followed the rules laid out for her and motivated herself to continue her weight loss by trying on her old clothes. Seeing herself as a slimmer and healthier woman made her commit to her weight loss, and she took photos of herself as she transitioned so she could see how much she had accomplished since her surgery. She recognized bariatric surgery was a tool that helped her lose weight and combined the surgery with other lifestyle changes. Although she previously had difficulty walking and running, she now had no problem exercising. She changed her mentality towards food and recognized she was an emotional eater when under stress or pressure. As a result, she developed the habit of talking herself through what she ate and cut unhealthy food from her diet. From cutting fried foods and watching her carb intake, she watched what she ate and counted calories to make sure she was getting the necessary nutrients she needed. She talked about how difficult it was to recondition herself to food and have self-control of what she put in her body. She said that self-control was a mental process for her and kept herself motivated by telling herself how much her weight loss was going to affect her life overall.

Participant 7 researched bariatric surgery for a long period of time and shared that after years of planning, she decided to take the plunge. Because she researched the process, she was aware of what to expect as a result of the surgery and had resources available to her that other participants did not. She reached out to support groups for advice and guidance as she made her transition to her new life. After getting the surgery, she continued to gravitate towards those individuals who went through the process because they had understood the dramatic change the surgery had on her life. She had the support of her family and peers throughout the process and found an accountability partner to keep her grounded in weight-loss maintenance. When she would go out with her friends, her friends reminded her about her goals and helped her steer clear of unhealthy food. The personal support she received was more substantial than the professional support she received. She mentioned the limited communication after surgery and felt the area of professional support could be improved. Participant 7 took into account her internal and external forces; she realized the power was in her hands to make changes. She stated in her interview that even though life stressors come, she cannot revert back to her old habits. She motivates herself with exercise and involves herself with outside activities, which has helped her stay on course. Although she has not achieved her weight-loss goal, she is happier and continues to remain on the weight-loss track.

Participant 8. Participant 8 shared her perceptions of the surgery and the process of losing weight, the lifestyle changes she made during her transition to her new life, the support she received from friends and family, the difficulties she faced, and how she felt

personally responsible for her weight-loss maintenance. For her, she was grateful for the surgery because the surgery saved her life and gave her a second chance. Her doctor recommended the surgery to her and she felt it was the best thing he could have recommended because it gave her the physical restrictions she needed. She shared how because of the surgery, there was no room for emotional eating after a meal because the surgery would not let her eat a large serving of food. To her, it was like a diet she could not cheat on because she was not physically capable of eating more than she could.

Participant 8 changed her lifestyle completely, including her eating habits and her mentality towards food. She talked about how she ate smaller and healthier meals, and how she would save food to eat later instead of trying to finish it in one sitting. She tried to make a normal sized meal last all day, and because of the surgery, she got full more quickly than she ever had before. She was conscientious about the food she ate because she had to make sure she got the nutrients she needed to stay healthy. She shared how she would reward herself every once in a while with a sugar free or light treat. She ate more fruits and vegetables, and when she went out with her friends she shared or split a meal with a friend. In addition to the changes in her eating habits, she went through a change in her thought process because of the surgery. She recognized she was making a life-long adjustment to eating right and getting exercise because the surgery was a permanent decision. She was mentally prepared for the changes the surgery would bring to her life and constantly reminded herself of her motivation to get the surgery. Immediately after her surgery, she tried to eat unhealthy food and had an adverse reaction to it, something she reminded herself of when she had cravings for unhealthy food.

Participant 8 took personal responsibility of her decision to get the surgery and to lose weight. She admitted she would what was necessary to keep the weight off, such as over-exerting and pushing herself with exercise. She had a practice in place in which she would buy pants one size too small for her and use those pants as her goal pants. The pants kept her motivated on days where she was struggling to stay committed to her weight-loss goal and gave her something to strive towards. She encouraged her sister to get the surgery alongside her so they could both become healthy together. She talked about how she was supported by her family, peers, and friends through Facebook, and outside support groups. She mentioned a variety of support groups available to people who got the surgery. To her, it was important to have a large support system because they encouraged her to keep on track. In her own household, everybody transitioned to eating healthier because of her surgery, which made it easier to avoid unhealthy foods at home.

Participant 8 reported difficulties with excess skin after getting bariatric surgery. She described the excess skin as horrifying and tried several solutions to hide the excess skin such as girdles, cling wrap, and waistbands. When she became pregnant, she was concerned about weight gain and was upset when she started gaining weight. During her pregnancy, she felt weight maintenance was a constant struggle for her and found herself emotionally eating potato chips. Despite those difficulties, she shared how she had so many positive outcomes as a result of her surgery. Her body changed so drastically that her doctor did not recognize her, her health improved dramatically, and she was feeling more confident than ever. She reiterated she was so grateful for the surgery and if given the opportunity to go back in time, she would do the surgery again.

Step 8: Composite Textural Description

To create a composite description based on the textural descriptions of each participant, I compiled the identified themes and aspects for each participant into one table. This compilation provides a visualization of how participants viewed their experiences with the phenomenon. Table 12 displays the composite description of the themes and aspects.

Table 12

Textural Themes and Aspects for All Participants

Participant	Textural Themes	Textural Aspects of Themes

Participant 1	1. Weight Loss Management 2. Lifestyle	1. Emotional Response 2. Disappointment 3. Eating Unhealthy Foods 4. Mental Change in Eating Habits 5. Looking to the Future 6. Second Chance at Life 7. Support from Medical Staff 8. Belief in Necessity of Support System

Participant 2	1. Committed to Change	1. Daily Responsibilities
	2. Support	2. Commitment to Exercise
		3. Determined to Continue Progress
		4. Being in the Right Mindset
		5. Conscious Eating
		6. Body Image
		7. Personal Responsibility
		8. Concern from Peers
		9. Encouragement
		10. Dietitian
		11. Following Doctor's Orders

Participant 3	1. Weight Loss Maintenance 2. Advice for Others 3. Misconceptions of Surgery 4. Difficulties After	1. Committed to Change 2. Changes in Eating Habits 3. Modify Behavior 4. Exercise 5. Positive Effects 6. Negative Effects 7. Lack of Education About Surgery 8. Minimal Support Offered 9. Lack of Support 10. Coming to Terms with Disillusionment 11. Life Changing Event

