Portfolio Volume 1: Major Research Project

A Qualitative Exploration of Candidates' Expectations and Preparations for Weight Loss Surgery in the NHS

Jennifer Clayton

June 2018

32,043 Words

Volume 1
Submitted to the University of Hertfordshire in partial fulfillment of the requirements of the degree of Doctorate in Clinical Psychology

ACKNOWLEDGEMENTS

Thank you to the participants in this study who gave their time and shared their experiences in order to make this research possible.

Thank you to the past weight loss surgery candidates, who gave their time to help me in developing the research and interview questions.

Thank you to the wonderful clinical staff at the Obesity Service, for supporting with recruitment, giving feedback on the results, and always being friendly faces who were willing to help.

Thank you to my project supervisors Dr Barbara Mason and Dr Rebecca Ramsden, for your support and encouragement.

Thank you to the trainees from cohort 15 for support, laughs and quick answers to little questions.

And finally, thank you to my family but most of all my husband who has walked every step alongside me both through clinical psychological training and writing this project.

CONTENTS

LIST OF TABLE AND FIGURES

ABSTRACT

Introduction: Weight loss surgery is the primary intervention offered by the NHS for patients with morbid obesity and associated health conditions (Welbourn, Fiennes & Kinsman, 2014). There are relatively few studies looking at candidates' experiences of this and only one since the implementation of NHS commissioning guidance (2013) for weight loss surgery pathways. This study therefore sought to explore this. It focused specifically on candidates' experiences of pre-surgical assessment, their hopes for life after surgery and how they have prepared for this.

Method: The study followed a qualitative design using a mixed inductive and deductive thematic analysis (Braun & Clark, 2006 & Boyatzis, 1998). Participants (N=11) were adults aged 18 or over, who were accessing weight loss surgery in a specialist NHS obesity service in the south of England. Semi-structured interviews were completed with participants to explore their experiences of their weight loss surgery journey so far.

Results: Six overarching themes were identified capturing what participants' decisions to pursue weight loss surgery were grounded in, their experiences of specialist obesity services, their conceptualization of weight loss surgery, their hopes and expectations for life after surgery, the roles of family and friends within their weight loss surgery journey, and finally, participants' plans and preparations for life thereafter.

Discussion: The results highlighted the additional hopes which candidates hold for weight loss surgery, beyond weight loss and improvements in physical health. The complex nature of participants' relationship with themselves, eating and weight was illustrated and how this impacts expectations and subsequent preparation for surgery. The clinical and theoretical implications are discussed, as well as future directions for research in this area.

CHAPTER 1: INTRODUCTION

1.1 Thesis Overview

Chapter 1 will orientate the reader to the researcher's epistemological position and the choice of weight loss surgery (WLS) and obesity as a subject area. An introduction to relevant research and theory will follow, setting the context and illustrating why the subject areas is important. Chapter 2 will present a systematic literature review on current knowledge about candidates' experience of WLS within the National Health Service (NHS). Chapter 3 will detail the method. An explanation as to why the chosen tool of analysis were selected will be given, together with procedural information on the study. In Chapter 4 the analysis and results of the research will be presented. In Chapter 5 the results will be discussed and their meaning in the context of WLS in the NHS explored. The chapter will offer a critique of the study, as well as considering future research.

1.2 Statement of Position

1.2.1 Philosophical Underpinnings

Inherent in being a qualitative researcher is the assumption that my own life experiences, assumptions and epistemology may interact with those of the participants in this research (Harper, 2012). As such I believe that the information yielded from this study, whilst useful, may not meet the criteria of objectivity in its entirety. At the same time, I do believe that the nature of what *is,* is something that exists and that with the right means, its material basis has the potential to be discovered. In this sense, I would label my epistemological position as critical realist (Ritchie, Lewis & McNaughton, 2003). In doing so, leaving space for social constructionist thinking (Harper, 2012), acknowledging the social interchange between

myself, participants, and the wider context, in ultimately arriving to the conclusion which has the most utility within the ecological setting of WLS in the NHS.

1.2.2 How I Arrived at This Study

The areas of health, food and obesity have always been of interest to me. This blossomed into academic curiosity during my undergraduate and Masters studies, when I first completed research in the area of body image and eating styles. This curiosity persisted into clinical psychology training and obesity was on my agenda as a potential topic area for my thesis.

But why WLS? The idea of obesity as an epidemic (World Health Organisation (WHO), 2003) is not a new one. I think there is a role for clinical psychology in understanding and intervening in relation to obesity. At the same time, I was mindful of rising discourses around fat phobia, thin privilege and critiques of the WHO and the medical institution as whole for the medicalisation of obesity (Cooper, 2010, Nash & Warin, 2016, Ortiz, Kawachi &Boyce, 2017 & van Amsterdam, 2013). This led me to consider beliefs I carried with respect to obesity, such as ideas around personal agency and weight, and the notion that obesity equates to ill health. Should I consider these through a more critical lens?

Initially I was shocked to learn that WLS is considered the leading intervention for obesity. I viewed it as a serious procedure which drastically restricts the freedom that individuals have to enjoy food in the social way that it is often consumed within western culture, whether it be festivities or sitting down to an evening meal with family. Surely there was a better solution for people seeking help with obesity than WLS and where was the psychological support for these individuals? With this backdrop, I sought to educate myself further on the area of WLS and from there this research was born.

1.3 Background

1.3.1 What is Obesity?

The Oxford English Dictionary defines obesity as *"the state of being grossly fat or overweight"* (2017). In the United Kingdom (UK) and the NHS, the metric by which *"grossly"* is measured within the context of obesity is commonly the body mass index (BMI) (NHS Choices, 2015). BMI is calculated using a person's height to weight ratio and this figure is then categorized to give a qualitative description of weight (Keys, Fidanza & Karvonen, 1972). The typical BMI classification system used in the NHS is presented in Table 1.1 (NHS Choices, 2016):

Table 1.1: *BMI Classification System*

Description	**BMI**
'Healthy Weight'	18.5 – 24.9
'Overweight'	25 – 29.9
'Obese'	30 – 39.9
'Severely Obese'	>40

The use of BMI to define obesity has come under criticism for not taking into account a person's body composition (Nuttall, 2015). This means that for example, a physically fit rugby player might fall within the obese range, when in fact their body fat percentage is low. A full critique of the different measures of obesity is beyond the scope of this research but it is relevant to the extent that, when obesity is referred to in the context of WLS, a BMI >35 is primarily assumed, along with excess body fat which is visible in the person's aesthetic appearance and measurable with body composition testing.

1.3.2 The Prevalence of Obesity

Global rates of obesity have doubled since the 1980s and 13% of the world population is now classified as obese (WHO, 2017). When looking specifically at the UK these figures are higher, with 25.6% of the UK population estimated to be obese (BMI >30), with figures set to rise (National Statistics, 2015).

1.3.3 Why is Obesity Increasing?

At a basic level, traditional models of obesity depict that the individuals who develop obesity consume more calories than they expend (Chang, & Christakis, 2002). However, the reasons why obesity is increasing are complex and still not fully understood. Genetic variability and individual biology is thought to play a role (Newson & Flint, 2011). Some people, no matter what they consume, do not seem to gain weight. In contrast, others gain weight with ease. Furthermore, the rates of metabolic disorders and other health conditions which can increase weight gain, are higher amongst individuals who develop obesity (Welbourn, Small & Finlay, 2014) and the complex roles these conditions play in relation to the storage of fat in the body is not fully understood.

Our social environment might also be implicated. Research has shown that culture, family and societal values are influenced by marketing and the media, and that they form a foundation from which we make food choices (Furst, Connors & Bisogni, 1996). Even when eating alone, we do so in a wider context. Thus, our culture and the way that food is marketed plays an important role in eating behaviour.

Over the past one hundred years, food provision has changed drastically. Some describe western environments as obesogenic, in that the abundance of convenient food encourages obesity (Kirk, Penney & McHugh, 2010). The chemical composition of available food has also changed (Cordain, Eaton & Sebastian, 2005). Substances which are deemed irresistible to us, such as sugar, are increasingly present in food (Lustig, Schmidt & Brindis, 2012). It seems that food is being designed in a way which, on a biological level, taps into our evolutionary tendency to consume calorific food.

Despite the complex factors underlying obesity, society most commonly places the responsibility for change within the individuals it affects (Chang, & Christakis, 2002). This means that it is the people who develop obesity who are ultimately required to make a change to their behaviour in order to lose weight and improve health.

1.3.4 The Impact of Obesity

The social, psychological, physical and financial impacts of obesity knit a complex tapestry. Commonly the relationship between these four variables is seen as bi-directional, with each mediating the impact of another. There is some argument as to whether these four domains are impacted by obesity, or in fact, whether it is these variables themselves that are implicated as causes of obesity. Regardless of their antecedent role, individuals with obesity undoubtedly experience the impact across a variety of domains, as highlighted below. This demonstrates the need to better understand obesity.

Social

Although it can vary between different cultures, there is considerable stigma surrounding obesity, with evidence showing that obese individuals are subject to multiple prejudices and

discrimination (Puhl & Heuer, 2010). The consequences of this are discussed in more depth in the most recent review of the literature regarding obesity discrimination (O'Brien, Latner & Ebneter, 2013). The review presents the evidence illustrating the far-reaching discrimination which individuals who are obese experience in the workplace, education, healthcare and the media. The upshot of this discrimination is presented as mass inequalities in how people are treated in all areas of their lives, with physical, psychological and financial consequences.

Physical

Obesity is associated with increased risk of health conditions such as diabetes, most cancers, cardiovascular disease, asthma and osteoarthritis. Furthermore, some health conditions can increase the risk of further weight gain and mortality (Guh, Zhang & Bansback, 2009). Obesity can also impact functional skills, impeding the person's ability to undertake tasks of basic daily living such as walking, bathing and dressing (Backholer, Wong & Freak-Poli, 2012). Thus, obesity can be associated with significant physical health problems and reduced functioning.

Financial

Whilst belonging to a low socio-economic income group can act as a risk factor for obesity (McClaren, 2007), the impact of obesity on the financial position of the individuals it affects is not well reported. In contrast, the public health cost of obesity is widely researched. The annual cost of obesity and its associated health conditions is estimated at approximately seven billion pounds per year. This figure includes costs to the NHS, sick benefits and loss of earnings (McCormick & Stone, 2007). Thus, obesity impacts public spending and, with

obesity figures projected to rise further over the next fifteen years (National Statistics, 2015), it is likely that spending in public health will only increase.

Psychological

The relationship between obesity and psychological well-being is complex and a degree of intersectionality with other social and political factors is likely to be at play. Research reports a positive association between obesity and poor psychological well-being (Gatineau & Dent, 2011, Scott, Bruffaerts & Simon, 2008 & Wardle & Cooke, 2005). This is stronger in the presence of other risk factors for mental health difficulties, such as being female, discrimination and low socio-economic status (Scott et al, 2008). Some studies report a reciprocal and positively correlated relationship between obesity and mental health difficulties such as anxiety and depression (Gariepy, Nitka & Schmitz, 2010 & Luppino, deluit & Boury, 2010). There is also a reported relationship between obesity and eating disorder symptoms such as binging and emotional coping through eating (Giaini, White & Mashels, 2013 & Ganley, 1989).

1.4 NHS Intervention for Obesity

The NHS offers intervention for obesity in a tiered model (see Figure 1). Access to specialist NHS obesity services begins at Tier 3, following referral from a health professional based within the community at Tiers 1 and 2. Tier 3 services aim to provide specialist multidisciplinary team (MDT) based intervention for obesity. Typically, this takes the form of weight management clinics utilising year-long programmes involving changes to diet, exercise and lifestyle. Following Tier 3 completion, individuals may progress into Tier 4 where surgical intervention is offered.

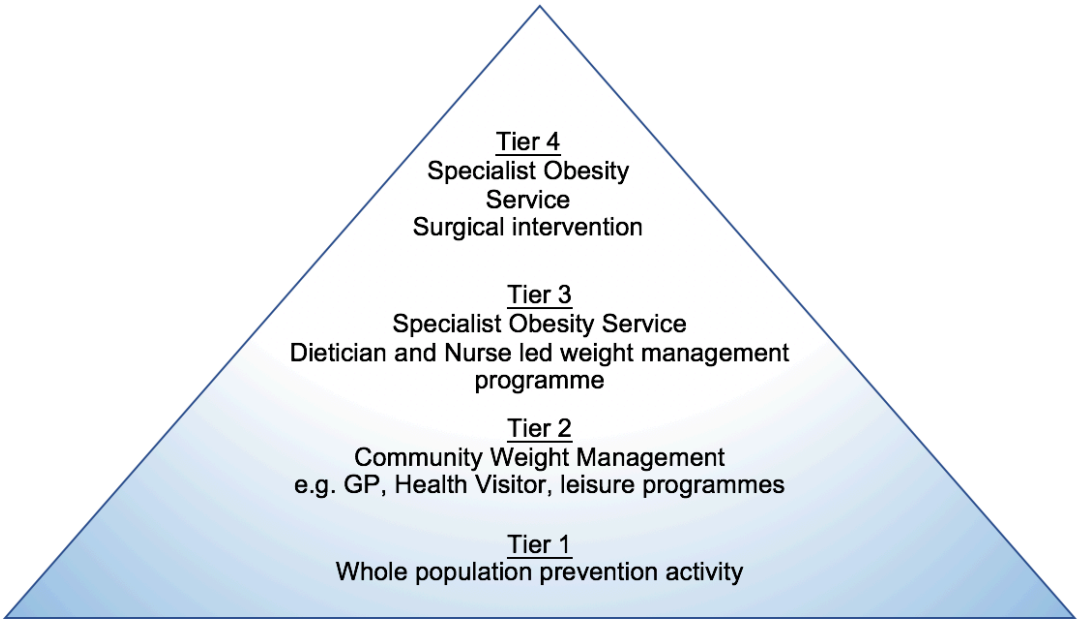


Figure 1: Tiered Model for Obesity Services in the UK (National Obesity Forum, 2009)

1.4.1 Surgical Intervention

At Tier 4, a range of surgical procedures for weight loss are offered on the NHS. The three most common procedures are briefly described below (NHS Choices 2017).

Laparoscopic Gastric Band

During this procedure, an adjustable silicone band is placed around the top of the stomach leading to appetite reduction. Whist considered the simplest weight loss surgical procedure and reversible, it may not work for everyone and candidates can require further surgical intervention.

Gastric Bypass

With this procedure, a small pouch is created at the top of the stomach. This pouch is connected to the small intestine, bypassing the rest of the stomach. This limits the amount of food consumed and alters hormone production in the gut, reducing appetite. This procedure is considered more effective than a gastric band, however it is irreversible and requires candidates to take a life-long vitamin supplement.

Laparoscopic Sleeve Gastrectomy

During this procedure part of the stomach is removed, leading to a 70-80% reduction in stomach size. This procedure is permanent and reduces both the amount of food which can be consumed, and the appetite.

1.4.2 Side Effects of Surgery

All types of WLS surgery can have unwanted side effects such as excess skin, digestive issues, gall stones, malnutrition and hair loss and it is common for candidates to experience at least some of these, which they will be required to manage post-operatively (NHS Choices, 2017). The gastric band is considered the least invasive, with side effects less severe (Gustravsson & Westling, 2002). The gastric bypass and sleeve gastrectomy are associated with more severe side effects including Dumping Syndrome, which presents as severe diarrhoea, nausea or vomiting following food consumption (Tack & Deloose, 2014).

