Introduction

Background

“Bariatric surgery (BS) has become an increasingly popular weight loss intervention for individuals diagnosed as ‘obese’ (WHO, 1994), for whom lifestyle approaches such as dietary and activity advice, behavioural skills training and pharmacological interventions have failed to produce significant improvements.

• In the past decade, much research has been published evaluating the effectiveness of BS, with most cases resulting in both weight loss and weight loss maintenance (e.g. Torgerson & Sjostrom, 2001).

• However, obesity surgery not only affects weight. A systematic review of the psychosocial outcomes of BS concluded that mental health and psychosocial status improve for the majority of people, resulting in improved quality of life (Herpetz et al., 2003).

Difficulties

• Despite the growing evidence base highlighting the benefits of BS, other studies have reported contradictory findings. Kalarachan et al. (2002) and Saunders (2004) both found that pre-surgical eating patterns and problems can persist following BS; (e.g. binge eating, ‘grazing’ or lack of control).

• The media often portrays such surgery as a “quick fix” and society labels obese individuals as “lazy” and lacking self-discipline. Obese individuals not only have difficulties in managing their eating behaviours, contrary to what many had anticipated prior to surgery. Patients require support from a range of sources to cope after surgery and possibly influence their weight loss outcomes.

Beliefs / Perceptions

• Patients’ beliefs and perceptions about their illness are key determinants of recovery (Petrie et al., 2002).

• Leventhal’s Self-Regulatory Model (SRM) starts from the premise that individuals are active problem solvers who make sense of a threat to their health by developing their own cognitive representation of the threat (Leventhal et al., 2006). This then influences the decisions we make regarding the advice and treatment options we are given by health professionals.

• Therefore, Leventhal’s SRM would appear a useful and appropriate theoretical framework to inform the exploration of patients’ beliefs and expectations relating to BS.

Aim

Qualitative research exploring BS has thus far focused on patient’s experiences of surgery and the impact it has had on their lives; however, there has been little consideration of patient’s views prior to surgery.

Therefore, this study aims to explore obese patients’ beliefs and expectations, from before and after their laparoscopic adjustable gastric band (LAGB) surgery, specifically relating to:

- their views regarding BS;
- the role of the LAGB;
- their own role following surgery; and,
- the impact of the surgery, both positive and negative.

Method

Design

A retrospective, qualitative design with in-depth interviews was utilised.

Participants

All patients who underwent LAGB surgery within the Glasgow and Clyde Weight Management Service (GCWMS), who met the inclusion and exclusion criteria for the study (See Table 1), were approached on a first come basis, between October 2009 and June 2010. Out of the twelve potential participants who were eligible during the period of recruitment, eight responded and were subsequently interviewed.

Procedure

In light of clinical experience, a year post-surgery was chosen as an appropriate time to speak to patients, as it was considered sufficient time for the band to have had an impact on the client’s life.

Interviews were exploratory, semi-structured, using open-ended questions to encourage participants to reflect back on their experiences, thoughts and feelings regarding BS. A topic guide, informed by Leventhal’s SRM, was developed specifically to help participants reflect on their pre-and-post beliefs/expectations about LAGB surgery.

Interviews were conducted at the GCWMS by the principal researcher (RTS). All interviews lasted between 60 to 90 minutes. The interviews were audio recorded and then transcribed verbatim by the principal researcher.

Ethical Issues

Ethical approval was gained from the West of Scotland Research Ethics Committee 4 (September 2009).

Analysis

The analysis was guided by the emergent interview themes rather than by any model in order to avoid imposing constraints on the analysis. Theematic Analysis (TA) was chosen as the method of qualitative analysis, and an inductive, semantic and realist approach to TA was carried out (in accordance with Braun & Clarke, 2006; pp.81-93).

It is important to note, however, that the process of interpreting the participants’ cognitions is complicated by the researcher’s own conceptions (Yarnall, 2000). In recognition of the potential for bias in interpretation, a second and experienced qualitative analyst (SLW), who had no prior interaction with the members of this patient group either professionally or personally, analysed a sample of three transcripts blind to the principal researcher’s analyses and identified the same themes.

Results

Three superordinate themes emerged from the analysis:

1. The Need for Surgery

Long history of struggling to lose weight:

• “The way I’ve looked at it…when I got the band, which was maybe the wrong way to look at it, was I’ve failed. ‘Getting the band was a sign of failure, you can’t lose weight!’” [Rachel, P19, L10].

Motivations for surgery:

• “It’s my goal to be able to be able to live for my family and play with my grandchildren, pick them up and have fun with them.” [Janice, P1, L4].

Last and only option:

• “I was dying a slow death, cause I just couldn’t help myself…I was a prisoner in the house by this time, I couldn’t do any exercising. I couldn’t do anything because I was far too heavy…I was gonna die either die a slow death or die on the operating table and if I was gonna die I’d rather die on the operating table!” [Margaret, P1, L30].

2. Not a Quick-fix:

Miracle cure:

• “I thought the band was gonna cure everything. I thought the band was going to be my saviour, I thought I would wake up and everything would fall into place” [Gillian, P15, L40].

Learning process:

• “You just want to be ‘normal’ and not bingeing…my emotions still rule a lot of my eating habits” [Janice, P14, L11].

Personal responsibility:

• “Well I see it now as about 80% me, 20% the band. Before I think it was probably the other way…thought the band did most of it for you and you could basically just swan about and sit at all the work and now I make its not that at all…I know it’s up to me” [Lesley, P12, L30].

3. Importance of Support:

Cannot do it alone:

• “For once in your life you felt as though somebody was actually listening to you because you’re crying out ‘please help me, I can’t do this on my own’ and for once somebody saw that and was there to ‘egg you on’…it was like you come to this hump in the road and you can’t get over that hump….but they gave you that wee push” [Margaret, P3, L35].

Patient perspectives:

• “I don’t think that people who don’t have struggles with food really will understand how much the surgery is needed…patients views need to be heard” [Janice, P15, L27].

Conclusions

• Overall, this study highlights that although LAGB surgery results in many beneficial outcomes for patients, the expectations that they hold about surgery may affect their ability to cope after surgery and possibly influence their weight loss outcomes.

• The participant accounts highlight that they see the band as an ‘aid’ and that they themselves play an important role in managing their eating behaviours, contrary to what many had anticipated prior to surgery.

• Additionally, patients require support from a range of sources (i.e. professionals, family/friends and patients) in order to gain maximum benefit.

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