Participant 4	1. Lifestyle Changes 2. Perceptions of Self and Feelings After Surgery 3. Support Systems	1. Exercise Helps Maintain Weight Loss 2. Commitment to Exercise 3. Desire to Live Better 4. Mindset/Mentality Change 5. Portion Control 6. Dietary Awareness 7. Healthy Snacking 8. Confidence 9. Afraid of Gaining Weight Back 10. Excess Skin 11. “Team Effort” in Weight Loss Maintenance 12. Health Provider Responsibility 13. Positive Social Interactions 14. Differences in Surgery Experiences

15. Ability to Maintain

Weight Loss

Participant 5	1. Motivation for Surgery 2. Weight Gain 3. Lifestyle Changes 4. Feelings 5. Support	1. Personal Responsibility for Maintaining Weight 2. Responsibility to Family 3. Falling Out of Good Habits 4. Concern for Others 5. Setting Realistic Goals 6. Eating Right 7. Getting Into Traps 8. Nervous 9. Support Groups 10. Professional Support 11. Family Support

Participant 6	1. Life After Bariatric Surgery 2. Real World	1. Personal Responsibility 2. Exercise 3. Difficulties and Challenges 4. Portion Control 5. Poor Eating Habits 6. Professional Support 7. Knowledge About Barriers

Participant 7	1. Personal Responsibility	1. Surgery as a Tool
	2. Lifestyle Changes	2. Motivational Tools
	3. Results of Surgery	3. Weight Loss Goals
	4. Support	4. Conscious Eating
		5. Changing Diet
		6. Conditioning Mind
		7. Self-Control
		8. Emotional Eating
		9. Life-Changing
		10. Excess Skin
		11. Emotional Responses
		12. Accountability
		13. Psychological Component
		14. Communication
		15. Support Groups

Participant 8	1. Lifestyle Changes 2. Personal Responsibility 3. Difficulties 4. Perception of Surgery and Process 5. Positive Outcomes 6. Support	1. Changing Thought Process 2. Mental Preparation 3. Pushing Self 4. Setting Goals 5. Reminding Self of Goals Daily 6. Medical Complications 7. Emotional Responses 8. Constant Struggle 9. Eating Healthier Foods 10. Eating Smaller Meals 11. Conscious Eating 12. Second Chance at Life 13. Would Do Surgery Again 14. Increased Confidence 15. Improved Physical Health 16. Family Support 17. Support Groups

18. Professional Supports

Lifestyle changes and mentality changes. I examined participants' experiences to identify commonalities between their lived experiences. These shared experiences were established to gain a composite understanding of experiences pertaining to the phenomenon. Table 13 presents keywords used to explain participants' experiences to demonstrate the breadth of their experiences.

Table 13

Keywords Used to Group Common Experiences among Participants

Keywords to Group Common Experiences	Participant
Lifestyle changes/commitment	2, 4, 6, 8
Personal responsibility/motivation	5, 6, 7, 8
Weight gain/complications/difficulties in maintenance	1, 2, 3, 5, 6, 8

I combined several related themes to create the keywords. *Lifestyle changes* and *commitment* were combined because when participants discussed the commitment required to cope with weight maintenance, they spoke about making changes to their lifestyle. Three of the four participants who felt lifestyle changes were necessary noted

the importance of a change in mentality. Being in the right mindset regarding recovery and having the determination to continue making progress were both important aspects of mentality shifts. Two participants shared that a commitment to physical activity significantly aided their recovery. Exercising regularly helped one participant maintain weight loss and engaged other participants in a healthy and active lifestyle.

The keywords *personal responsibility* and *motivation* were combined because participants spoke about how different motivational factors kept them on track with their personal responsibilities. Four participants expressed they were personally responsible for their weight gain or loss following RYGB surgery. Two of the four participants noted the importance of setting goals and pushing themselves to achieve them. One participant shared responsibility to family provided necessary motivation to want to maintain weight. Another participant thought of surgery as a tool in the weight-loss process, which required the participant to hold herself accountable for any progress or lack thereof.

Of the eight participants, five spoke specifically about difficulties and challenges they faced as a result of the surgery. The keywords *weight gain, complications,* and *difficulties in maintenance* were combined because participants tended to discuss these in the same terms. Participants experienced emotional responses to regaining weight, including disappointment and depression. Three participants experienced outside influences that affected their ability to cope, which included stress, medical complications, and resulting emotional issues. These three participants' parents encountered medical issues, one of whom passed away. The stress of dealing with an ill or deceased parent significantly affected the participants' ability to cope.

Eating habits. A few themes were common among participants, and other themes were not mentioned more than once. To present a composite understanding of the participants' lived experiences, I combined themes and aspects. Table 11 outlines the full breadth of participant experiences using keywords.

Table 14

Keywords to Group Common Experiences Among Participants

Keywords to Group Common Experiences	Participant
Conscious eating	2, 4, 5, 7, 8
Improving eating habits	1, 2, 4, 7, 8
Mental change	1, 7
Poor eating habits	1, 5, 6, 7

Note. Participant 3 was excluded due to lack of discussion about eating and weight maintenance.

Five of the seven participants who provided responses to the second research question spoke about conscious eating as a way to maintain their weight. Three of these five shared they counted calories for their meals to remain conscious of the food they consumed. Three of the five also paid attention to portion sizes when they ate. One of these three participants spoke about how she could make one meal last an entire day by eating small amounts at a time. Another participant shared she maintained her weight by watching her carbs.

Five participants discussed eating habits they adopted to maintain their ideal weight. Four of these participants reported they cut out junk food from their diets. One participant noted specifically cutting out soda, and another shared she stopped eating fast food. Participants felt by reducing the intake of unhealthy foods, they would be better

able to maintain their ideal weight. In an effort to do this, they also chose healthier snack options. One participant believed substituting lettuce for the bread on sandwiches was a good way to eat healthier. For another participant, adding more fruits and vegetables to her diet was essential. Some of these participants had received advice from their doctors pertaining to healthy eating and weight maintenance.

Two participants believed a significant mental change was necessary to change eating habits. One of the two participants noted that, although the process was difficult, conditioning her mind to eat certain things was necessary to maintaining her weight. To this participant, conditioning her mind meant thinking about everything before eating it. Remaining aware of the foods consumed was vital to weight maintenance. The other participant agreed that to be able to maintain an ideal weight, she needed to change the way she thought about eating. This meant that she had to condition herself to not eat foods that would make her sick and focus on eating healthier.

Of the eight participants, four shared how poor eating habits affected their ability to maintain their ideal weight. Two participants indicated increased stress caused them to eat more, and they described themselves as emotional eaters. One of these participants reported eating was her comfort zone, so whenever she experienced stress, she wanted to eat. The other participant explained the stress she experienced caused her to stay up and eat throughout the night. She shared that the snacks she ate when stressed were unhealthy snacks, such as potato chips. The other two participants mentioned specific foods they ate that negatively affected their weight maintenance. One participant admitted she forced her body to accept sugary foods and drinks, even though they made her sick at first.