1.4.3 Referral Criteria for Surgery

To receive assessment in a Tier 4 WLS service, candidates are required to satisfy the criteria (NHS Commissioning Board, 2013) which is presented in Table 1.2.

Table 1.2: *Referral Criteria for WLS*

I.	BMI >40, or between 35 - 40 and another serious health condition, which could be improved with weight loss, such as type 2 diabetes or hypertension.
II.	All appropriate non-surgical measures have been tried, including Tier 3 weight management, but the person has not achieved or maintained adequate, clinically beneficial weight loss.
III.	The person is fit enough to have anaesthesia and surgery.
IV.	The person has been receiving, or will receive, intensive management as part of their treatment.
V.	The person commits to the need for long-term follow-up.

1.4.4 Objective Outcomes after Surgery

Weight loss outcomes are routinely reported by the UK Bariatric Surgery Registry (NBSR) (Welbourn et al, 2014) and this is the source of the information presented in this section.

One year following surgery, on average, candidates lose 58.4% of the excess weight that they are required to lose, in order to reach what is considered a healthy BMI. On average, three years after having WLS, candidates have 40% of their excess body weight left to lose in order to reach what is considered a healthy BMI range. It is not uncommon for some candidates to regain weight.

According to the NBSR, the aim of weight loss is secondary. The NBSR reports a multitude of co-morbid conditions associated with obesity such as arthritis, hypertension, diabetes and sleep apnoea and that the primary aim of WLS is to reduce such conditions and improve functional status. At two years following surgery, the NBSR reported that 80% of candidates with type 2 diabetes were in clinical remission, 61% who had sleep apnoea were able to end their treatment and 64% were now classified as having no functional impairment. So, whilst

candidates may not lose the amount of weight they had anticipated, many achieve significant improvements in physical health.

The longevity of outcomes can vary with the type of WLS. The gastric bypass is the most commonly performed on the NHS, followed by the sleeve gastrectomy and then the gastric band. The latter, whilst the least invasive procedure, has less successful long-term outcomes. The first 12 months following surgery is commonly seen as a 'honeymoon period' in which candidates lose weight with ease. Following this, lifestyle adjustments are required for candidates to continue and maintain weight loss and it is then that candidates may encounter challenges (Lynch, 2016).

1.4.5 Predicting Outcomes

It is common practice to assess psychological factors with WLS candidates. There is, however, little consensus in the literature on which factors, psychological or otherwise, predict outcomes (Wimmelmann, Dela & Mortensen, 2013). In their literature review, the only conclusive finding reported by Wimmelmann et al (2013) was that irrespective of pre-surgical factors, post-surgical eating behaviour and binge eating predicts weight loss. Possibly reflecting the lack of evidence, the National Institute for Clinical Excellence (NICE) guidance is also vague on which psychological factors should be considered during pre-surgical assessment (NICE, 2014). Currently assessment for WLS is guided by a combination of clinical experience and theoretical knowledge. There is therefore a need to build the empirical evidence to help scaffold such assessments, particularly with a view to understanding whether candidates are best placed to make the required health behaviour changes for WLS and identify what help might be required to facilitate this process.

1.4.6 Subjective Outcomes after Surgery

The NHS is predominantly focused on the objective outcomes of WLS which are well reported through statistics on weight loss and improvement in physical health problems. For candidates however, other outcomes such as improvement in quality of life and improvement in satisfaction with aesthetic appearance may be important but are seen as secondary by NHS commissioners. Subjective outcomes might therefore reflect the less spoken about hopes and expectations, as well as candidates' overall satisfaction with surgery.

The literature describes how candidates reported improved health related quality of life, improved depression and anxiety, improved self-esteem and improved social relationships following WLS. These were positively correlated with weight loss and in many cases at least a moderate weight loss was required before candidates began to experience improvements in other areas (Loaisa, Carrillo & Coll, 2015).

Candidates can also experience challenges after WLS. As changes (or a lack of changes) in weight occur, candidates have to navigate adjustments in their self-concept and image. The resulting tensions which may arise from this can be difficult (Bocchieri, Meana & Fisher, 2002). Even when the desired weight loss is achieved, candidates can be left with excess skin, which can cause dermatological conditions and functional difficulties (Kitzinger, Abayev & Pittermann, 2012).

The issue of excess skin is common with WLS and candidates are made aware of this prior to surgery. Despite good objective outcomes, some candidates still report feeling dissatisfied with the aesthetic appearance of their body post surgically due to excess skin (Kitzinger et al, 2012). This may be of particular importance for candidates accessing WLS in the NHS, as

only in rare cases and after significant sustained weight loss is excessive skin removal a funded procedure.

Candidates may also experience changes in their social relationships. On the one hand this may be positive, for instance, reduced stigma and discrimination or increased sexual interest from a romantic partner. On the other hand, some candidates struggle as they find themselves exposed to new situations (Sogg & Gorman, 2008). Candidates might also experience unwelcome challenges in their relationships, if partners struggle to adjust to their relative changing and perhaps assuming a new role within the family system (Kluever Romo & Dailey, 2014).

Some research indicates that irrespective of the realities that candidates faced, they remained extremely positive about their decision to have surgery (Wysoker, 2005). Wysoker speculates that this positivity can be used to provide psychological structure once the constraints on eating provided by the surgery become less rigid. It is difficult to know the trajectory of this positivity as most of this research was done one year post-surgery. It is often in the subsequent years at two, five and ten years post-surgery where candidates have been living with the long-term challenges of WLS that satisfaction may reduce. The optimism experienced at one year post surgery therefore may vary in subsequent years.

Collectively this shows us that for candidates, outcomes of WLS are more than the amount of weight loss and improvement in physical health conditions. They can experience a host of physical, psychological and social changes that are not always necessarily anticipated, or welcomed.

1.5 Psychological Aspects of Health Behaviour

In order to have a successful WLS experience, candidates are required to make significant lifestyle changes both before and following surgery (Elder & Wolfe, 2007). Understanding theory relevant to health behaviour might be useful in considering why some candidates are more successful in achieving their desired outcomes than others.

1.5.1 Self-Efficacy

Self-efficacy refers to the extent to which a person believes that they will succeed in performing a behaviour (Bandura, 1977). It is a key component of many health behaviour change models and those that do not include it have been criticised for lacking explanatory and predictive power (Bandura, 1997). With WLS, research has shown that post operatively, increased self-efficacy is associated with higher weight loss (Batsis, Clark & Grother, 2009). This may be an important idea to hold in mind when considering candidate suitability.

The amount of self-efficacy that individuals view themselves as having is influenced by a variety of factors such as perceived task complexity, effort required and whether help is available (Schunk & Carbonari, 1984). Further, self-efficacy operates within a sociocultural context in which factors in a person's life might enhance or deplete it (Bandura, 1989). This is important in light of multiple failed attempts to lose weight through non-surgical methods, as well as the stigma that can be experienced by individuals with obesity (Gibbons, Sarwer & Crerand, 2010, Puhl & Heuer, 2010). These factors may impact narratives which WLS candidates hold about themselves in relation to obesity (Homer, Tod & Thompson, 2015 & da Silva & da Costa Maia, 2012). This may influence how empowered candidates feel in making lifestyle changes.

1.5.2 Locus of Control and Learned Helplessness

Locus of control is a concept introduced by Rotter (1966), which refers to how much control someone perceives themselves as having over an event. In health, this is sometimes referred to as health locus of control. People with high perceived control are labelled as having an internal health locus of control and those who do not, an external health locus of control (Wallston, Wallston & Kaplan, 1976).

As well as conceptually overlapping with self-efficacy, locus of control has been linked to learned helplessness (Sarafino, 2006). If people are exposed to high distress and repeated failures they are at risk of learned helplessness, which refers to a sense of powerlessness (Maier & Seligman, 1976). According to this theory, the attributions a person makes about their control over a failure, how stable the cause of the event is and how global or specific the failure is perceived to be, will impact the occurrence of learned helplessness.

The pathway to WLS is usually littered with failed attempts at weight loss for candidates (Gibbons et al, 2010), meaning that candidates could be at risk of learned helplessness. This may impact success in implementing requisite lifestyle changes alongside WLS. Whilst no studies have examined this, ideas which learned helplessness speaks to, such as perceived control over weight loss, are recommended as considerations when assessing candidates for WLS (Lemont, Moorehead & Reto, 2004). This may therefore be a useful factor to consider in research with WLS candidates.

1.5.3 Health Belief Model

The Health Belief Model originated in the 1950s with applications in the context of public health (Hochbaum, Rosenstocl & Kegel, 1952). The model attributes health behaviour

change to beliefs regarding the seriousness of a health problem, benefits of taking action, barriers to taking action and internal and external cues regarding taking action. In line with this, according to Armstrong and colleagues (2009), perceived susceptibility and seriousness of obesity associated health conditions, candidates' belief in the efficacy of the WLS and cues to action, such as family members are important in improving outcomes. These ideas are, however, theoretical rather than empirically proven.

Despite its appeal, the Health Belief Model has been criticised; firstly, for being ill equipped to explain more habitual health related behaviours in which a person gives little consideration to their beliefs; secondly, for the lack of standardised methods for measuring beliefs. This makes it difficult to ascertain similarities and differences across research, or to assess the validity of findings (Sarafino, 2006). Finally, whilst the Health Belief Model has a range of pragmatic applications, it has been criticised on conceptual grounds. The constructs within it are poorly evidenced and anomalies in the literature are often justified rather than considered as evidence of the weak conceptual underpinnings (Ogden, 2003). Within the context of WLS, the Health Belief Model is perhaps best considered a useful heuristic when considering the experiences and behaviours of WLS candidates.

1.5.4 Theory of Planned Behaviour

According to the Theory of Planned Behaviour (Ajzen, 1985), it is our intentions that lead to health behaviour change and our intentions are determined by a number of factors: Whether we believe that the health behaviour change will be good, bad or rewarding, the perceptions of others, and how much we believe we can succeed. Like the Health Belief Model, the Theory of Planned Behaviour has been celebrated for its pragmatism having been applied in a range of settings including exercise following WLS (Courneya, Plotnikoff & Hotz 2001).

However, again, the theory has been criticised for conceptual weaknesses as well as for the assumption that people explicitly process advantages, disadvantages and risks when making decisions (Ogden, 2003 & Sarafino, 2006).

In practice, our intentions do not necessarily translate into behaviour. Furthermore, the Theory of Planned Behaviour does not acknowledge our historical experiences (Sarafino, 2006). This may be crucial in the area of WLS. As previously mentioned, surgery is a treatment of last resort following a trajectory of intentions and failed attempts to lose weight through alternative means. These experiences could place candidates in disempowered positions, influence how they conceptualise WLS and impact intentions to change health behaviour alongside surgery.

1.5.5 Motivation and Stages of Change Model

The Stages of Change Model (Prochaska & DiClemente, 1986) states that individuals go through five behavioural stages and levels of cognitive processing. As individuals advance through the stages they become aware of a problem, evaluate the advantages and disadvantages of changing, explore options, make a plan and so have higher levels of readiness to change. Individuals at more advanced stages of change are considered more likely to be successful in implementing change.

The model has been useful in its application to a range of health behaviours (Sarafino, 2006) and also informs motivational interviewing, a technique which can be used to help facilitate individuals' thinking and planning with regards to change (DiClemente & Velasquez, 2002). The theory within the Stages of Change Model makes intuitive sense and can be a useful framework in shaping the assessments and interventions of health professionals. However,

how ready someone is to change has not yet been shown to be related to outcome in WLS (Dixon, Laurie & Anderson, 2009).

A key issue which is not considered within the Stages of Change Model, or other health behaviour change theories is that our decisions do not always follow logic (Sarafino, 2006). For example, a person who smokes may continue to do so despite knowing the health risks. Often, when justifying or making the decision to undertake a behaviour that the evidence tells us is 'bad' for us, we will be biased in our processing of the information in support of our decision. For instance, a person who decides to drink a large amount of alcohol, despite having done so previously, being ill as a result, might glaze over this previous experience paying it little attention so as to temporarily convince themselves that "it will be okay". Kunda (1990) called this motivated reasoning.

1.5.6 Self-Determination Theory

Self-Determination Theory seeks to differentiate between the qualities of motivators to help explain the likelihood of whether motivation will be linked to success (Ryan & Deci, 2000). It sees motivations as existing on a spectrum ranging from doing something solely for the satisfaction of doing so (intrinsic motivation), through to doing something for the avoidance of a feared consequence or attainment of a particular goal (extrinsic motivation). The closer a motivator is to intrinsic, the more likely it will translate to change. As extrinsic motivations become more aligned with personal values and perceived control over the world, they move more closely to intrinsic motivation on the spectrum.

Ryan and Deci (2000) describe three conditions which need to be satisfied to facilitate the process of motivations becoming more intrinsic. The first is relatedness, which refers to how

much we feel attached to and cared for by others. The second is autonomy and the third is competence. When considering any given behaviour change, if these three conditions are satisfied, then the motivating factors behind the behaviour will become more intrinsic and we are more able and likely to successfully implement the behaviour.

There is some support for ideas from Self-Determination Theory within the area of weight loss and WLS. Using this framework, Park (2016) explored the reasons for choosing WLS amongst 14 people in America who were due to have WLS within the next 6 months. Park reported the results to support the idea that the more motivators were internally regulated and directly related to personal life goals, the more hopeful anticipations were for post-surgical outcomes. Whilst this fits within a Self-Determination Theory framework and seems clinically intuitive, we do not know the impact on outcome. As Park noted, more longitudinal type research is required to see how this might relate to the actual outcomes achieved and subjective satisfaction with these.

1.5.7 Acceptance and Commitment Therapy

Some of the ideas within Self-Determination Theory have conceptual overlays with Acceptance and Commitment Therapy (ACT). ACT is based on Relational Frame Theory and is concerned with supporting people to live in accordance with their values (Hayes, 2004). It encourages people to make behavioural choices aligning with their value system (Flaxman, Blackledge & Bond, 2011) in a way that is workable for them (Hayes, 2004). As a therapy, ACT has a strong emerging evidence base with positive outcomes in a range of areas (Hayes, 2004, Hayes, Luoma & Bond, 2006 & Öst, 2014). ACT has also started to be used in a WLS context, for instance, following surgery, supporting candidates with emotional eating, body

image and quality of life (Weineland, Arvidsson & Kakoulidis, 2012 & Weineland, Hayes & Dahl, 2012).

In ACT, of particular relevance to WLS, is the assumption that what presents on a surface level as the goal, is a means by which people try to live in alignment with their underlying values (Hayes, 2004). Based on this, achieving WLS goals may be a means by which WLS candidates can begin to live a life which sits more closely with what is important to them, that is, their underlying values. When making behavioural changes in the context of WLS, candidates' awareness of the value base which underpins their goals may be important with possible consequences for outcome following surgery. To date there is no research in this area.

1.5.8 Summary

Theoretical models of the psychological factors that underpin health behaviour change may be useful in facilitating our understanding of WLS candidates' decisions and their readiness for change. In addition, these models may inform us about facilitating the sustained lifestyle changes that are needed for WLS to be successful. More research in this area is required to bridge the gap between theoretical usefulness, conceptual issues and practical implications for WLS.

1.6 Areas Warranting Further Exploration

WLS is a serious life changing procedure offered by the NHS. There are gaps in our understanding of the experiences of candidates and why some are successful in the longer term while others are not. Psychological models of health behavior change suggest that a range of factors during candidates' WLS journeys may be important in achieving lifestyle

changes and outcomes. These factors start with the candidates' experiences leading to their pursuit of WLS, which may influence their beliefs about themselves, their obesity and physical health and what will be most influential in changing these things. In addition, these experiences may impact how candidates present during pre-surgical assessment and their willingness to be open and honest about struggles as well as hopes and expectations for WLS. In the next chapter a detailed systematic review of existing studies on the experiences of WLS candidates within the NHS and their decisions to have WLS will be presented.