Because she reverted to her old eating habits, she gained some of her weight back. Another participant spoke of the importance of avoiding a trap in her diet. When she encountered a stressful situation, she began eating snacks, including cookies, candy, and chips, and drinking soda.

Physical and mental changes as a result of bariatric surgery. Some themes were not mentioned multiple times, and one participant did not provide responses that answered the research question. I examined the commonalities among all participants' themes and aspects to fully understand the breadth of their experiences. Table 15 outlines the keywords used to describe these experiences.

Table 15

Keywords to Group Common Experiences among Participants

Keywords to Group Common Experiences	Participant
Quality of life	2, 3, 4, 7, 8
Body image	2, 3, 7, 8
Emotional response	1, 3, 4, 5, 7

Note. Participant 6 was excluded due to lack of discussion regarding feelings about surgery.

Six of the eight participants shared changes in their quality of life as a result of RYGB surgery. Two participants spoke about improvements in weight-related health

issues. Both participants had diabetes and cholesterol problems prior to the surgery. For one of those participants, the diabetes went away completely. The other participant no longer had to take diabetes medication. Cholesterol returned to normal for both participants. One of these participants had issues with her blood pressure that also went away after the surgery. These participants and three others noted improvements in their physical capabilities because of the surgery.

One participant reported decreased pain in her knees and back. Two participants shared their ability to run and jog for exercise, whereas before the surgery they could hardly walk comfortably. For one participant, RYGB surgery gave her a new lease on life. This meant she had more energy and engaged in activities that she may not have before. Another participant shared her new ability to climb stairs and ride a bike thanks to the surgery. Having these physical abilities made her feel powerful and in control of herself. One participant reported more pain associated with physical activity than she had before the surgery. She noted she made an appointment to manage that pain.

Five participants shared how their body image changed as a result of the surgery. One participant stated she did not experience a change in self-esteem, but felt physically stronger and more confident in herself. Three other participants also felt more confident after their surgery. One of these participants shared she was confident immediately after the surgery, and was excited for her future. She was happy with the way she looked, and noted she did not regret the surgery. For another participants, this confidence encouraged her to continue losing weight. Additional, one participant felt encouraged to take time to pamper herself. Despite having increased confidence, this participant struggled because

of excess skin. She tried to hide her excess, but it still heavily influenced her self-esteem. Another participant noted she did not have the surgery for cosmetic reasons, but struggled with the excess skin that resulted from weight loss. She was self-conscious about her excess skin and wanted to have it removed.

Of the eight participants, four shared how surgery influenced their emotions. One participant felt liberated and thankful for the results of the surgery. For her, the surgery allowed her to feel more like a woman than she had before. Upon regaining weight, she felt disappointed in herself. Another participant was excited and looked forward to losing weight. She was happy with the results of her surgery. Another participant shared that she was nervous before the surgery, but did not describe her feelings resulting from the surgery. For one participant, it was difficult to adjust to life after surgery. She became depressed because she had to sacrifice things she loved to maintain her weight. She also worried about how her husband would react to her significant weight loss.

Support systems. I compiled the themes and aspects from the participants to identify pertinent keywords. Some themes were repeated by participants while others were not. Table 16 illustrates the keywords identified from the participants' accounts. I outlined these keywords to provide an understanding of the breadth of participants' experiences.

Table 16

Keywords to Group Common Experiences Among Participants

Keywords to Group Common Experiences	Participant

Professional support	1, 2, 3, 4, 5, 6, 7, 8
Personal support	1, 2, 4, 5, 7, 8
Knowledge/communication	3, 4, 6, 7

All of the participants spoke about professional support after RYGB surgery. Seven participants mentioned the availability of support groups to help them cope after surgery. Two participants noted although their hospitals provided support groups, they did not attend them. One of these two acknowledged support groups for before and after surgery, but was unsure how long a patient could remain a member. Two participants mentioned online support groups as useful tools. For one of these participants, members tried to keep each other positive about their progress. The other participant shared a similar experience with online support groups, noting the groups available on Facebook allowed members to share their experience with RYGB surgery and ask for advice. She also shared her hospital provided support groups with doctors and counselors present to keep patients on track with their progress.

One participant attended a support group provided by her hospital, but did not return because of the negative atmosphere. Another participant was a lifetime member of a weight-loss clinic that provided various support services. She was unaware of support groups other than this location, which was where she had the surgery. Support groups

provided by another participant's hospital allowed her to meet people who were going through similar situations and build relationships with them.

The hospital provided appropriate support to one participant, who noted she could call the hospital and be put in contact with whoever she needed. Another participant felt a counselor was necessary to deal with the emotions that came with RYGB surgery. She did not feel like she had adequate professional support in this sense. She shared her hospital did not provide patients support other than a website for those who had surgery at that specific hospital. Another participant believed more follow-up should have been given by her surgeon after the surgery. The surgeon did follow up for a few years, but the participant felt follow-up should continue for a much longer period. She believed other professional support groups existed other than the ones she knew about. To her, the hospital where a patient had surgery would be the first place to look for support. One participant shared her primary doctor was encouraging through the process but did not believe enough support was given by the medical professionals involved in the actual surgery. She believed hospitals and care facilities where surgeries are performed should have a representative to provide patients with support.

In addition to professional support, six participants spoke about personal support they received following RYGB surgery. One participant did not have a successful support system after surgery. She believed a strong support system was key to having success after surgery. Another participant shared how she did not have anyone to talk to regarding her experiences with surgery. She noted the progress she made with her weight created a cycle in which she encouraged others to lose weight and they encouraged her.

One person could have provided her with support, but their experiences with surgery were too different. Another participant had a group of people from work who encouraged each other to stay physically active, which allowed her to maintain her weight loss.

Two participants shared they had accountability partners who helped them stay on track. For one of these participants, her accountability partner was her strongest supporter because she had gone through RYGB surgery and the recovery process. She noted a strong support system was key to her having a positive and successful experience. Another participant believed her biggest supporters were her mother and sister, and without them, she may not have had the motivation to remain committed to her weight loss.

I combined the keywords *knowledge* and *communication* because of the similarities in participants' descriptions. Four participants believed they did not have enough knowledge about the surgery. One participant expressed she did not know what to expect from RYGB surgery, except that it would allow her to continue losing weight more easily. As a result, she felt that the surgery needed to be communicated as a tool. Another participant felt her surgeon did not attempt to communicate enough after the surgery, leaving her in the dark about steps she was supposed to take. Three other participants shared this sentiment. They believed their surgeons had not provided them with a plan to follow after the surgery was completed. One of these participants acknowledged that limited knowledge about maintenance made it difficult to make appropriate decisions. Another of these three received a dietitian after the surgery, but

after one consultation, was not contacted again. Overall, these participants did not feel they were adequately prepared to properly live after RYGB surgery.

Step 9: Composite Structural Description

Participants expressed a variety of sentiments during their interviews pertaining to their experience with bariatric surgery. Participants struggled with their emotions after bariatric surgery, from unrealistic expectations to happiness for managing their weight loss. Many sentiments were shared among participants, as summarized in Table 17.

Table 17

Common Sentiments Expressed by Participants

Sentiments	Participants
Happy to lose weight	1, 2, 3, 4, 5, 6, 7, 8
Guilt/shame for regaining weight	1, 3, 5, 6
Fearful of gaining weight	4, 5, 7, 8
Disappointment because of unrealistic expectations	1, 3, 6
Lack of commitment to changes	1, 3
Committed to changes	2, 4, 5, 6, 7, 8
Realistic expectations	2, 4, 5, 7, 8
Confidence in self after surgery	2, 4, 7

Every participant replied how happy they were with their weight loss because of bariatric surgery. Even without any major changes to diets, participants lost a significant amount of weight because of the surgery. Several participants reported feeling more energized because of their weight loss, which made them want to be active. For a few participants, losing weight gave them an opportunity to be more active than they could before the surgery. As a result, those participants were grateful for the positive effect bariatric surgery had on their lives and were happy to have another chance at living life. When asked if they regretted their decision for the surgery, every participant mentioned how they were grateful for the opportunity for the surgery and were happy they got the surgery. The results of the surgery made several participants feel confident in their new body, but nearly all participants reported no previous body image issues before bariatric surgery.

Although every participant was happy, and even grateful, to have lost weight because of the surgery, four participants talked about regaining some weight. Participants expressed several emotions during their interviews: shame, guilt, and disappointment, to name a few. Those participants who regained their weight also talked about their lack of commitment to healthy eating habits and mental commitment to change. For a couple of participants, their weight loss was discussed relating to taking fertility treatments or getting pregnant. For those participants, they were invested in getting healthier for themselves but found they wanted to get pregnant after they were healthier. Although

participants did not discuss the possibility of their weight as a barrier to them getting pregnant, I deduced the probability that those participants faced that barrier due to obesity. These cases were unique and not shared across all participants who regained their weight or were not committed to making the necessary changes to maintain their weight loss.

Participants also experienced unsettling life situations, such as the death or serious ailment of a close family member. For a couple of participants, the stress with either becoming a caretaker for the addled family member or the depression from losing a close family member had a negative effect on their weight-loss maintenance. One participant talked about how being a caretaker of her family member disconnected her from the support groups she needed to remain committed and the stress of being a sole caretaker; this situation made her put her weight-loss maintenance on the back burner. These sacrifices were not uncommon for those few participants who experienced the loss or serious ailment of a close family member. Despite their sacrifice, those participants recognized the importance of getting back on track with healthier eating habits and maintaining an exercise routine.

A few participants talked about how they were fearful of regaining weight, to the point of working out excessively. Participants were fearful of going back to the way they were before bariatric surgery and did not want to feel as if the surgery was for nothing. These participants wanted to see results and although may have been focused on their weight, they were taking healthier approaches to maintaining their weight. These participants were realistic about the expectations from the surgery and recognized that

bariatric surgery equated to achieving skinniness. Instead, bariatric surgery required a long-term, even life-long, commitment to healthy eating habits and exercise to maintain weight loss.

Although nearly every participant talked about their struggles with making such major changes in their lives, several participants talked about two important aspects that made a tremendous difference in making those changes. Those participants shared making a change in their mentality towards food and their bodies was a significant aspect to success after the surgery. The other factor was understanding what to expect after bariatric surgery, such as what one needed to eat and how to have balanced meals. These two aspects were also unique to the participants' experiences, as they were implemented before the surgery. Instead of waiting until the surgery to make those changes, like others, those participants began making the changes in their daily life before surgery so they understood what they needed to do. The participants adopted healthier mindsets toward food and their weight-loss goals, and began to eat healthier and more balanced meals.

The commitment to change and recognition of what to expect realistically made a significant difference in several participants' experiences. The participants utilized outside resources to find the support they needed from others who went through bariatric surgery and health professionals. Participants' commitment to change made them reach out to those who would support them through this transition and give them the tools they needed to stay on the right track. Not every participant shared this commitment to change though. Some participants did not change their eating habits, get exercise, or reach out to

outside resources for additional support. Several participants were not interested in changing those aspects either; instead, they continued their previous lifestyle with the additional restrictions.

Step 10: Textural-Structural Synthesis

Each participants' lived experience was unique, with a range of emotions and narratives that contradicted one another. Despite the contradictions, common aspects existed to each experience. Participants talked about their struggles both before and after bariatric surgery, and the changes they went through as a result. Participants recognized the overarching influence that real-life had on their weight-loss management, from situations including the loss of a close family member or receiving fertility treatments. Commitment, and the lack of, were important to the participants' experience of bariatric surgery and was a common thread across all the participants. Several participants talked about the need to change their mindsets regarding how to eat properly and approach food in a more conscientious manner.

Several participants were interested in managing their weight loss to reach their goals through strict adherence to diets and exercise plans. Others were not interested in changing their eating habits after bariatric surgery or following an exercise routine. Each participant was unique in how they approached weight-loss maintenance, and despite these differences, the mentality of the participant was a common aspect for all participants. Participants who approached bariatric surgery with a mentality of committing to the change reported they had outside resources they could rely on, whereas other participants who were not committed shared no outside resources were available to

them. Participants who utilized outside resources mentioned how important it would be for their health professionals to keep in contact with them after the surgery and check their progress. This was especially true for participants who did not have realistic expectations about the surgery and found themselves with a variety of misconceptions regarding the results of the surgery. Several participants talked about how they did not know the surgery was not automatic skinniness or understand the real possibility of excess skin.