CHAPTER 2: SYSTEMATIC LITERATURE REVIEW

2.1 Overview

This chapter presents a systematic literature review of existing research on candidates' experiences and decisions to have WLS in the NHS. A detailed account of the steps taken in completing the systematic review can be found in Appendix A, with summarized information here and in the following sections. To complete the literature review, Scopus, PubMed, CINAHL Plus and Psycharticles were the search engines of choice, along with the following search terms; 'bariatric surgery', 'weight loss surgery', 'decision', 'preparation', 'expectation' and 'experience'. The search yielded 4133 results, a total of 212 abstracts were screened, 11 full copies retrieved, with nine papers retained for the final review.

2.2 Inclusion and Exclusion Criteria

Table 2.1 details the inclusion and exclusion criteria for the systematic review. Consideration was given as to whether non-UK based studies should be included. Whilst such studies might be useful in aiding understanding of WLS in the UK, the NHS is a unique context. Many non-UK studies include candidates having privately funded surgery, which may have implications for access and experiences of the services received. This informed the decision to exclude non-UK based research.

Table 2.1: *Inclusion and Exclusion Criteria for Systematic Literature Review*

Inclusion Criteria	Exclusion Criteria
Research on adults aged 18 or over who are having or have had WLS.	Non-NHS based research.
Research that attempts to understand why candidates pursue WLS.	Research on candidates who are having/ had privately funded WLS.
Research that attempts to understand candidates' knowledge, understanding and preparation for WLS and life afterwards.	Research on adolescents.
Research that attempts to understand candidates' hopes and expectations for WLS.	
Research that attempts to understand how WLS candidates plan and prepare for lifestyle change.	

2.3 Evaluating the Literature

The quality of studies was evaluated against two sets of criteria. Of the 11 full copies retrieved, all were qualitative and so criteria for assessing the quality of qualitative research was used. The first set of criteria was the Critical Appraisal Skills Programme (CASP) qualitative research screen (2018). This consists of a series of tick box questions, allowing for initial evaluation of each study. If the CASP screen highlighted studies without clear aims, or other significant methodological issues, these studies were excluded, in this case two studies (Hancock, Jackson & Johnson, 2016 & Throsby, 2008). For a detailed account of CASP criteria along with information on the initial screening of studies identified for inclusion in the systematic review, see Appendices A-B.

Studies which met CASP criteria were evaluated further using criteria outlined by Mays and Pope (2000). These criteria were chosen as they are specific to qualitative research in healthcare settings. Information on Mays and Pope's (2000) criteria and a subsequent review table is located in Appendix C.

2.4 Synthesis of Findings

Following study evaluation, nine studies remained in the systematic review, with a summary of each in appendix D. The findings of these studies have been synthesized and are discussed here. Through synthesizing the findings, a number of themes were identified with respect to methodological issues and study results. These are presented in table 2.2.

Table 2.2: *Systematic Literature Review: Themes in Methodological Issues and Study Results*

	Homer et al (2015), Expectations and patients' experiences of obesity prior to bariatric surgery	**Lloyd et al (2017). "It just made me feel so desolate" Patients' narrative of weight-regain following laparoscopic insertion of a gastric band**	**Ogden et al, (2011). Negotiating control: Patients' experiences of unsuccessful weight loss surgery**	**Ogden & Hills (2008). Understanding sustained behaviour change: the role of life crises and the process of reinvention**	**Owen-Smith et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study**	**Owers et al (2017). Designing pre-bariatric surgery education: The value of patients' experiences**	**Pfeil et al (2013). The patient journey to gastric band surgery: A qualitative exploration**	**Pfeil et al (2014). Living with a gastric band: A qualitative study**	**Wood & Ogden, (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study**
Obesity and Weight Loss Surgery Stigma	✓	X	X	X	X	✓	✓	X	X
Repeated Weight Loss Failures	✓	X	X	X	✓	X	✓	X	X
Life Events	X	X	X	✓	X	X	✓	X	X
Access to Surgery	✓	X	X	X	✓	X	X	X	X
Professional Support	✓	✓	✓	X	✓	✓	X	✓	X

	Homer et al (2015), Expectations and patients' experiences of obesity prior to bariatric surgery	Lloyd et al (2017). "It just made me feel so desolate" Patients' narrative of weight-regain following laparoscopic insertion of a gastric band	Ogden et al, (2011). Negotiating control: Patients' experiences of unsuccessful weight loss surgery	Ogden & Hills (2008). Understanding sustained behaviour change: the role of life crises and the process of reinvention	Owen-Smith et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study	Owers et al (2017). Designing pre-bariatric surgery education: The value of patients' experiences	Pfeil et al (2013). The patient journey to gastric band surgery: A qualitative exploration	Pfeil et al (2014). Living with a gastric band: A qualitative study	Wood & Ogden, (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study
Personal Support	X	X	X	X	X	✓	X	X	X
Expectations	✓	✓	X	X	X	X	✓	X	X
Control and Choice	✓	X	✓	✓	X	X	✓	✓	X
Lifestyle Adjustments	✓	X	✓	✓	X	X	✓	X	✓
Side Effects from Surgery	✓	✓	X	X	X	✓	X	✓	X
Emotional Hunger and Coping	X	✓	✓	✓	X	✓	X	X	✓

	Homer et al (2015), Expectations and patients' experiences of obesity prior to bariatric surgery	**Lloyd et al (2017). "It just made me feel so desolate" Patients' narrative of weight-regain following laparoscopic insertion of a gastric band**	**Ogden et al, (2011). Negotiating control: Patients' experiences of unsuccessful weight loss surgery**	**Ogden & Hills (2008). Understanding sustained behaviour change: the role of life crises and the process of reinvention**	**Owen-Smith et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study**	**Owers et al (2017). Designing pre-bariatric surgery education: The value of patients' experiences**	**Pfeil et al (2013). The patient journey to gastric band surgery: A qualitative exploration**	**Pfeil et al (2014). Living with a gastric band: A qualitative study**	**Wood & Ogden, (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study**
Learning Through Experience	X	X	✓	X	X	X	X	✓	X
Interview Time Point (pre-op/ post-op)	Pre-op	Post-op	Post-op	Post-op	Pre- & post-op	Post-op	Pre-op	Pre- & post-op	Post-op
Surgery Type of Sample (band, bypass, sleeve, mixed)	Mixed	Band	Mixed	Unknown	Unknown	Mixed	Band	Band	Mixed

	Homer et al (2015), Expectations and patients' experiences of obesity prior to bariatric surgery	**Lloyd et al (2017). "It just made me feel so desolate" Patients' narrative of weight-regain following laparoscopic insertion of a gastric band**	**Ogden et al, (2011). Negotiating control: Patients' experiences of unsuccessful weight loss surgery**	**Ogden & Hills (2008). Understanding sustained behaviour change: the role of life crises and the process of reinvention**	**Owen-Smith et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study**	**Owers et al (2017). Designing pre-bariatric surgery education: The value of patients' experiences**	**Pfeil et al (2013). The patient journey to gastric band surgery: A qualitative exploration**	**Pfeil et al (2014). Living with a gastric band: A qualitative study**	**Wood & Ogden, (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study**
Sample Accessed Tier 3 After Implementation of NHS England Commissioning Guidance (2013).	X	✓	X	X	X	X	X	X	X

2.4.1 Obesity and WLS Stigma

Receiving negative and judgmental comments relating to body size was in three of the studies, including from strangers, family members and non-obesity specialist health professionals (Homer et al, 2015, Owers et al, 2017 & Pfiel et al, 2013). The impact of obesity stigma was reported as shame, embarrassment regarding appearance and avoidance of social situations (Homer et al, 2015). In two of the studies participants reported how their experiences of obesity stigma had impacted their decision to pursue surgery with a view to wanting to become "normal" (Homer et al, 2015 & Pfiel et al, 2013). Both of these studies interviewed participants pre-operatively, meaning that we cannot determine how the pursuit of "normality" is experienced post-operatively and whether this has any bearing on the outcomes of WLS.

One study touched on the WLS stigma that their participants experienced (Owers et al, 2017). The study described experiences such as comments towards participants by the general public on the misuse of NHS funding for WLS and a lack of understanding as to why they "didn't just diet?" Participants expressed how this further fed in to experiences of shame and embarrassment with regards to obesity and attempts to lose weight. It might be useful to consider the experience of potentially trading one type of stigma for another and how this impacts adaptive coping and outcomes following surgery.

2.4.2 Repeated Weight Loss Failures

Three studies made references to participants' experiences of repeated and failed weight loss attempts (Homer et al, 2015, Owen-Smith et al, 2016 & Pfiel et al, 2013) and the resulting conceptualization of WLS as a last resort (Homer et al, 2015 & Pfiel et al, 2013). Research spoke of participants feeling disempowered due to their failed weight loss attempts (Pfiel et

al, 2013). However, none of the studies expanded on the psychological implications of this and what this meant for subsequent lifestyle change and adaptive coping following surgery. For example, did the repeated failures in losing weight result in lowered self-efficacy and could this mean that requisite lifestyle changes are more challenging? Or, in contrast, could repeated failures lead to a focusing of mind and motivation?

2.4.3 Life Events

Ogden & Hills (2008) were interested in understanding the factors typical to people who experience long term success maintaining lifestyle changes. They found that a significant life event which involved a threat to physical health was a common feature. Participants described how the life event helped to shed light on the relationship between behaviour and health, triggering change. For others, there was a significant life event unrelated to health, such as a major birthday, and this led to a time of reflection on how life is versus how they would like it to be.

Ogden & Hills (2008) purposely sought a heterogeneous sample and only 12 of the total 34 participants belonged to the WLS group. It is therefore difficult to ascertain how much the findings around life events relate to this particular group. However, Pfeil et al (2013) used a sample of WLS candidates only and found similar results. Their participants noted landmarks such as reaching a specific age or weight spurring on the decision for WLS.

This might be useful when considering the "why now?" question with WLS candidates. The two studies that looked at the role of life events included either pre-operative participants or post-operative participants whose surgery had been successful. It is not clear therefore how

the results of these studies might be applied to candidates who are dissatisfied with post-operative outcomes.

2.4.4 Access to Surgery

Two studies referenced participants' experiences in accessing WLS, most of which were reported as negative. These ranged from a lack of awareness that surgery was an option to difficulties accessing referrals to the appropriate clinical pathways (Homer et al, 2015 & Owen-Smith et al, 2016). Owen-Smith et al (2016) found that the quality of doctor-patient relationships was integral to accessing referrals for WLS. In their study participants who found access difficult spoke about experiencing their doctors as unapproachable or perceiving an underlying note of disapproval.

In accordance with NHS England commissioning guidance (NHS commissioning board, 2013 & NHS England, 2016), candidates are required to demonstrate a commitment to weight loss and lifestyle change prior to surgery. As a result of challenges with this, some research reported participants' fears that they would not be accepted for surgery (Homer et al, 2015). None of the research speculated on how this might impact on honesty during pre-surgical assessment, or on candidates' preparation for surgery and post-surgical lifestyle changes.

2.4.5 Professional Support

Four studies included samples where participants were disappointed with outcomes and the support received prior to and following surgery. Candidates reported feeling that this contributed to the difficulties they faced in achieving positive outcomes (Homer et al, 2015, Lloyd et al, 2017, Ogden et al, 2011, Owen-Smith et al, 2016). Dissatisfaction with support

ranged from issues with the amount of support available to problems with the nature of the support. For example, one study reported that the information pamphlets and repeated weight taking with dieticians were not sufficient in helping participants to make the required lifestyle changes (Lloyd et al 2017).

Despite some issues with the amount and quality of support, participants in one study commented on the warm and empathic stance of specialist obesity staff relative to other health professionals (Homer et al, 2015). In another study, candidates referred to the post-operative support provided by obesity specialists as essential, particularly bariatric nurses who were framed as "knowing everything" (Pfiel et al, 2014).

Participants in some studies highlighted the need for additional psychological support in "re-ordering thinking" to assist them in managing emotional hunger while the surgery dealt with physical hunger, and with the need for this being seen as life-long (Homer et al, 2015, Lloyd et al, 2017, Ogden et al, 2011, Owen-Smith et al, 2016). One study interviewed participants who had experienced an unsuccessful surgery followed by a successful surgery. Participants reported that a key difference between the two surgeries had been the role of health professionals in facilitating psychological change, although the specific nature of this was not expanded upon (Ogden et al, 2011).

The nature of Tier 3 services was also commented on. Participants welcomed the opportunity to access specialist support alongside others with similar difficulties to themselves (Homer et al 2015 & Owen-Smith et al, 2016). One study reported that the Tier 3 support was not long enough but did not specify the length accessed by its sample (Homer et al, 2015). All of the five studies that addressed the area of professional support interviewed participants who

accessed Tier 3 services prior to the implementation of the 2013 commissioning criteria (NHS Commissioning Board, 2013). This makes it difficult to equate the experiences of Tier 3 services of the participants in these studies with people currently accessing WLS. The nature and quality of pre-surgical pathways is constantly evolving and we do not yet know how this relates to the quality of preparation for surgery or to long term outcomes.

2.4.6 Personal Support

One study which interviewed participants post-operatively reported that candidates felt surprised by the amount of social support required following WLS (Owers et al, 2017). The study described participants' experiences of friends and family responding in various ways to the surgery, with some more supportive than others. Participants reported feeling ill prepared on how to navigate this. The study did not focus on how these experiences might relate to the implementation of lifestyle changes, adaptive coping and outcomes. As no information was provided on the nature of outcomes for participants, the potential impact of variations in personal support remains speculative.

2.4.7 Hopes and Expectations

Two studies reported that participants' expectations for life after surgery were "high" or "unrealistic" (Homer et al, 2015 & Lloyd et al, 2017); however, it was difficult to determine from the research what specifically made expectations unrealistic. Research focusing on participants who did not maintain long-term weight loss described the discrepancy between participants' high expectations for outcomes and their lived reality, which resulted in a sense of regret about the surgery (Lloyd et al, 2017). Not having surgery was not seen as viable by participants in some studies. For instance, some reported that without surgery they felt that they may as well be dead or would die due to physical health problems (Homer et al, 2015 &

Pfiel et al, 2013). It may be that this type of binary thinking underpins unrealistic expectations, although this was not stated explicitly in the studies.

Hopes and expectations included: improved health, reduced physical health problems, improved relationships, improved confidence, improved physical appearance and an increased "zest" for life (Homer et al, 2015 & Pfiel et al, 2013). Amongst the studies there was little information about what the hopes and expectations for WLS were grounded in or whether they related to an underlying value base.

One study touched on the role of education in informing expectations. When asked at the pre-surgical stage, candidates expressed that they had researched WLS from multiple sources including health professionals, other WLS candidates, television, newspapers and journals, and that their expectations were based on this. (Pfiel et al, 2013). However, this study did not follow participants up post surgically. A longitudinal approach could be helpful in understanding the role of pre-surgical education, whether self-driven or formally delivered by Tier 3 and 4 services, in preparing candidates and facilitating change.