Participants shared their coping strategies during the interviews, such as reaching out to support groups or friends who were supportive of the surgery. Support groups, friends, family, and coworkers provided the support that participants needed when dealing with barriers and challenges to their weight-loss maintenance. Participants who had extensive support systems and utilized those support systems were successful in implementing long-term lifestyle changes. Participants were also successful in maintaining their weight loss when they committed themselves to changing their eating habits. By changing their eating habits, participants changed their mentality towards food and their weight-loss goals. If a participant did not change her mentality towards food or her weight-loss goals, often the changed eating habits would be temporary and she would resort back to unhealthy eating habits. Participants admitted and recognized their responsibility to maintain their own weight; however, a few participants felt that without the necessary support, they were alone regarding this process. The participants who took full responsibility for their weight-loss maintenance recognized how their changes were in their control.

RQ1: What is the experience of post-RYGB clients with coping skills related to weight loss and weight gain following RYGB surgery? Initially, there was consensus among participants regarding coping skills and what was needed to lose a significant amount of weight. However, life altering events and future expectation caused some RYGB patients to regain weight by emotionally eating during the process of weight loss.

RQ2: What is the experience of post-RYGB clients with eating habits and how do they contribute to the success or failure in maintaining ideal weight following surgery? All the participants were informed prior to surgery about modifying their eating habits, the importance of portion control, and how motivation would contribute to weight loss or weight gain. The participants experienced life changing events, such grief and loss, family sickness, depressions that contributed to emotionally eating and regaining weight post-RYGB surgery.

RQ3: What does RYGB surgery mean to post-RYGB clients related to body image? Participants stated in their interviews that the excess skin after significant weight loss caused them to have feelings of depression and low self-esteem. It was further disclosed that the hanging skin from their arms, stomach, and thighs caused medical problems such as skin irritation and odors. Additionally, participants revealed that the excess skin resulted in stares from individuals while in public. The participants stated the stares caused them to withdraw from friends, family, and co-workers.

RQ4: What does social support mean to post-RYGB clients? The participants mentioned feelings of abandonment post-RYGB surgery. The participants stated that they

received support from a close friend, family member, or online support group. They did not receive support from medical professionals within their affiliated facility. They did not receive phone calls nor were they offered the services of a dietitian, physical therapist, o counselor while losing weight. The post RYGB participants stated they did not have any follow-up or guidance from the facility and felt alone following their procedure. Participants shared that as a result they either resorted back to emotionally eating or tried finding others who shared the same experience of weight loss surgery.

RQ5: What is the influence of perceived self-efficacy on maintaining weight loss goals post RYGB surgery? Initially there was consensus among participants regarding development of new behavior habits. They were motivated to modify their old experience of emotionally eating, not exercising, failing to control their portions, and watching their eating habits. The participants stated in their interview they felt empowered to stay on task and lose weight, and many participants lost 100 or more pounds. Self –efficacy motivated participants to face their fears and take responsibility for their actions.

RQ6: How do participant perceptions of locus of control influence their perceived responsibility for maintaining weight-loss goals? Participants' perceptions regarding the causes of events that affected their lives were varied. Some individuals believed the events were destined, while others believed the events were caused by outside forces. Many of the post-RYGB surgery participants placed their issues of relapse on personal situations. Some of these personal situations included taking care of

a sick family member, infertility issues, and body image. These issues altered their belief system, causing them to lose and regain weight.

Summary

In this study, the data were generated from the interview protocol and I analyzed the data through the modified van Kaam analysis plan. I discussed each participant in detail through individual textural and structural descriptions, which revealed evidence and insight into participants' lived experiences with bariatric surgery. Participants mentioned a variety of coping skills, such as reaching out to support groups for help and guidance during the transition to life after bariatric surgery. These coping strategies connected to the likelihood of success in maintaining their weight loss, along with a other factors. Participants' level of commitment to changing their lifestyle and their mentality were the other two factors that indicated a higher level of success maintaining weight loss. Several participants reported feeling more confident in their appearance, but nearly all participants did not report any body image issues before the surgery. Participants talked about one specific body image issue, their excess skin after losing the weight. For several participants, the excess skin made them feel as if they did not lose the weight because of their physical appearance with the excess skin. This made them feel self-conscious about their physical appearance and made them look at their options to get rid of the excess skin, such as cosmetic surgery.

Social support from participants' family, friends, and coworkers were important to adjusting to the changes they faced after surgery. In addition, support from health care professionals and support groups were perceived as important to understanding the many

changes their bodies would go through after surgery. An even number of participants had realistic and unrealistic expectations about the surgery, and participants unanimously agreed there was a need for additional support and follow-up from health professionals after the surgery. The participants talked about how important it was for them to have outside support systems so that they could reach out to others who went through the surgery as well. The participants believed it would be beneficial to have others who went through the process to help answer their nonmedical questions as their lives changed after surgery. Participants talked about how their self-efficacy with maintaining their weight-loss goals was dependent on their coping strategies and changed mentality. They recognized they were only as successful as they were supported and committed to change, and took personal responsibility for their weight-loss maintenance. In Chapter 5, I will present a discussion about the results of the research study along with the implications of the findings for practitioners and researchers.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Obesity has become a problem for individuals from every cultural background, age group, gender, and socioeconomic group in the United States. Additionally, obesity has become one of the leading causes of illness and premature death in the United States and surrounding countries (Flegal et al., 2010). Previous researchers have shown that weight loss surgery is the best treatment for obesity and preexisting medical issues; however, surgery patients report difficulty in maintaining the weight loss long-term (Wysoker, 2005). The psychological effects of failure to maintain weight loss long-term include low self-esteem, depression, anxiety, social isolation, and eating disorders (Huberman, 2008). In addition to physical effects, obesity significantly affects an individual's employment. Employers pay a higher cost for obese employees because of the amount of time taken off work for preexisting medical issues related to obesity, as well as increased health insurance usage (Bachman, 2007). The consequences of obesity have compelled health care professionals to search for effective weight loss treatments. Unfortunately, many current diet programs and behavior treatments promote short-term weight loss, which often results in individuals regaining what they lost or surpassing their original weight (Huberman, 2008). Weight loss surgery patients often fail to lose weight or maintain weight loss, or regain weight because of cognitive and behavioral adherence difficulties. This lack of behavioral adherence plays a significant role in weight maintenance following surgery (McVay et al., 2012). Psychological screening for WLS

patients pre- and postsurgery may be useful in identifying barriers to overall treatment for obesity and weight-related comorbidities (Canetti et al., 2009).

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the lived experiences and perceptions of women who regained weight during the first year following RYGB surgery. Specifically, I engaged participants in an exploration of their perceived self-efficacy and body image, and of how their coping skills, eating habits, social support, self-efficacy, and locus of control influenced their ability to maintain their weight loss within 1 year or later following RYGB surgery. The study was formative in nature, as limited information and resources existed regarding the issues associated with weight gain following bariatric surgery. Zalesin et al. (2010) noted that prior researchers have conducted several studies on the follow-up of WLS patients who participated in treatment trials, with indication that their relapse was correlated with weight-related behavior, personal stressors, and poor coping and problem-solving skills (Byrne et al., 2003).