2.4.8 Control and Choice

One study, which interviewed candidates prior to WLS, found that participants hoped that surgery would remove the issue of choice with regards to eating and that this would be determined instead by the physical constraints of the surgery (Homer et al, 2015). This reflects earlier findings from two studies that interviewed candidates post-operatively (Ogden et al, 2011 & Pfiel et al 2014). Some candidates who experienced surgery as a failure attributed this to the operation failing to offer sufficient control and restriction over what they could eat. At the same time participants noted behaviours whereby they would "cheat the

surgery" such as by stretching their gastric band (Ogden et al, 2011). In contrast, for successful candidates, the same study reported a "shift in mind set" where candidates relinquished physical control to the surgery whilst retaining psychological responsibility and an active rather than passive role in making lifestyle changes (Ogden et al, 2011 & Pfiel et al, 2014).

One study looked at successful health behaviour change more generally (n=34) but included a sub-group of WLS participants who had had WLS (n=12) and found that a reduction in available choice was important for sustaining change (Ogden & Hills, 2008). The research reported on the sub-group of WLS candidates and that for them, the belief that it was no longer physically possible to eat certain kinds and amounts of food meant that some decisions around eating had been taken out of their hands. This was experienced as liberating and the participants felt this had contributed to their long-term success.

The research in this area has usefully focused on the experiences of both successful and unsuccessful candidates. It could be helpful to add to this through gaining an understanding of how candidates' beliefs around control and choice develop and grow. For example, are they present pre-surgically and if so at what time points? What is it that informs the beliefs and could providing information at certain points aid success?

2.4.9 Lifestyle Adjustments

Three studies reported on participants' views that the surgery is a "tool" alongside which they need to make lifestyle changes to diet and exercise (Homer et al, 2015, Ogden et al, 2011 & Pfiel et al, 2013). For candidates who experienced the surgery as successful in the long-term, all made lifestyle changes (Ogden et al, 2011 & Wood & Ogden, 2016). This fits with earlier

research, which found that participants who had a behavioural understanding of their difficulty and who held subsequent beliefs that a behvaioural solution was most appropriate, experienced long-term success following surgery (Ogden & Hills, 2008). Unfortunately, the study lacked a control group therefore it is difficult to know how beliefs might differ for candidates who are not successful following surgery.

In maintaining lifestyle changes, one study referenced candidates' residual fear that old habits could return or that their stomach would stretch; this fear was said to maintain focus and motivation (Ogden et al, 2011). In contrast, another study reported on participants' hopes that they would not have to make all the recommended lifestyle changes. Homer et al (2015) found that some participants knew of other people who had undergone WLS and that this was used to inform this line of thinking. Amongst participants who experienced their surgery as unsuccessful, one study described a process whereby candidates learned ways around the limitations placed on them by surgery, for example, by being aware of times when they were able to eat more, or chewing food to a pulp (Ogden et al, 2011).

Pfiel et al (2014) found that whilst changes to eating habits were achieved by all successful candidates, only three out of 20 participants reported introducing exercise into their life. Participants who had not made this lifestyle change said that exercise was not enjoyable. Instead they reported focusing their attention on increased activity levels in general rather than exercising.

Collectively the studies reviewed suggest that changes in eating behaviour are essential and a common feature for successful candidates, whereas exercise is less so. The studies do not go into detail about what specific steps successful candidates take in making lifestyle changes.

Nor do they address what facilitates this process, beyond notions of beliefs and cognitions around choice and control. What, for example, is the role of family, friends and professionals in facilitating these processes, and how much planning and preparation is required?

2.4.10 Side Effects from Surgery

One study found that prior to surgery, participants acknowledged the possibility of side effects but tended to believe that this would not be the case for them, or at least, that this would not outweigh the positive outcomes of surgery (Homer et al, 2015). This might be formulated as an acceptable level of denial that all humans may have when approaching big decisions, as without it, perhaps our plans would never come to fruition (Kunda, 1990). Alternatively, it might be formulated as an unrealistic understanding of the possibilities for life after surgery, and therefore might prevent adequate preparation and planning. Either way, it is difficult to know without following candidates in vivo as they progress through surgical pathways.

Lloyd et al (2017) interviewed candidates following surgery and found that all participants noted the impact of negative side effects of WLS. The nature of side effects was described as unpredictable and participants reported that this impacted their social life, for instance avoiding social interactions. Similarly, Owers et al (2017) note that participants felt that they were not sufficiently educated on the negative side effects prior to surgery. Pfiel et al (2014) found that participants saw vomiting after surgery as a reminder of the new limited capacity of the stomach, with this being framed in an almost helpful light. In the same study, some participants reported concern over excess skin, which they tried to avoid through slowing the rate of weight loss. These studies are useful in highlighting the need for information and perhaps support regarding the negative side effects of surgery.

2.4.11 Emotional Hunger and Coping

Ogden and Hills (2008) found that for WLS candidates who experience long-term weight loss, the function of meeting emotional needs through eating becomes disrupted and that this is a key stage in moving towards success. It could be hypothesised that in the initial stages, the WLS itself and the physical limitations this places on eating may provide a disruption to the function of eating behaviour.

These ideas fit with accounts of unsuccessful surgery. Some candidates reported dealing with challenges after surgery by "seeking solace in the wrong foods" (Lloyd et al, 2017). Others reported seeking comfort generally through food and noted a tension between needing to eat less but needing to satisfy emotional needs (Ogden et al, 2011). Other research found that participants developed other potentially unhelpful ways of coping following surgery such as drinking alcohol. It specified that some participants felt that their "addiction had transferred" to other methods such as exercise, shopping and sex (Owers et al, 2017).

Research exploring the experiences of both unsuccessful and successful WLS candidates eight years after surgery found that one factor which differentiated the two groups was emotional eating (Wood & Ogden, 2016). Here successful candidates reported an absence of emotional eating having sought alternative ways of coping with emotions. This meant that the role of food in their lives had become more functional and that food felt less important to them than it had prior to surgery. Participants spoke about the functionalization of food not only in terms of the physical constraints induced by the surgery, but also a change in mindset whereby they no longer felt the need to eat for emotional reasons. This is useful in understanding how long-term success is achieved. What is less clear is how these processes

unfold over the duration of the WLS journey, which could highlight key time points for targeting help and support.

2.4.12 Learning Through Experience

Learning directly through experience was not explicitly reported in the reviewed studies; however, numerous examples are given which point to this idea and its potential role with respect to lifestyle changes. For instance, candidates described getting to know their body and digestion after surgery and that through testing the limits of the surgery they made both desirable (e.g. diet changes) and undesirable changes (e.g. chewing food to a pulp) (Ogden et al, 2011 & Pfiel et al 2014). Some studies spoke to the idea that participants learn as they go rather than pre-planning, for instance, with respect to portion sizes when eating out, or learning which foods can be tolerated (Owers et al, 2017 & Pfiel et al, 2014). A certain amount of experiential learning might be anticipated in the area of WLS. To what degree and at what point this might represent a lack of information and pre-surgical education rather than an inevitable amount of learning through experience is unclear.

2.5 Methodological Issues and Limitations

Overall, the quality of the studies included in the review was high, with useful insights and contributions to our understanding of WLS in the NHS. There were however several methodological issues which may limit the generalisability and application of the findings (see Table 2.2 for a summary of key findings and design issues). Details of the appraisal of each of the studies against the CASP quality checks and Mays and Pope's (2000) criteria for evaluating qualitative research in healthcare settings are provided in Appendices B-C.

Of the nine studies reviewed, five either interviewed participants pre-surgically only (Homer et al 2016 & Pfiel et al, 2013), or did not differentiate between candidates with respect to outcomes when interviewed post-operatively (Owen-Smith et al, 2016, Owers et al, 2017 & Pfiel et al 2014). Pfiel et al (2014) did specify that two participants were "disappointed" with the slow pace of their weight loss but it was not clear whether those participants also differed in terms of the themes presented in the results. As a result, these studies are limited in helping us to understand how the experiences of candidates who are satisfied with surgery differ from those who are not. Ogden and Hills (2008) specified interviewing successful candidates only and Lloyd et al (2017) unsuccessful candidates only. Whilst both studies might be usefully compared as research using contrasting samples, there are risks in making assumptions from this kind of comparison.

Ogden et al (2011) used a mixed sample of successful and unsuccessful candidates and looked at how the experiences of candidates from different groups varied. Participants in this study had their surgeries between 1-10 years ago. There is a significant amount of variation within this, with those participants closer to the one year post-operative stage more likely to easily lose weight due to the physical constraints of the surgery with the opposite true of those closer to the ten-year mark. The study did not specify at what time point specifically participants were, which may impact experiences of success or lack thereof. Wood and Ogden (2016) also used the same approach as Ogden et al (2011), except all participants were interviewed at least eight years after the surgery. This is useful in helping to rule out the impact of any 'honeymoon effect' following surgery, as well as allowing for sufficient time for the long-term post-surgical challenges to unfold.

Five of the studies interviewed post-surgically (Lloyd et al, 2017, Ogden et al, 2008, Ogden & Hills, 2008, Owers et al, 2017 & Wood & Ogden, 2017). Due to the time point of these interviews, which relied on retrospective recall, it is difficult to know whether they captured participants' experiences as they were at the time or whether they had been altered by hindsight. This could be important in knowing at which time points to target education, as well as which issues are relevant at the time of pre-surgery assessment. Pfiel et al (2014) did use a longitudinal qualitative design; however, the study did not make any comparisons or references to how their participants experiences, attitudes and beliefs changed pre- and post-surgically. Similarly, Owen-Smith et al (2016) followed their participants up over a 3-year period but reported only on their pre-surgical experiences of accessing the surgery. Therefore, of the two longitudinal designs used, neither captilised fully on this research design.

Historically there has been variation in the type of pre-surgical provision for WLS candidates. This changed following the introduction of new guidelines in 2013 (NHS Commissioning Board 2013). All WLS candidates are now required to compete 6-12 months of lifestyle-based intervention in a Tier 3 weight management service. Of the available studies, none used a sample which accessed services post 2013 or contextualised the nature of the pre-surgical provision (Homer et al 2016, Lloyd et al, 2017, Pfiel et al, 2013, Pfiel et al 2014, Ogden et al, 2008, Ogden et al, 2011, Owen-Smith et al, 2016, Owers et al, 2017 & Wood & Ogden, 2016) making meaningful comparison to current NHS provision difficult. This is important if we are to consider its usefulness in preparing candidates for surgery and subsequent impact on outcomes.

In their studies, Owers et al (2017) and Wood & Ogden (2016) acknowledge the relationship between the researchers and participants, for instance the potential impact of their clinical roles in obesity services which the participants were using, or not being an obese person and how this might impact participants. None of the other studies (Homer et al, 2015, Lloyd et al, 2017, Ogden et al, 2011, Ogden & Hills, 2008, Owen-Smith et al, 2016, Pfeil et al, 2013 & Pfiel et al, 2014) detailed evidence with regards to reflexivity. As with all qualitative research, but particularly with groups who have been marginalized or discriminated against, such as obese people, this is important. Amongst the reviewed studies there was almost no discussion of the impact of thin privilege (Cooper, 2010) the research team may have held, nor of the researchers' own beliefs with regard to obesity and WLS.

2.6 Gaps

Journeys through WLS pathways within the NHS and subsequent outcomes can be impacted by multiple factors. Research in the NHS has begun to shed light on some of these issues; however, there are many gaps, particularly with respect to understanding how lifestyle changes, necessary for successful outcome, unfold. Nearly all research has been conducted with samples accessing NHS services prior to the implementation of contemporary commissioning guidance, which has improved the standardization of pre-surgical pathways. Currently there is no research investigating the impact of this change on the quality of candidates' decisions to have surgery, how they conceptualize the surgery or how prepared they feel. Nor does the existing NHS-based research explore the impact of significant relationships on this process. This may be important given the social components of eating and lifestyle-related behaviours within UK society.

2.7 Rationale for Current Research

There is a need for a study that follows candidates longitudinally through their WLS journey to explore how their decisions, preparations, expectations and experiences unfold and evolve. In doing so, the subjective and objective outcomes of candidates should be monitored. This would aid our understanding of the processes that differentiate candidates who deem their surgery a success from those who do not. As well as forming the first part of a planned longitudinal study, this research stands in its own right, expanding our understanding of candidates' pre-surgical experiences including the pre-surgical assessment process, expectations for surgery, preparation and plans, and the roles that health professionals, family and friends may have played within this from the point of view of the candidates.

2.8 Research Aims

This study aimed to addressed the following:

For NHS WLS candidates who have been accepted for WLS but are still awaiting surgery:

- Why did they decide to have WLS?
- What helped them to make their decision to have WLS?
- What do they anticipate for life following surgery?
- What has helped them to prepare for WLS and life thereafter?

CHAPTER 3: METHOD

3.1 Chapter Overview

This chapter presents the research design and rationale for choosing a qualitative approach. The process of ethics and considerations within this will be discussed along with recruitment and participant characteristics. Finally, the procedure and process of data analysis will be explained.

3.2 Design

3.2.1 Rationale for a Qualitative Approach

This research aimed to further our understanding of the experiences of candidates awaiting WLS in the NHS. Psychological theory shows the wide range of factors which might impact this and there is limited research which this sample pre-surgically. For these reasons, an open and exploratory position was taken, which lent itself to a qualitative approach (Thompson & Harper, 2012). The research was interested in learning about what facilitated candidates' preparation for WLS, for instance, in making the required pre-surgical lifestyle changes. Qualitative approaches can be useful in understanding health behaviour change (Starks & Brown-Trinidad, 2007) and the subtleties and complexities of human response to illness and treatment (Sandelowski & Barroso, 2003). This further supported a qualitative approach.

3.2.2 Rationale for Thematic Analysis

Thematic Analysis (TA) is a qualitative tool which identifies, analyses and reports on patterns within data (Braun & Clark, 2006). It is a flexible approach suitable for use with a range of epistemologies (Joffe, 2012). Historically it has been criticised for being too loose (Antaki, Billing & Edwards, 2002), viewed instead as a tool which is applied across different qualitative analyses (Boyatzis, 1998). More recently there has been growing momentum

towards recognising TA as a method in its own right. Braun & Clark (2006) argue that the variety of ways that TA can manifest is not a limitation, as long as why, how and what is done, is clearly stated.

TA was chosen as the desired method for a number of reasons. Firstly, TA aims to identify patterns and similarities across a group and so it is well suited to understanding how a group of people conceptualize a given phenomenon (Joffe, 2012), or in the case of this study, the NHS candidates' decisions to have WLS and their understanding of what might follow. Secondly, TA permits analysis based on existing theoretical knowledge whilst at the same time leaving space for interpretation which is data driven (Braun & Clark, 2006). This was important in this study, as it enabled the analysis to be informed by theory relevant to health behaviour, whilst remaining open to additional patterns and themes that emerged inductively from the accounts of participants.

Thirdly, due to the flexibility in how the method can be utilised, TA enables the researcher to both reflect reality through what is presented on a semantic level within the dataset, as well as unravel the service of reality through interpreting implicit themes held across the data (Braun & Clark, 2006). In this sense, it compliments the critical realist stance taken in this research. It is assumed that from the data collected, we are able to infer knowledge of the participants' motives and experiences. At the same time, it is acknowledged that the issue under study operates within a socio-cultural context in which there are existing narratives about obesity, WLS and their meanings, which may impact the experiences of the participants in this research, as well as the interpretation of the researcher.

3.2.3 Other Qualitative Tools of Analysis

Grounded Theory (GT) is a qualitative tool of analysis developed by Glaser and Strauss (1967) and aims to produce an inductively driven theory (Charmaz, 2008). It was not appropriate to use a GT approach in this research, as to a degree, the research had analytical aims based on existing theory which required a deductive approach (Tweed & Charmaz, 2012).