Misconceptions and lack of information on maladaptive behaviors, depression, socioeconomic status, culture and ethnicity, and family influences, lead to problems of negative body image, low self-esteem, and poor self-discipline for WLS patients and those considering surgery as an option (Myers, 2005). One of the misconceptions about bariatric surgery is that it is a quick fix of obesity, in contrast to losing weight without the aid of surgery (Lee et al., 2004). Gaining an understanding of the necessary lifestyle adjustments may improve the long-term success rate of WLS patients.

Researchers have conducted ethnographic research to identify, examine, and understand the possible triggers that prevent WLS patients from maintaining their ideal weight (Gunstad et al., 2010). Behavioral and cognitive findings have indicated that cognitive function could play a role in how successful a patient is in losing weight or maintaining weight loss after WLS (Gunstad et al., 2010). According to Gross (1980), holistic self-care management study participants stated that the major influences on behavior are thoughts, feelings, and circumstances. Moreover, SLT pertains to inner forces, such as need, drive, and impulse, which often operate below the level of consciousness (Bandura, 1966). Closely viewing the weigh-loss patients' environments may provide awareness of the psychosocial stages of their development. Evidence has show how impulses, feelings, environment, and behavior play a role in the long-term success of WLS (McVay et al., 2012).

Interpretations of the Findings

The overarching research question guiding this study was: How do the experiences and perceptions of women who have undergone RYGB surgery influence their ability to maintain weight loss? In this subsection, I will discuss the participants' responses, including emerging themes and conclusions that address the research question. For the first research question, multiple participants identified similar themes, while others were not repeated. I examined participants' experiences to identify commonalities between their lived experiences and to gain a composite understanding of experiences pertaining to the phenomenon. Tables 11–16 show keywords used to explain participants' experiences. I combined several similar themes to create the keywords. *Lifestyle changes*

and *commitment* were combined because when participants discussed the commitment required to cope with weight maintenance, they spoke about making changes to their lifestyle. Three of the four participants who felt lifestyle changes were necessary noted the importance of a change in mentality. Being in the right mindset regarding recovery and having determination to continue making progress were both important aspects of mentality shifts. Two participants shared that a commitment to physical activity significantly aided their recovery. Exercising regularly helped one participant maintain weight loss and engaged other participants in a healthy and active lifestyle.

I combined the keywords *personal responsibility* and *motivation* because participants spoke about how different motivational factors kept them on track with their personal responsibilities. Four participants expressed they were personally responsible for their weight gain or loss following RYGB surgery. Two of the four participants noted the importance of setting goals and pushing themselves to achieve the goals. One participant shared that responsibility to their family provided necessary motivation to maintain weight loss. Another participant thought of surgery as a tool in the weight-loss process, which required the participant to hold herself accountable for any progress or lack thereof. Of the eight participants, five spoke specifically about difficulties and challenges they faced because of the surgery. I combined the keywords *weight gain, complications,* and *difficulties in maintenance* because participants discussed these in the same terms.

Participants experienced emotional responses to regaining weight, including disappointment and depression as well as outside influences that affected their ability to cope such as stress, medical complications, and resulting emotional issues. Six of the

eight participants shared changes in their quality of life because of RYGB surgery. The participants spoke about improvements in weight-related health issues, such as diabetes and cholesterol problems prior to surgery. After surgery, diabetes improved and the participants no longer needed diabetes medication, cholesterol levels returned to normal, and high blood pressure was controlled.

One participant shared that WLS encouraged her to take time to pamper herself. However, despite having increased confidence, this participant struggled because of excess skin. She tried to hide her excess skin, but it still significantly affected her self-esteem. Of the eight participants, four shared how surgery influenced their emotions. One participant felt liberated and thankful for the results of the surgery. For her, the surgery allowed her to feel more like a woman than she had before. After regaining weight, she felt disappointed in herself. Another participant was excited and looked forward to losing weight. She was happy with the results of her surgery. One participant said she was nervous before the surgery, but she did not describe her feelings resulting from the surgery. For another participant, it was difficult to adjust to life after surgery. She became depressed because she had to sacrifice things she loved to maintain her weight. This participant also worried about how her husband would react to her significant weight loss.

The factors of *lifestyle change* and *commitment* are important in maintaining weight loss long-term because taking personal responsibility for one’s actions, following the directives of weight-loss professionals, and practicing healthy coping skills helps women not only to think differently, but also to be aware of their actions. Being

knowledgeable of diet and exercise will help patients maintain weight loss long-term. The bariatric surgery participants in this study began emotional eating items such as sugary foods and soda, and eating larger portion meals. These characteristics started the roller coaster ride to weight regain. *Mindset change* is another important factor in weight loss following RYGB surgery. Taking personal responsibility, such as interacting with individuals or outside sources, helps positively motivate one to stay on track to exercise and eat healthy to maintain a healthy lifestyle. The participants in the study began to blame others for overeating by using negative events that caused their situation to negatively affect to their lives; in turn, they failed to take personal responsibility and began to regain weight.

The theme *weight gain, difficulties with weight-loss maintenance* related to issues of coping, depression, and personal stressors that caused the participants to resort to old behaviors and regain weight postsurgery. *Changes in the quality of life* was another important factor. Because of significant weight loss, participant's self-esteem increased; diabetes, high blood pressure, and cholesterol issues became normal; and mobility increased, allowing participants to engage in physical activities. *Excess skin* also was a significant result of rapid weight loss, and the disappointment associated with losing weight and having the loose skin caused negative emotional responses to the procedure that was intended to be an accomplishment.

Discussion of Results

Exploring the perceptions and experiences of eight women provided explanation for their reasons for regaining weight 1 year or later following RYGB surgery. In the

interviews, 18 themes emerged, indicating different causes for regaining weight such as *knowledge, communication, professional support, personal support, quality of life, body image, emotional response, conscious eating, improving eating habits, mental change, poor eating habits, lifestyle changes, commitment, personal responsibility, motivation, weight gain, complications*, and *difficulties in maintaining weight*. The findings showed factors that contributed to the lack of long-term weight-loss maintenance. Based on the literature provided in Chapter 2, the findings supported the participants issues of self-esteem, coping skills, emotional eating, weight gain, weight loss, excess skin, body image, locus of control and self-efficacy.