There are also a range of qualitative tools concerned with giving voice to participants through analysing the stories that they tell, how they are told and the contexts within which they are told. Interpretative Phenomenological Analysis (IPA) considers how people make sense of their experience (Larkin & Thompson, 2012). It tends to have an idiographic focus (Mcleod, 2001) and is attached to a phenomenological epistemology (Smith & Osborn, 2004). Given that the current research is not inductive in its entirety and takes a critical realist position, IPA was not chosen as a tool of analysis.

Similar to IPA, nor were Discourse Analysis (DA) and Narrative Analysis (NA) appropriate with the current research. DA is concerned with the construction and function of language (Gee, 2004). Whilst the latent coding which can be utilised with TA can be similar to DA, the present research aimed to stay closer to the data than might be typically seen in DA. NA is interested in the stories that people tell and how they tell them (Riessman, 2005). It is particularly interested in which stories are privileged (Wells, 2011). In the current research this could be important. Participants may feel inclined to portray certain narratives due to issues of obesity stigma or ensuring that they are successful in accessing WLS. However, whilst it is important to acknowledge the potential impact of this on the research, this was not

a primary aim of this study. For these reasons DA and NA were not selected as a tool of analysis.

3.2.4 Quality and Validity in Qualitative Research

Several steps were taken to ensure the quality of the research. These were based on guidance from Spencer and Ritchie (2012) and Elliott, Fischer and Renne (1999), on relevant considerations for qualitative research. Throughout the research, care was taken to ensure a clear and accessible account of the decisions made and why. This is important because if it is unclear how the researcher went about analysing the data and what assumptions informed this, it will be difficult to evaluate and compare the research with other studies (Attride-Stirling, 2001).

Transparency began with stating the researcher's epistemological position and pre-existing beliefs which might influence the research. In ensuring quality this served multiple functions. It helped to ensure a reflective approach which is useful in reducing unnecessary bias or, at times when this might be inevitable or helpful, showing a thought-out justification as to why. In extending this further, the researcher also kept a reflective diary throughout the research process (Spencer & Ritichie, 2012).

To help ensure the validity and integrity of the research, the aims and design of the study were informed by relevant existing literature. How this has been achieved and the particular literature drawn upon has been presented in Chapters 1-3, enabling the reader to understand the thinking underpinning the research. This along with the provision of demographic information on the participants can also facilitate research interpretation, understanding of generalisability and research critique.

Different mediums of consultation were received during research design and analysis. People with lived experience of WLS and professionals with expertise in the area were consulted. Their feedback and insights were used to inform, improve and refine the design and analysis. Specific details on the consultation sort are provided below and during sections 3.3 and 3.8.

The steps taken during the procedure and analysis have been described in a clear and accessible way, as have the findings of this research. In doing so the limitations of the research have been acknowledged and discussed. In section 3.8, further information is provided on the specific steps taken during the data analysis to help ensure the integrity and validity of the results. In brief, this included checking the reliability of the coding frame using an independent coder and consulting with clinicians working in WLS on the validity of the results. Collectively this should help the reader in understanding the thinking processes behind the procedure and analysis and any critique within this.

A final but over-arching step taken to ensure the quality and validity of the research was in subjecting this study to Mays and Pope's (2000) criteria for evaluating qualitative research in healthcare settings, which was used to evaluate research included in the systematic review. Details of this study evaluation can be found in Appendix E.

3.3 Service User Consultation

Consulting service users is important in ensuring that research is carried out with integrity, sensitively and relevantly to those whom the research relates (DoH, 1999a & DoH 1999b). For this research, a service user contact list from an NHS Obesity Service was accessed. The list consisted of 15 people who had previously had WLS with the service and consented to

people contacting them with questions relating to this area. Of the those listed, three responded to an invitation for service user consultation. The researcher subsequently met with respondents individually. During the consultation, feedback was sought on the research proposal itself and the planned interview schedule. Further details on how this impacted the development of the study are presented in section 3.6.3.

3.4 Ethics

3.4.1 Applying for Ethical Approval

The research was registered with the University of Hertfordshire ethics committee (Appendix F) and ethical approval was sought from the Health Regulatory Authority (HRA) for research in the NHS (Appendix G). Once the research had been approved by HRA, ethical approval was sought from the relevant local Research and Development Departments (Appendix H) and an honorary contract arranged.

3.4.2 Issues Considered

A variety of ethical issues were considered, including power within the recruitment process, informed consent and right to withdraw. Further information on these aspects of design can be found in sections 3.5 and 3.7. Other ethical considerations not covered elsewhere are briefly discussed here.

Possibility of Distress & Prevention of Harm

The research interviews required participants to talk about their journey to and expectations for WLS. Given the stigma, associated health difficulties and repeated failed weight loss attempts which can accompany obesity, there was a risk that the research interviews might trigger feelings of distress for participants. Participants were therefore reminded of their right

to withdraw, have a break or decline to answer. The researcher also utilised their clinical skills as a Trainee Clinical Psychologist in creating a containing space.

If participants became distressed in relation to the WLS and required ongoing support, they were able to contact the Obesity Service. If participants became distressed with respect to non-surgical issues and required ongoing support, they were encouraged to contact their GP, who was informed in writing about their participation in the research (Appendix I). The research site covered a large geographical area, meaning that participants were from varying regions. This meant it was not possible to signpost participants directly to the local services in their area beyond their GP.

It was also considered that participants may experience distress to the degree that they were at immediate risk of self-harm or suicide. If this had occurred, participants would have been supported to access A&E. Similarly, should any safeguarding issues have arisen, a safeguarding alert would have been made through the appropriate local authority and the participant informed.

Confidentiality & Anonymity

Participants were made aware that data would be anonymised and stored confidentially. Each participant was assigned a unique pseudonym and identifiable information was removed from their transcripts. Participants were able to specify if they did not want something they had talked about during their research interview to be included in the transcript and this information was removed accordingly. A transcription service was used to transcribe some data. Participants were made aware of this and a confidentiality agreement was put in place with the transcription service (Appendix J).

Data Storage

Data was stored in accordance with the Data Protection Act 1998 and the Caldicott Principles (Crook, 2003). Anonymised data was stored in two locations. The first was on the researcher's university drive. The data and the drive itself were password protected and accessible only to the researcher. The second was on the research supervisor's university drive. Again, the data and the drive were password protected and accessible only to the research supervisor. All audio recordings were destroyed following transcription. All data was stored separately to participant information such as name and contact details. The latter was stored in a lockable filing cabinet in a lockable office of the research supervisor. Following study completion, data was deleted from the researcher's university drive. Data was to remain on the research supervisor's drive for five years.

Possible Benefits to Taking Part

The research interview was not intended or designed to be clinically beneficial. Nevertheless, taking part in the research may have provided an additional space for participants to reflect on their decision to have WLS. There was potential for this thinking to further help in psychological preparation for the surgery.

3.5 Recruitment

3.5.1 Sample

All participants had completed the Tier 3 weight management programme, progressed into the Tier 4 WLS programme and been assessed by their MDT as suitable for WLS. Details on the nature of pre-surgical provision is presented in Appendix K. As all participants had been approved for surgery, it was hoped that this might reduce any concern they might have about

their involvement in the research impeding their access to surgery. Most were scheduled to have surgery within two weeks of their research interview. There were 11 participants in total. Demographic information is presented in Table 3.1. and the sample was largely representative of the NHS WLS seeking population.

Table 3.1: *Participant Demographics*

Pseudonym	Age	Gender	Surgery Type	Employment Status	Relationship Status	Highest Qualification	Ethnicity
Gill	61	Female	Sleeve	Employed part time	Single	Level 4	white British
Amy	49	Female	Sleeve	Long term sick	Single	Diploma	black British Caribbean
Joanna	31	Female	Sleeve	Employed full time	Single	NVQ level 3	white British
Paul	44	Male	Bypass	Long term sick	Married	GCSE & City and Guilds	white British
Stacey	34	Female	Bypass	Homemaker	Single	Level 3 in Childcare	white British
Sam	46	Male	Bypass	Employed part time	Married	Masters degree	white British
Jamie	40	Female	Bypass	Employed full time	Married	GCSEs	white British
Carrie	47	Female	Sleeve	Employed full time	Divorced	BTEC Diploma	white British
Sharon	66	Female	Bypass	Retired	Single	None	white British
Rachel	38	Female	Bypass	Employed full time	Married	NVQ level 2	white British
Sophie	34	Female	Sleeve	Employed full time	Single	BND	white British

3.5.2 Inclusion and Exclusion Criteria

To ensure a degree of sample homogeneity, that prospective participants would be able to complete a research interview and that the research aims could be met, the inclusion and exclusion criteria presented in Table 3.2 were followed. A degree of homogeneity was aimed for to permit the exploration of themes across a group with common characteristics. Instances where a particular characteristic would result in significant deviation from this, potentially impairing the ability to look for similarities across a group were taken into consideration when deciding on the inclusion and exclusion criteria. This was the case for participants aged under 18. Whilst WLS is a growing area in child and adolescent populations, there are specific systemic issues as well as some modifications (based on gender and age) with BMI classification (Centre for Disease Control & Prevention, 2015) which mean there may be too many differences when compared with an adult population.

Table 3.2: *Participant Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Be awaiting WLS with an NHS Obesity Service. Be aged 18 or over. Not had any previous WLS. Have the mental capacity to make the decision to take part in the research. Have a good working knowledge and use of the English language.	Candidates who are not able to attend a research interview at a site in or near to the research site.

3.5.3 Recruitment Strategy

A purposive sampling approach was used (Marshall, 1999) to recruit participants from an NHS Obesity Service. The researcher met with staff at the recruitment site to provide

information on the research, the protocol (Appendix L) and on the inclusion and exclusion criteria.

To raise awareness, the study was advertised via a poster (Appendix M) displayed in the waiting area of the NHS Obesity Service used for recruitment. Members of the team who facilitated the pre-surgical information groups and Clinical Psychologists within the team made prospective participants aware of the research and their eligibility to take part. Information sheets (Appendix N) were provided at this time and potential participants encouraged to contact the research team with any questions. Participants who were interested in taking part were asked to complete a registration of interest form, which was then shared with the researcher.

The researcher contacted interested participants via telephone. There was opportunity to discuss the research, to answer any questions and a screening questionnaire (Appendix O) was completed. Initial verbal consent was taken and a time and date for the interview was arranged. In total 37 candidates registered interest in taking part in the research. Of those, two people did not meet eligibility criteria, 12 wanted to take part but were unable to attend at a time prior to their surgery, one decided not to take part and 11 were not successfully contacted by the researcher.

3.6 Measures

3.6.1 Screening Questionnaire

A screening questionnaire (Appendix O) was used during recruitment to ensure that prospective participants met the inclusion criteria.

3.6.2 Demographics Questionnaire

A demographics questionnaire (Appendix P) was used to gather information on the participants' age, ethnicity, marital status, employment status and type of surgery they were scheduled to have. The purpose of this information was to provide data on similarities and differences within the sample, which might be relevant during analysis and study critique.

3.6.3 Semi-Structured Interview Schedule

A semi-structured interview schedule (Appendix Q) was created for the research interviews. The interview schedule was intended to provide a frame to the interview, whilst allowing participants freedom to respond and discuss the issues most salient to their experience. The interview schedule was informed by a combination of existing research, clinical literature, clinical experience of the research team and service user consultation.

Guidance by Rubin and Rubin (2011) was used to inform the structure of the interview. Areas of interest in the context of WLS and the research aims were identified and linked to relevant literature. Existing literature was also reviewed for gaps. Based on this, the main questions were constructed. These questions acted as scaffolding for each research interview, ensuring that all important lines of enquiry were covered. A series of follow up questions were generated to act as prompts depending on the level of detail spontaneously provided by participants. Appendix R details the relevant literature, main questions and follow up questions initially generated in designing the interview schedule.

The interview schedule was reviewed by three service users as well as two professionals with clinical expertise in the field of WLS. Helpful feedback was given with regards to question topics and pacing. All three service users felt it was particularly important to ask about the involvement of friends and family in the WLS journey. This led the researcher to explore this area further in the literature and the interview schedule was subsequently altered. A pilot interview was also completed with a person who had already had WLS. Based on this collective feedback the interview was refined.

3.7 Procedure and Data Collection

3.7.1 Arranging the Research Interviews

A date and time for each research interview was arranged over the telephone with participants. The date and time was determined by room availability and participant preference.

3.7.2 Research Interviews Location

Rooms for the interviews to take place were secured at the hospital which housed the Obesity Service or a local community-based NHS Centre. All venues had disabled access. Rooms were private, with only the researcher and the participant present. To ensure participant comfort, bariatric furniture was provided.

3.7.3 Research Interviewer Characteristics

Previous qualitative research conducted with participants who are obese has been criticized for a lack of thought on obesity stigma and how this might impact the relationship and data gathered between researcher and participants (Brown & Gould, 2013). The researcher was

female, aged in her early thirties and a weight which would be classified in the normal BMI range. These are stated here as an acknowledgement that such difference within a sociocultural context of obesity stigma may impact the data gathered.

Research has shown that individuals who are obese who receive care from professionals with specific training and skills in obesity, report positive treatment, relationships and interactions in comparison to with other health professionals (Homer et al, 2015). The researcher was trained in working with difference, health inequalities and had clinical experience in working with people who are obese. It was anticipated that this would help to reduce the potential negative impact of stigma and difference.

3.7.4 Informed Consent

Written consent was taken on the day of research interviews (see Appendix S for the consent form). There was opportunity to discuss the research and ask questions. Participants were made aware of what would happen to the information they provided and their right to withdraw until two weeks after the date of their research interview.

3.7.5 Process of Research Interview

The semi-structured interviews lasted between 30-75 minutes, with a further 20 minutes allowed for information giving and taking consent along with completion of the demographic questionnaire. The interview schedule guided the interview process. At the end of the interviews, participants were thanked for their time and given the opportunity to ask questions.

3.7.6 Data Recording and Transcription

All interviews were audio recorded using a dictaphone. Audio recordings were either transcribed by the researcher or using a transcription service. The accuracy of the transcriptions was checked by the researcher through cross referencing with the audio recordings before they were destroyed.

3.8 Data Analysis

The analysis was based on guidelines for TA by Braun and Clark (2006). Additionally, guidance outlined by Boyatzis (1998) was utilised to inform the development of the coding frame and Fereday and Muir-cochrane (2006) was used as a best practice example to inform the hybrid approach taken. This meant that data was coded both deductively and inductively.

3.8.1 Step 1: Familiarisation with Data Set

The researcher spent time becoming familiar with the data (Braun and Clark, 2006). For most of the data, this began during transcription. For a small proportion of data, a transcription service was used. Here familiarisation began by checking for accuracy against the audio recordings. Either way, transcripts were re-read several times.

3.8.2 Step 2: Deductive coding

A code refers to the most basic segment, of the raw data that can be assessed in a meaningful way with respect to the research area (Boyatzis, 1998). In line with Boyatzis' (1998) recommendation, deductive codes were developed based on existing theory and research relevant to the research aims. Each code had a name and definition of what should be classified within the code (Joffe, 2012). In total 82 deductive codes were created. Details of these and the literature they were grounded in, is in Appendices U, V and W.

3.8.3 Step 3: Applying the coding frame

NVivo is computer software which has been recommended for use with large amounts of qualitative data (Guest, MacQueen & Namey, 2012). NVivo was used to apply the deductive aspects of the coding frame, which focused on the semantic content of the data (Braun & Clark, 2006). This allowed the researcher to organise data under codes, as well as data which was not captured by the deductive codes.

3.8.4 Step 4: Inductive coding

Data which did not fit within the deductive coding frame was noted and used to inform data-driven codes. Inductive coding was used for both semantic and latent content (Braun & Clark, 2006). Boyatzis (1998) recommends making notes of initial ideas of inductive codes following reading the data set as a whole, then re-visiting this process to review and refine the codes. Following this approach 91 codes were created in total. As with Fereday and Muir-cochrane (2006), these were then added to the deductive portion of the coding frame as it evolved (Appendix U), to capture meaning missed by the deductive codes. As per Step 3, inductive codes were also applied using NVivo.

3.8.5 Step 5: Checking the reliability of the coding frame

The researcher coded the data set and reliability was checked by an independent coder. The independent coder reviewed the application of codes for 10% of the data, an amount which has been proposed as suitable in reliability checking (Joffe, 2012). Discrepancies were discussed and the coding frame reviewed and refined. This process led to the re-defining of some codes, increasing their clarity and reducing ambiguity. Appendix U contains a breakdown of which codes were refined and subsequently added to the overall coding frame

(Appendix V) used to guide the analysis. As the coding frame evolved, step 3 in the analysis was re-visited. For an example of a portion of coded transcript see Appendix W.

3.8.6 Step 6: Identifying initial themes

A theme captures important meaning within the data and is usually represented by a patterned response. When grouping codes to inform themes, the number of instances a pattern occurred across the whole dataset was considered, however a high instance did not necessarily dictate the salience of a theme. Rather, the theme was reviewed against the story told by the dataset as a whole, as well as how themes linked to the research aims and objectives (Braun & Clark, 2006). To facilitate this process, paper copies of each code were printed so that codes could be visually manipulated with ease. To further aid this process, thematic networks (Attride & Stirling, 2001) were used to provide a visual illustration of differences, similarities, overlap and the relational position of different themes and sub themes. See Appendix X, for photographs of the analytical process of organising codes in to themes and themes into maps.

3.8.7 Step 7: Organising Themes

As the themes were established, consideration was given to how different sub-themes and codes within themes fitted together and related to each other (Braun & Clark, 2006). Using NVivo, the coded data was organised according to the identified themes and sub-themes. Data extracts were used under multiple themes if appropriate. Again, thematic networks (Attride & Stirling, 2001) were utilised to provide a visual representation. In instances where coded data did not yet belong to a theme, these items were stored and subsequently reviewed to determine whether they belonged to an existing theme or whether a theme needed to be extracted from them (Javadi & Zarea, 2016). In these instances, Steps 3-5 of the analysis were re-visited.

3.8.8 Step 8: Reviewing and Refining Themes

Themes were reviewed based on internal and external heterogeneity, whereby the data within a theme should be meaningfully related to each other and the themes themselves should be clearly differentiated (Jevadi & Zarea, 2016).

Coded data within each theme was examined for whether the codes formed a consistent pattern. If this was not the case, the theme was further reviewed to consider whether the theme and sub themes were appropriate or required further refinement. For example, through separation into more than one theme or removing some coded extracts.

For themes where codes formed a consistent pattern, the theme was then reviewed against the data set in its entirety to check that they validly captured something meaningful about the dataset. This was done by returning to the original transcripts and re-reading them.

3.8.9 Step 9: Defining and Naming Themes

Themes were defined, named and further refined as necessary. A range of stages recommended by Braun and Clark (2006) and presented below were utilised to inform this process.

Theme names were chosen to capture the essence of the theme. The contents of each theme were surmised in a few sentences to provide immediate detail about what the reader can expect from the theme.

The analytical process has the potential to go on indefinitely. Braun and Clark (2006) recommend stopping when refinements are no longer adding anything substantial to the analysis in light of the research aims. Analysis therefore ended when this was the case, there was clarity on what the different themes were, how they fitted together and the story they told in relation to the overall data set. To help ensure the robustness of this approach, the research also met with two members of the obesity MDT to validate whether the results fitted with the clinical picture they experience in working with WLS candidates.

3.8.10 Step 10: Producing the report

The purpose of the report was to tell the story of the analysis in an understandable way which helps to support the validity of the themes (Braun and Clark, 2006). In producing the report, evidence for each theme was presented through quotes chosen to capture the essence of each theme. Examples were presented in a way that embedded them within the story told by the overall data set as relevant to the research aims and objectives. In addition to being presented in Chapter 4, the final superordinate themes, sub-themes codes and examples of supporting quotes are presented in Appendix Y.

CHAPTER 4: RESULTS

4.1 Summary of Themes

During the analysis the data was organised into six superordinate themes:

- Theme 1: Foundation of Pursuit
- Theme 2: Specialist Obesity Services
- Theme 3: Conceptualisation of Surgery
- Theme 4: Hopes for Life After Surgery
- Theme 5: A Journey in Context
- Theme 6: Plans and Preparation

These superordinate themes, the sub-themes within them and links between them are portrayed in figure 4.1. A breakdown of the analytical process which led to this is described in Chapter 3 as well as presented in Appendices U-Y.

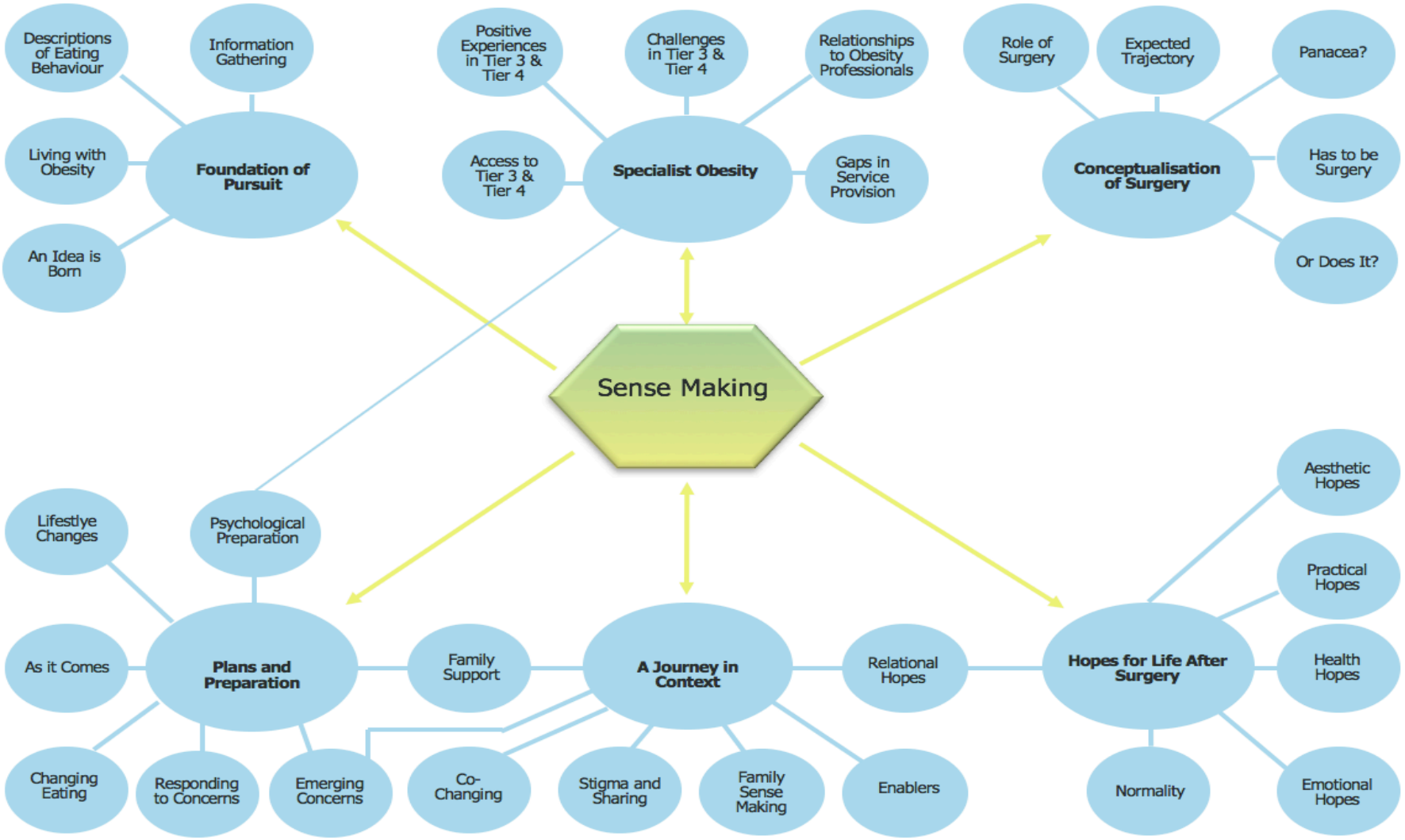


Figure 4.1: Thematic Map of Themes, Sub-Themes and Links Between Them

4.2 Theme 1: Foundations of Pursuit

This theme captured participants' descriptions of how they arrived at the point of pursuing WLS. Figure 4.2 highlights the five subordinate themes encompassed within the over-arching theme of 'Foundations of Pursuit'. Each sub-theme acts as a pillar which underpins participants' pursuits of WLS and is presented below.

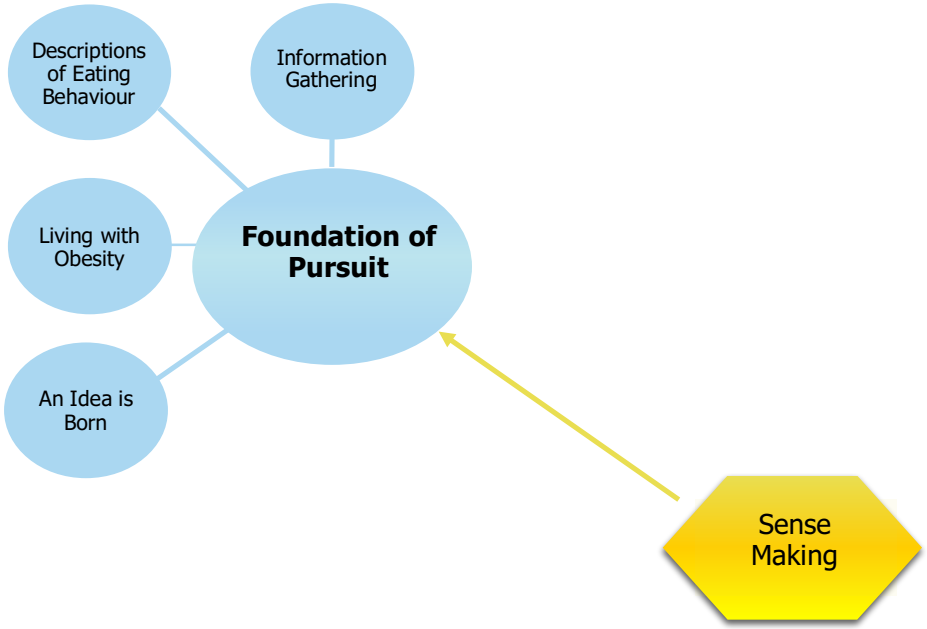


Figure 4.2: Superordinate Theme: 'Foundations of Pursuit'

4.2.1 Living with Obesity

All participants talked about their experiences of being an obese person and how such experiences had influenced them to want to change this. Most participants reported experiencing obesity stigma and some explained that they coped by avoiding or withdrawing from the world. Participants talked about how this withdrawal limited the way that they lived life and that this was something which they wanted to change.

> Carrie: I do go out and do some voluntary work and see people that I know will accept me but I want to go back to where I can go out and not feel I'm being judged.

Participants described the limitations they experienced as an obese person, such as reduced mobility or not being able to physically fit into seats, which was another driver for change.

> Sharon: We do go out but like if you go to the fair or something, you can't go on the ride because you can't pull the bar down because your stomach gets in the way.

One participant talked about how obesity, in their view, had led them to become a burden to their family and that this was a source of dissatisfaction for them, which needed to be resolved.

> Sam: The burden I've been putting on people, the inability to do things that are perfectly normal for people my age and considerably older is unfair, it's just not right, it's not what my wife signed up for.

4.2.2 Descriptions of Eating Behaviour

All participants described the eating behaviours which were related to weight gain and that this had led them to consider WLS as a means to change. These descriptions were captured under the sub-theme of 'Descriptions of Eating Behaviour'. Some participants described poor routines and structure, large portion sizes and over-eating.

> Amy: Because you're so used to guzzling food down because you're rushing and you've only got a certain amount of time.

> Gill: I can just eat and eat and eat and eat and eat and I never actually feel full up.

Most participants identified as emotionally driven eaters and the desire to change this.

> Rachel: I eat for comfort, boredom, when I'm feeling down.

> Sam: Comfort eating has certainly been a significant part of my life.

4.2.3 An Idea is Born

The ‘An Idea is Born’ sub-theme captures participants’ accounts of how the idea to pursue WLS arose. For some the idea was their own.

> Gill: Yeah it was [my idea], when I very first started going through the system I must have been in my later 30s early 40s so that would be around 20 years ago, that’s when I first considered it…

For others, it was suggested by medical professionals.

> Carrie: He [orthopedic surgeon] said you need the surgery to get the weight off.

Regardless of its origins, all participants spoke of key events surrounding the initial idea such as significant birthdays, health issues or living with the impact of obesity becoming unfeasible.

> Rachel: Basically, I wasn’t living, I was just existing.

> Paul: People like my GP told me if I don’t lose weight I will die.

4.2.4 Information Gathering

Participants described how they found information about WLS. These descriptions were collated under the sub-theme of ‘Information Gathering’. Some participants undertook research through their own resources such as the internet or leaflets, whilst some utilised professional sources.

> Gill: I have looked online, I’ve checked various different things.

> Carrie: They [the GP] talked me through it, was literally on the screen with me going through, right, this is what we need to do, she printed everything.

Half the total number of participants remarked on the option of privately funded surgery, ruling it out either for financial reasons or because of concerns about the nature of private provision.

> Stacey: I did go to look at having it done privately but I couldn't then afford the procedure because it was quite expensive.

> Sharon: Apart from going private but then you hear all these horror stories, especially these people that go abroad.

4.2.5 Sense Making

As well as linking with 'Foundations of Pursuit', the 'Sense Making' sub-theme had links with the other five overarching themes (see figure 4.0). These additional links will be discussed in section 4.8. The 'Sense Making' sub-theme is concerned with participants' understanding of their relationship with eating, weight and self, which in turn underpinned their pursuit of surgery. Some participants explicitly described their relationship to food as disordered.

> Jamie: Well obviously I've got an eating disorder to be this over-weight but I wouldn't make myself sick or anything like that.

Most participants reflected on the amount of control they felt they had over eating.

> Gill: I can control at times but I can't control it at others which is bizarre really.

In light of their desire to change, most participants also described a vicious cycle explaining why they might engage in less helpful behavioural patterns with regards to eating.

> Joanna: Yeah me and food, we have a love-hate relationship, I love it and it hates me, yeah, I wish I could say that if I felt down or whatever I could do something else, but mine is to comfort eat, so anything- if my depression is bad, the first thing I do is raid the cupboards and I feel awful because I've done it and then it makes me feel worse so I eat more, it's a vicious cycle.

Half of the participants appeared to illustrate periods of 'self-work' and that their level of self-care and self-value may have increased as a result, leading them to a point of perhaps being ready to care for themselves through pursuing WLS.