Bandura (1969) suggested that thoughts, feelings, and situations play a fundamental role in behavior as it relates to maintaining weight loss long-term. What I discovered in my study was that three out of eight participants experienced issues of infertility due to obesity. Two of the participants were able to conceive once they lost a significant amount of weight following RYGB surgery.

Study participants expressed issues with infertility, excess skin, inadequate family support, and lack of professional follow-up support from their weight-loss facility. Many of the women expressed that after losing weight, they were left with stomach pouches and excess skin on various parts of their bodies. Sarwar et al. (2012) noted that despite positive outcomes, 5% to 39% of patients regain weight after bariatric surgery because of the remaining surplus skin that negatively affect psychological and psychosocial well-being postsurgery. The rapid weight loss results in loose skin, skin envelopes, and fat deposits primarily located on the upper arms, thighs, and abdomen, which cause a

multitude of problems and discomfort. The literature reviewed in this study affirmed how patients felt, emotionally and mentally, after weight loss. Many of the women stated their self-esteem declined when they discovered that medical insurance did not cover removal of excess skin; it was an additional cost of which they were unaware. Hewitt (2009) stated that self-esteem is an overall subjective emotional evaluation of one's self-worth. It is the judgment or attitude toward the self that encompasses beliefs and emotions, such as pride, despair, triumph, and shame. Self-esteem is how one evaluates oneself positively or negatively (Smith & Mackie, 2007). Although participants reported self-esteem increased after surgery, psychological constructs show that self-esteem is an influential predictor in outcomes such as achievement, happiness, criminal behavior, and self-defeating behavior (Greenberg, 2008).

The participants stated that after 1 year, no follow-up communication or programs existed to help maintain their weight loss. During this time, many of the women reverted to old habits, causing them to regain some or all the weight they had lost. Bandura (1986) stated the SLT is significant to understanding the relationship between obesity and the driving force that motivates or deters changes required for long-term weight-loss maintenance. For these participants, the lack of family and professional support caused some participants to revert to emotional eating. ***Social Support*** as it relates to Chapter 2 literature by Zalesin et al. (2010) and Byrne et al. (2003) support the literature on personal stressors, poor coping, and problem-solving skills relating to participants' internal and external forces for maintaining or regaining weight. The participants in the study expressed the lack of support from medical/peer support as it relates to Chapter 2

literature by Wang, Wild, Kipp, Kuhl, and Veugelers (2009) report that obese individuals will likely suffer low self-esteem and have increased levels of sadness, loneness and exhibit destructive behaviors. The participants believe it takes a team effort between the patient and health provider to maintain weight loss. Surgery is drastic procedure that should require pre and post counseling due to different emotions inckludig suicidal thoughts resulting from the surgery. Erueti et al. (2012) stated that medical professionals should inform themselves regarding an individual's psychological, psychosocial and body image conditions. ***Effects of Body Image*** was a concern of the recipients and those seeking to have surgery. The procedure is not a magic pill. It is a constant battle to follow the necessary steps and modify behavior by educating self of what and what to eat. The surgery recipients expressed the importance of physical exercise, which they avoided to maintain weight loss. The recipients expressed the effects of excess skin following surgery. Although, their bodies seemed smaller they were unhappy with sagging skin from their arms, stomach and thighs that caused medical issues and depression. The recipients realize it takes a complete life style change including taking care of your body and mind after surgery, which allows one to be conscious of their food consumption. ***Commitment to change*** involved changing their eating habits before and after surgery. The participants stated this was a part of the process that is conducive to living a healthy life by eating smaller meals rather than eating large portions until all the food was gone helps control food intake. Mentality and behavior was an important factor in the process of weight loss. The participant anticipated losing large amount of weight however, the recipients did not execute self-control or maintain a healthy lifestyle. The participants

saw surgery as a second chance but failed to adhere to healthy diet and life. The recipients expressed the lack of education, minimum physical and psychological support in the case of life changing events. The biomedical provided an explanation of how diseases manifest. The model focused on the physical threats to a healthy life, and researchers use it to analyze the causes of a given disease and strategies for recovery. The biopsychosocial paradigm focused on three essential components: biological, psychological, and social etiologies (Engel, 1980). In addition to the biological, genetic, and physiological factors of the human body, the framework includes the recipient's perception, cultural and economic background causing a lack of personal effectiveness and responsibility for their actions. These factors played a role in how participants think about themselves, lack personal effectiveness by fearing facing obstacles, and the lack of taking responsibility for their actions. The results in my study highlight the various reasons such as health issues, body image and personal issues that caused participants to gain weight pre- and post-RYGB surgery, which Porter et al. (2012) identifies in chapter 2 literature regarding obesity and excess skin as it relates weight-related teasing, depression, and self-esteem.

Limitations

Because I retrospectively explored women's experiences within 1 year following RYGB surgery, the participants' abilities to accurately access memories and recollections limited the study. Additionally, external factors, such as relationships, health, and employment, may influence WLS patients' behaviors and abilities to maintain long-term weight loss; however, these factors were not considered within the scope of this study.

This study was further limited by my position as an instrument of data collection, analysis, and reporting. My position within the study left the findings vulnerable to the influence of my own biases and preconceptions on the findings. Finally, this study had limited generalizability, as the participants included eight African American females and the results may not be representative of a larger, more diverse population.

Recommendations

Future researchers should explore the relationship of obesity, infertility and commitment to change among women of all ethnic backgrounds. Furthermore, exploring the experiences and perceptions of women using a quantitative approach will broaden the constructs of the study from a larger population. Exploring the memories and experiences, such as personal stressors, eating habits, personal responsibility and mentality toward weight loss management of women from all backgrounds will provide a better understanding of how their perceptions have affected them during the process of weight loss. The research should also be conducted with women from all ethnic backgrounds to explore the lived experiences and perceptions of women who regained weight during the first year following RYGB surgery. I suggest future researchers analyze how women deal with personal stressors, which because of poor coping skills, may result in women resorting to old behaviors that cause weight gain postsurgery.

Summary and Conclusions

The SLT was important in examining individuals' self-defeating beliefs in the areas of attention, memory, and motivation by analyzing their patterns of low self-esteem and self-efficacy as it related to issues of weight loss and maintenance (Bandura, 1986).

The theory provided an understanding of the relationship between obesity and the internal or external locus of control that motivates or deters changes required for long-term weight-loss maintenance. In conclusion, the issues of self-defeating behaviors, knowledge and communication, professional and family support, and body image should be addressed during the process of WLS pre-and postsurgery to increase weight-loss maintenance long-term for patients.

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Appendix A: Letter to Professional Association

July 31, 2016

Dear Nicole Ryan of Facebook Weight Regain after Weight loss Surgery (chat-room).