> Gill: … I mean when I had the clinical depression I came an awful long way because I'd suffered with depression all my life and never really got any help with it, and I came an awful long way, it sounds a bit stupid, in discovering myself, and I came an awful long way with the depression but it still didn't solve the weight problem, so that's why I thought well, because I'd sort of got over the mental problems, the depressive problems, that the surgery could be the answer to the weight problem. Because even though I'd come to terms with so many things, the weight had always been an issue.

In contrast, other participants indicated a dissatisfactory relationship to self which was grounded in being unhappy with their weight and size. This seemed to be a driving force for pursuing the WLS, possibly from a position of lacking in self-compassion.

> Stacey: I'm hoping that things will be better and I might get married or engaged or something. I'll feel happier about that because at the minute it's not something that I can

imagine at the size I am. I know that sounds pathetic because everyone should want to get married but I don't want to walk down the aisle big.

In summary, the superordinate theme of 'Foundations of Pursuit' captured how key events, participants' eating behaviours, experiences living with obesity, information gathering on WLS and sense making of their relationship to eating, weight and self, underpinned the initial pursuit of WLS.

4.3 Theme 2: Specialist Obesity Services

This theme encompasses participants' experiences of accessing specialist Tier 3 weight management and Tier 4 surgical services. Figure 4.3 illustrates the sub-themes sitting within the overarching theme of 'Specialist Obesity Services'. There are five new sub-themes each discussed below. Additionally, this theme also linked with the sub-theme of 'Psychological Preparation'. This sub-theme and how it links with 'Specialist Obesity Services' will be discussed in section 4.7.

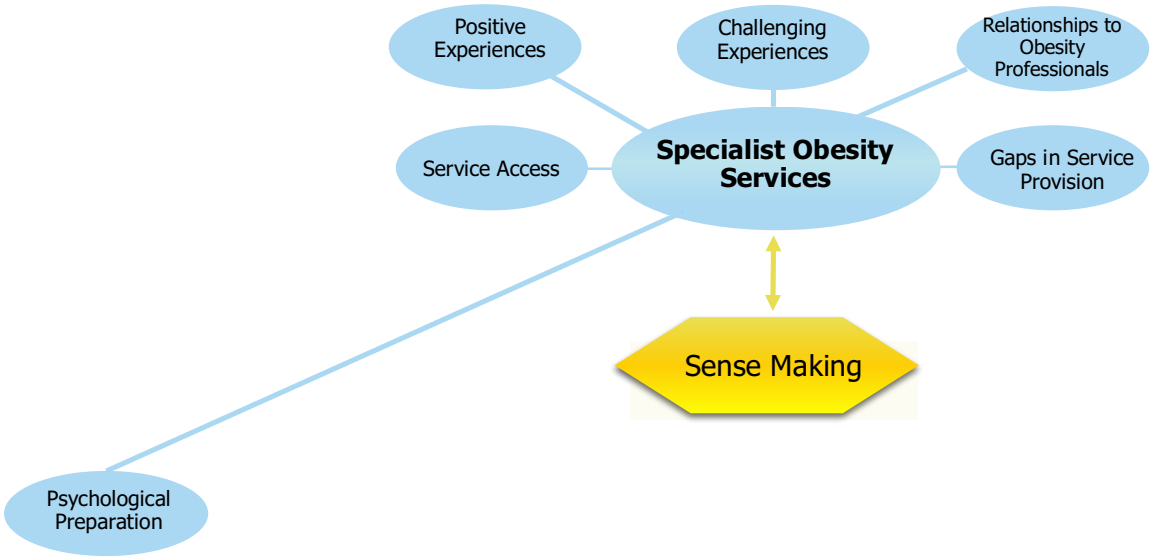


Figure 4.3: Superordinate Theme: 'Specialist Obesity Services'

4.3.1. Positive Experiences

This sub-theme is about participants' reports of what was helpful during their experiences in Tier 3 and Tier 4 services. All participants expressed finding Tier 3 and Tier 4 helpful in general.

> Paul: They've been extremely helpful down there and I don't think I could have done it without them really.

Participants reported that the obesity pathways were informative. Experiences ranged from learning about lifestyle changes;

> Amy: …So for me, the other thing that's come out, is really training how you eat…

Learning about the WLS itself;

> Gill: To be honest, the one good thing about it was that it did make me think more about whether or not I really wanted it, from that point of view it was excellent because it did give me a chance to say well no this isn't for me.

Through to learning about themselves.

> Stacey: I think it was helpful. When I was at Tier 3 they had therapy and things like that to see why I'm eating and what caused the over-eating and things and I think it was helpful.

4.3.2 Relationship to Obesity Professionals

Many participants commented on their relationship with specialist obesity staff and these experiences were clustered under the sub-theme of 'Relationship to Obesity Professionals'. All participants reported that they felt able to be honest about their eating with specialist staff.

> Stacey: I'm quite an honest person anyway, so I'll just tell the truth, I don't think it can harm in anyway being honest.

However, the extent of honesty appeared to vary amongst participants. Many participants described a belief that the staff were there to help and there was therefore no reason to lie.

> Joanna: I mean they ask have you stuck to it and you tell them the truth because I mean everyone who goes to the clinic obviously has some kind of problem with food.

A small number of participants expressed regret at their level of honesty, as this had resulted in additional steps being added to their pre-surgical preparation or WLS being delayed. These participants said that this had made them reluctant to be as honest in the future.

> Gill: Yeah I did (feel able to be honest), I did, but at the end when I was deferred, I wish I hadn't been quite so open and honest.

One participant reported that the extent of her honesty varied based on her experience of the health professional as a person, and whether they sensed negative judgement from them.

> Rachel: Yeah to a certain degree [was open and honest]. They want to know kind of your eating habits and I don't know, sometimes, seeing different people there were some people that I felt more comfortable seeing than others and sometimes it felt a little bit judged.

Other participants commented on the non-judgmental nature of staff, noting a lack of obesity stigma, leading them to feel more comfortable.

> Carrie: They are really nice people, they don't make you feel like a freak or a leper.

Some participants reported a level of trust in specialist staff which appeared to offer containment as they proceeded towards WLS.

> Amy: I know they've got it covered because they've told us.

> Jamie: The nurses have been really good and said that you can always phone.

4.3.3 Challenging Experiences

This sub-theme captured participants' descriptions of what was challenging or unhelpful about their experiences of Tier 3 and Tier 4.

> Carrie: There is a whole lot of run up and that run up is hard.

Most participants made reference to the process of the pre-surgical workup being long and difficult in some way, although this was not necessarily seen as unhelpful but rather an inevitable part of the process, such as completing a low-calorie liquid diet, often referred to as the 'milk diet'.

> Rachel: Seeing everyone eat and I'm just so hungry and to physically drink 4-5 pints of milk, it's just horrible.

Specific complaints named were:

Candidates' information being lost or not referred onwards in line with the pathway;

> Sharon: The original dietician I saw, let's put it this way, I've got nothing to say about her. I was with her for just over a year and I did do, I got down to 17 stone so I lost a stone and kept waiting and waiting and I went back to my doctor and she never bothered sending anything through.

Appointments feeling rushed, which impacted how forthcoming some participants were with questions and concerns;

> Rachel: I think they were good don't get me wrong but I think there should be a bit more time, it's very rushed.

And finally, the process being unclear, with participants not knowing what to expect at different time points in their pathway.

> Jamie: I suppose you have 100s and 100s of questions to ask that's how I felt, and I don't always think it was made clear to me what the process was.

4.3.4 Service Access

The 'Service Access' sub-theme is concerned with participants' experiences gaining access to specialist obesity services. Most participants acknowledged the pivotal role of GPs in gate keeping this. Some participants experienced this as positive whilst others reported that their GP had initially declined to refer them.

> Stacey: I went to my GP and they recommended me for this.

> Jamie: I asked my doctor for quite a few years and he'd always refused.

Participants noted how gaining access was difficult with various criteria to be met.

> Carrie: It does feel like you've got to jump through so many hoops to be considered for an appointment and even an appointment doesn't mean you're getting through.

Following access to specialist obesity services, most participants described a fear of loss with regards to whether they would ever have WLS, with this fear persisting until the time of the operation.

> Gill: I keep thinking it's not going to happen.
>
> Joanna: If they say the liver hasn't shrunk enough and they say you can't do surgery.

4.3.5 Gaps in Service Provision

Participants highlighted several gaps or areas where specialist obesity services could be improved, including clearer mapping of surgical pathways, group sessions and support, preparation for maintaining weight loss, better links with other resources such as past candidates and forums, more information on side effects and additional help which offers a viable alternative to WLS.

> Amy: I feel there's no group to talk to or it would have been nice to have met people on the other side.
>
> Joanna: I mean you have the pictures on the board in the waiting room of before and after, but there's nothing really of before the before bit of the surgery.
>
> Carrie: Lots of people can help you in forums but it may not be something that the service actually hosts but if they know that it's there, make it clear that this isn't our forum, it's a patients' forum, it may be of use to you or it may not, or here's a good place to get information from, that would be useful because that isn't there.
>
> Rachel: I've tried loads of different things but I think that when it comes to weight, I don't think there is as much help as there is for someone suffering with anorexia…I really do believe that there should be more help out there, WLS should be the last resort.

Despite these gaps, overall in the superordinate theme of 'Specialist Obesity Services', once participants had been able to access the specialist pathway, there was a sense that the positive experiences reported by participants amalgamated with their experiences in meeting the challenges raised, led them to value specialist obesity services.

4.4 Theme 3: Conceptualization of Surgery

The theme of 'Conceptualization of Surgery' was concerned with how participants understood the surgery, what it may or may not achieve and their role within this. Five new sub-themes were identified and are displayed in Figure 4.4.

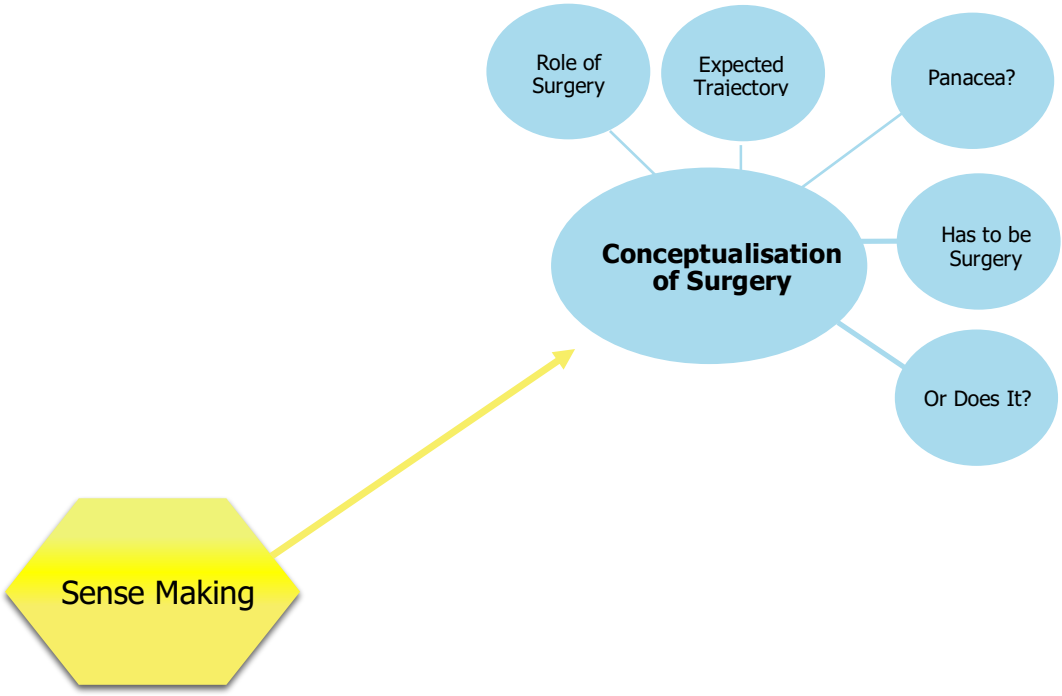


Figure 4.4: Superordinate Theme: 'Conceptualization of Surgery'

4.4.1 Panacea?

The 'Panacea?' sub-theme captured the degree to which participants viewed WLS as a cure-all for not only weight related difficulties but other difficulties too. Some participants

explicitly questioned the limitations of surgery, acknowledging what they understood WLS would not achieve.

> Paul: I'll still have the problems with my legs that I've got.

> Sam: Why I hope that a successful outcome of surgery will improve things I know it's not going to wave a magic wand, all the health issues I've got will still be there.

Other participants talked about how wonderful they hoped life would be following surgery, anticipating changes in things which perhaps the WLS might not be able to change, at least directly, such as getting a new job or moving house.

> Stacey: Perfect. I live in a little pokey flat at the minute so I'm hoping to move anyway, I'm hoping that will happen in the next 2 years, I'm hoping that things will be better and I might get married or engaged or something, I'll feel happier.

4.4.2 'It Has to be Surgery'

The sub-theme of 'It Has to be Surgery' captures how for some participants, WLS is felt to be the only feasible option available to them or the 'last resort'. Holding this belief related to participants' experiences of failure using other weight loss methods.

> Sam: Not really because I'd explored a lot of diets and seen a lot of dieticians and everything else and nothing was working. I just felt that this was my last resort really to try and lose a bit of weight.

Nearly all participants expressed how, without surgery, they thought life would be dissatisfactory or depressing in some way and for some this linked to the view that WLS was the best solution.

Sharon: Very very depressing, at my age it probably wouldn't be too long, I wouldn't have that long to go.

Rachel: [without WLS] …maybe my relationship has ended, I would be even bigger, I may not be working because I'm in so much pain.

4.4.3 Or Does It?

The 'Or Does It?' sub-theme referred to participants' doubting and questioning of the surgery. Some participants viewed WLS as 'drastic' and described a process of questioning whether it was the right option for them.

Amy: In the back of your mind it's so drastic.

Carrie: That you have to doubt it. You have to ask yourself is this something that I want to do? Is this something that I can live with.

In doubting the WLS, some reported assessing the pros and cons of surgery. Often this involved a full acknowledgement of the less welcome side effects of surgery and consideration of whether these were worth living with in light of their desired outcomes, as well as considering the likelihood that things might go wrong.

Paul: I spoke to my surgeon about the hair loss and he said it will grow back, nothing to worry about, it's just a small price to pay for a life changing operation.

4.4.4 Role of the Surgery

The 'Role of Surgery' sub-theme captured participants' descriptions and beliefs about the role of WLS in achieving their outcomes. Most participants referred to the surgery as a tool which they could use in working towards their goals.

> Jamie: It's been described as a tool to use it's not going to be like a magic wand so obviously you've got to work at it, I know that.

Participants anticipated that WLS would help change their relationship with eating and for some, help them to feel full.

> Gill: One thing I have been told is that after the surgery I will feel fuller and that is the one thing that I'm looking forward to.

Some participants discussed how they saw surgery as a way to help accelerate or sustain their weight loss in the longer term.

> Carrie: Well I think, I'm hoping that the surgery will be a kick start.

> Joanna: If I couldn't have the WLS I think that my weight would just go up and down.

Ultimately, all participants explicitly reported that the long-term outcomes of surgery would be their responsibility.

> Paul: I think 100% of the change will be on me.

> Amy: It's down to me at the end of the day to make it work, no one else, they can't feed me, it's my option.

4.4.5 Expected Trajectory

The 'Expected Trajectory' sub-theme referred to participants' descriptions of the expected WLS trajectory. Most participants noted that the work associated with WLS begins prior to the surgery. Many saw pre-surgical lifestyle changes as the ground work for life following surgery.