My name is Samone R. Marion and I am a doctoral candidate at Walden University. I am conducting dissertation research on the experiences of women who has undergone RYGB surgery and has regain weight 12 months and beyond post surgery. Previous researchers have determined many reasons for weight regain. However there is a gap in research that explores the relationship between the psychological effects, eating disorders, and body image (excess skin) on women maintaining their ideal weight loss goal long-term. This research will provide insight into the attitudes and beliefs of women 1-year and beyond post surgery and their lived experiences during the process.

Your assistance in conducting this much-needed research is vital to identify women who would be willing to participate in the study. Those currently are struggling with weight regain 12-months and beyond after RYGB-surgery Once identified, I will contact these individuals to discuss the nature of the study. They will be free to choose participation and, if they accept the invitation will be free to discontinue participation at any time. Information provided by the participants will be strictly confidential.

I would welcome a telephone call from you to discuss any questions that you may have concerning this study and your role in identifying research participants. I can be reached at (313) 974-0088

Thank you for your consideration.

Samone R. Marion, MS-MHC, LLPC.

Doctoral Candidate

Walden University

Appendix B: Recruitment Letter

[Potential Participant]

[Address]

Dear ___________:

My name is Samone Marion and I am a doctoral candidate at Walden University. I am conducting research in partial fulfillment of my doctorate on the lived experiences of women who has I am conducting dissertation research on the experiences of women who has undergone RYGB surgery and has regain weight 12 months and beyond post surgery. A vast number of studies have accessed many reasons for weight regain. However there is a gap in research that explores the effects of weight-related depression, eating disorders, and body image (excess skin) and the effects it has on women maintaining their ideal weight loss goal long-term This research will fill that gap by providing insight into women attitudes and beliefs 1-year and beyond post-surgery and their lived experiences during the process.

Acknowledging the value of your time, I would appreciate your consideration of participation in this important study. To fully understand your experience, a 1.5 to 2-hour

interview would be conducted with you at a location of your choosing. Nothing uncomfortable will be required of you. The interview is designed to simply learn of your experiences surrounding weight regain after RYGB surgery. All information gathered during the interview will be held strictly confidential and you are free to discontinue participation at any time with no adverse repercussions.

Please contact me at your earliest convenience to schedule a date and time for the study interview. My telephone number is (313) 974-0088. You can also email me at samone.marion@waldenu.edu

Thank you for your consideration.

Samone R. Marion, MS-MHC, LLPC.

Doctoral Candidate

Walden University

Appendix C: Interview Questions

Research Question	Phenomenon	Type of Question	Interview Question
What is the experience of postRYGB clients with coping skills related to weight loss and weight gain following RYGB surgery?	Coping with weight management following RYGB surgery	Think	How do you manage the steps necessary to maintain your weight loss? (Prompts) Explain your process.
		Feel	Describe the emotional aspect of managing your weight following RYGB surgery. (Prompts) Tell me about the process.
		Reaction	Explain your reaction to any weight loss or gain you have experienced following RYGB surgery. (Prompts) Explain your reactions.
What is the experience of postRYGB clients with eating habits and how they contribute to the success and failure in maintaining ideal weight following surgery?	Eating habits and their influence on maintaining weight loss following RYGB surgery	Think	How have your eating habits changed following your RYGB surgery? (Prompts) Tell me how you changed your habits.
		Feel	Describe the emotional aspect of changing your eating habits to maintain your weight loss. (Prompts) Tell me about your emotional experiences.
		Reaction	How did you react when you experienced weight gain due to a failure to adhere to the eating habits that maintain your weight loss? (Prompts) Tell me about the specific events when you reacted.
What does RYGB surgery mean to	Meaning of RYGB surgery	Think	How would you describe RYGB surgery to women considering having the procedure? (Prompts) Tell me what would you say to them.

postRYGB clients?		Feel	Describe your feelings related to RYGB surgery. (Prompt) Tell me your feelings.
		Reaction	Explain your perceptions of RYGB surgery now that you have undergone the procedure. (Prompts) Tell me your views.
		Think/feel/react 2	Describe your thoughts related to the influence of RYGB on your life since you have undergone the procedure. (Prompt) Tell me some of your thoughts.
What does your social support mean to postRYGB clients?	Social support and RYGB surgery	Think	What support systems that you know of are available to individuals who have undergone RYGB surgery? (Prompts) Can you provide some sources?
		Feel	How do you perceive that social support systems influence your ability to maintain your weight following RYGB surgery? (Prompt) Tell me about how did they influence you.
		Think/feel/react 2	Do you perceive that adequate support is available to individuals who have undergone RYGB surgery? (Prompt) If there is support available, tell me where/who.
What is the influence of perceived self-efficacy on maintaining weight loss goals post RYGB surgery?	Perceived ability to maintain weight loss	Feel	Describe how your feelings of self-efficacy influenced your weight management. (Prompt) Tell me your feelings regarding your ability to maintain your weight.
		Think	How has your belief in your ability to maintain weight loss influenced your ability to reach your weight loss goal? (Prompt) Tell me how your belief in your ability to keep the weight off influenced you.

		Reaction	Describe your reactions to excess skin following RYGB surgery and how I influenced your feelings of self-efficacy. (Prompt) Share your reaction to your excess skin and how it influenced your feelings of ability to maintain weight loss.
How do participants' feelings of locus of control influence their perceived responsibility for maintaining weight loss goals?	Locus of control	Think	Describe your thoughts related to support and control for maintaining weight loss goals? (Prompt) Tell me your thoughts regarding who you believe should provide support to you as you attempt to maintain your weight loss goals. (Prompt) Tell me your thoughts regarding who bears responsibility for weight loss maintenance following RYGB surgery.
		Feel	How do your feelings regarding responsibility for maintaining weight loss following RYGB surgery influence your weight loss management? (Prompt) Tell me how your thoughts regarding who is responsible for supporting you in maintaining weight loss influences your ability to maintain weight loss.

Background and BMI Questionnaire

First and Last Name
Email Address:

DEMOGRAPHIC INFORMATION

* Profession:

*Age:

*Gender:

*Marital Status: Single Married Partner/Relationship Divorced

*Weight

*Height

PAST SURGERIES Have you had Roux-en-Y surgery? If yes, when did you have Roux-en-Y surgery?
WEIGHT MANAGEMENT Weight prior to surgery: Current weight: Goal weight: Have you had issues maintaining your goal weight following surgery:

AGREEMENT

I understand that I am voluntarily participating in research and at anytime can withdraw without obligation.