> Paul: I've been seeing the obesity clinic so that's 2 years of ground work and dietary changes.
>
> Sharon: Well I'm already cutting down my portions. Obviously it's got to go down a lot lower to what that will be but my way of looking at it is if I can lower it down now at least it won't be as hard to do afterwards.

Half of the participants anticipated a period of adjustment immediately following surgery, which over time would see them settle into a new 'normality'.

> Sam: I suspect that in the first period after surgery and adjusting to everything and trying to find a new normal.
>
> Paul: I'm hoping that after 6 months to a year, it will just be so natural that I'm going to live the rest of my life like it.

Participants anticipated that there may be setbacks and challenges at different points after surgery. This was framed as a normal part of the process which participants were expecting to be able to manage.

> Carrie: I'm under no illusions, there will be something that's not particularly pleasant, I'm just hoping that I will be able to address it and work with it and minimize it as best I can.
>
> Rachel: It probably is going to be hard, there's going to be days where it's going to be tough.

The changes required following WLS were seen as life-long by participants, with surgery itself being just the beginning.

> Gill: It's also the realization that the work isn't over, it's just beginning, the journey hasn't ended, it's just starting.

In summary, the superordinate theme of 'Conceptualization of Surgery' illustrated participants' understanding of the role of WLS in changing eating behaviour. Participants varied in the extent to which they framed WLS as the 'only option' for them, however, all reported that they held the ultimate responsibility for the long-term outcomes following WLS.

4.5 Theme 4: Hopes for Life After Surgery

Participants talked about their hopes for life after surgery and these were collated under the theme of 'Hopes for Life After Surgery'. Figure 4.5 illustrates six new sub-themes within this superordinate theme.

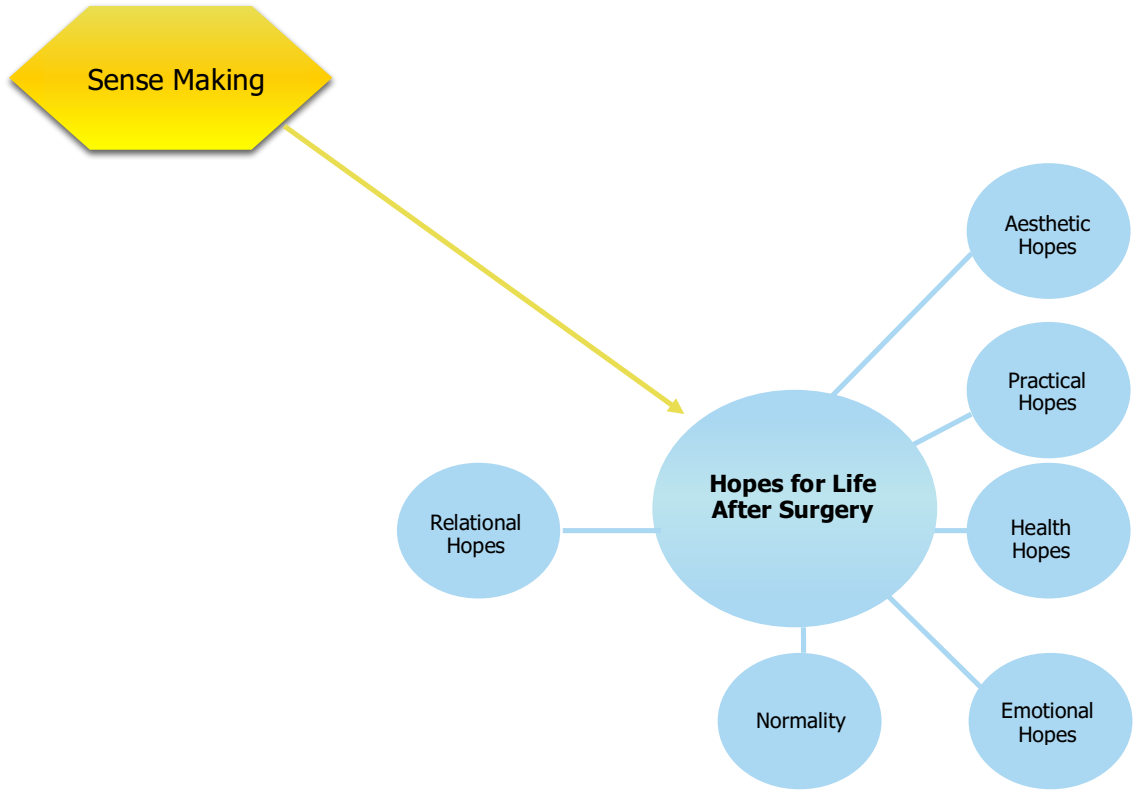


Figure 4.5: Superordinate Theme: 'Hopes for Life After Surgery'

4.5.1 Aesthetic Hopes

This sub-theme was concerned with hopes relating to appearance. All participants expressed hopes about weight loss. A shrinking body size was seen as representing an improved appearance, something which was desired by most participants.

> Gill: The fact that I'm going to be able to lose weight, whatever speed it comes off, it's going to be brilliant.

As a direct function of weight loss, participants hoped that their body image would also improve.

> Paul. Good hopefully. I'm nice and thin, I'll be looking good.

Some participants also hoped that they would be able to wear what they considered to be more aesthetically pleasing clothing. Improvements in aesthetic appearance were often portrayed in the same breath as increased enjoyment in life. This suggested that for some, other non-appearance related hopes were conditional on aesthetic improvements.

> Amy: I could be a size 10, actually wearing something that's nicer and just going out and enjoying life again.

4.5.2 Emotional Hopes

The 'Emotional Hopes' sub-theme captured the different emotional changes that participants hoped for. A common hope was an improvement in happiness and mental health.

> Sam: I would hope that some of the depression and anxiety problems that I've got will lessen.

> Sharon: I think I would be a happier person.

Over half of the participants hoped for improvement in confidence and their level of self-like.

> Amy: Hopefully I will feel more confident because everyone thinks that I'm confident but quietly I'm not.

> Carrie: I think the most important thing for me is how I see me and I think this surgery will help me with that, I need to like me again and at the minute I don't like me with this weight.

For one participant, their anticipated improvement in confidence seemed closely tied with their anticipated intrinsic sense of pride and achievement following WLS.

> Joanna: Every step I take will just be like I've done this, you know, just to be proud of myself every day.

> Joanna: I will be feeling pretty good about myself as well, as I will know that I've achieved something amazing.

4.5.3 Practical Hopes

All participants hoped for practical changes following surgery. Participants described how surgery would improve their mobility with secondary consequences for the level of autonomy they could exercise in undertaking activities of daily living.

> Gill: It's just the thought of being able to get up and down those stairs again without having to use the railings to drag me up.

Most hoped that they would be able to improve their employment in some way.

> Amy: Hopefully, I might be gigging a bit more, because I've got the stamina because I'm not gigging at all now, it's difficult when you've got to carry the equipment and you just can't do it, so maybe that will be it, yeah.

Almost all participants discussed how, following surgery, they hoped that the level of activities they did for fun would increase. It was not clear whether such hopes were associated with increased mobility and ability due to WLS, or emotional changes such as improved confidence. Either way, a tangible metric of fun activities was hoped for.

> Stacey: Just maybe having more social life, like going out with friends to the cinema.

> Rachel: The first thing that I'm going to do once I start to lose weight is to go on holiday.

Finally, most participants reported hopes that travel would become easier, whether that be fitting in seats on public transport, not needing to rely on disabled access or not needing extension belts when flying.

> Sharon: Go on an airplane and not have to ask for an extension belt.

4.5.4 Health Hopes

The 'Health Hopes' sub-theme captured participants' hopes that through surgery, they would improve or prevent health conditions. Hopes for improvements in health ranged from increased energy and reduced joint pain to the cure of physical health conditions.

> Gill: I've got health issues myself, my knees are giving up which is one of the reasons I want the surgery.

> Paul: Obviously number one is my health, that's going to greatly improve after surgery. I'm not going to have diabetes, well hopefully not.

Participants also hoped that surgery would prevent the development of health conditions or extend their life expectancy.

> Amy: I could live longer now because I've made this change now, so your mortality rate is better… We've got a history of late onset diabetes in the family so you suddenly look at that and you think actually, it's going to be early onset diabetes for me if I carry on.

4.5.5 Normality

The 'Normality' sub-theme referred to participants' hopes and expectations that following surgery, that they might be closer to 'average' rather than significantly obese and that with this, any stigma might dissipate. Most participants expressed hopes in line with this. For some participants, this took the form of expecting less judgement and stigma.

> Carrie: I want to go back to where I can go out and not feel that I'm being judged.

For others, this took the form of wanting to live a 'normal life' but without a clear explanation of what this meant.

> Gill: Just lead a normal life.

> Jamie: …So just maybe blending in and being normal.

The pursuit of normality appeared underpinned by the belief and/or reality that people with slimmer bodies might be doing or accessing things that participants were not able to as a result of obesity.

> Rachel: Not worrying about my size, going to the cinema, just every day to day things that people do that is normal.

> Stacey: I won't mind going out shopping whereas no I dread it, I'm quite looking forward to going into normal shops.

4.5.6 Relational Hopes

The 'Relational Hopes' sub-theme portrayed participants' hopes for improved relationships and roles within these. Some participants hoped that their existing relationships would improve and others hoped that they might develop new ones.

> Rachel: I think it's going to bring us closer together I really do.

> Sophie: I hope to be in a relationship. I've been single for a very long time.

Participants talked about hoping for improved independence and autonomy in relation to others. Some also expressed the importance to them of being able to contribute more to the lives of those around them and how this offered them a sense of purpose.

> Gill: I could just sort of sit down and say no- let somebody else look after me but I'm not ready for that.

> Paul: At the moment all I do is sit around, I can't do much, but after the surgery, a couple of years down the line I'll have a purpose to get out of bed every day, to go and do stuff, to go to work and living for the family you know, so yeah I will have a purpose in life.

Whilst organised into semantic categories under the theme of 'Hopes for Life After Surgery', many of the hopes were interrelated. For instance, improvements in emotions such as happiness and confidence were often linked with other more practical or aesthetically based hopes. Overall, the hopes that participants had for life following surgery were both varied and extensive.

4.6 Theme 5: A Journey in Context

The superordinate theme of 'A Journey in Context' was concerned with participants' social context of family and friends and how this related to their WLS journey. This theme captured how participants' family and friends impacted their experiences of preparing for and sense making around the surgery. There were six new sub-themes clustered within this and these are displayed in figure 4.6. The sixth sub-theme of 'Emerging Concerns', whilst having links with 'A Journey in Context', sat within a later superordinate theme and is therefore discussed in section 4.7, where an explanation of its links to 'A Journey in Context' will also be provided.

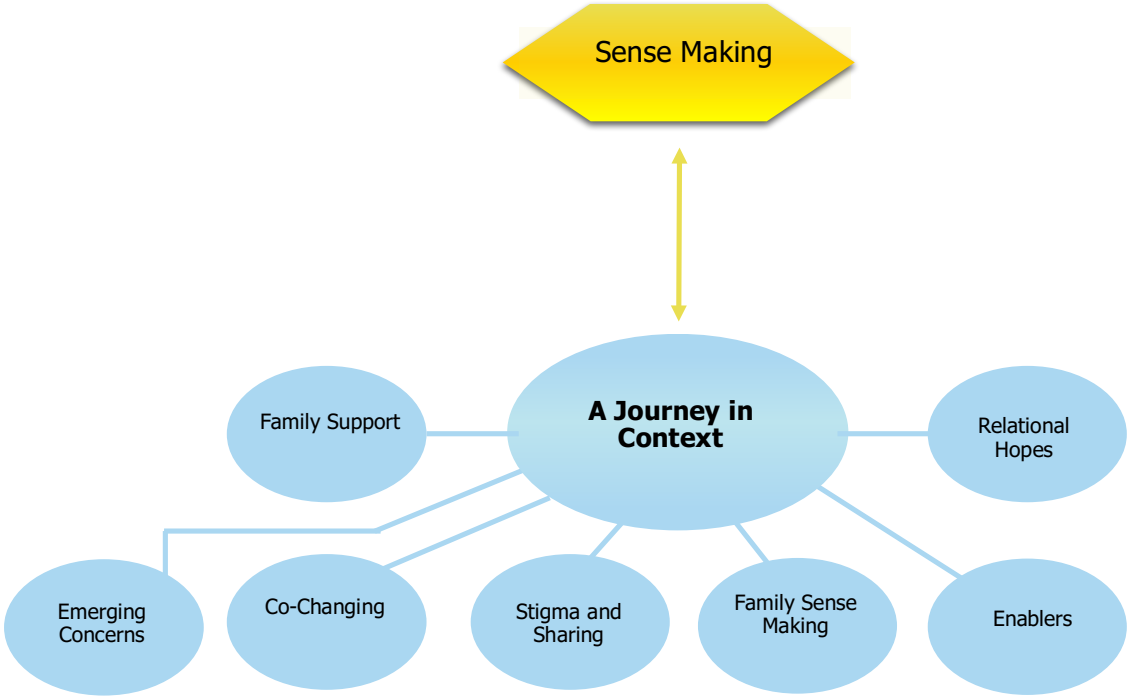


Figure 4.6: Superordinate Theme: 'A Journey in Context'

You will note from Figure 4.6 that a seventh sub-theme, 'Relational Hopes' is linked with the superordinate theme of 'A Journey in Context'. Previously presented in section 4.5, the 'Relational Hopes' sub-theme referred to participants' hopes in relation to their social

context, such as the improved quality of existing relationships or the formation of new ones. As such this sub-theme had clear links to the overarching theme of 'A Journey in Context'.

4.6.1 Enablers

The sub-theme of 'Enablers' captured participants' portrayals of how family and friends impact their relationship to food and eating behaviours. Half of participants saw family or friends as 'enablers' of eating. Of these, all saw this enabling as an expression of care and love.

> Carrie: I realised and saw my mum as a semi enabler because of her role as a mum I suppose.

One participant additionally described enabling which they experienced as abusive.

> Joanna: I got into a horrible relationship and he just said no one else is going to want me, he's the only one and he took pleasure in basically manipulating me and mentally abusing me and yeah he was a feeder, so if we went out for something to eat he would be like you can eat this and eat this.

Half the participants anticipated how those in their system might be 'bad influences' in relation to lifestyle choices following WLS. This involved encouragement to eat larger amounts of food or the 'wrong' foods.

> Amy: She'll palm me with chicken and rice and stuff like that and I'm going- mum I can't eat it and you know, a big portion!

4.6.2 Stigma and Sharing

Participants reported their experiences of disclosing the WLS to others as well as any associated WLS stigma. All participants reported telling at least one other person that they were having WLS.

> Sam: I've also talked about it with my mother-in-law, I have a good relationship with my mother-in-law.

The degree of sharing appeared related to the amount of stigma that participants experienced in relation to WLS. Participants who reported less stigma also reported being most open about WLS with others.

> Paul: Because everyone I know has always been supportive, even when I'm trying a diet, so I think they have a right to know when I'm getting the surgery and that all their hard work as well as my own is going to pay off eventually, so that's why I've made it public because people do have a right to know.

Some participants spoke about their decision not to tell others about WLS. This was often linked with wanting to avoid the judgement of others.

> Rachel: I don't want to have to go into work and everyone talk about it so I'd rather just not [share].

> Carrie: Anybody else, even close friends, if I've got that slight doubt or I think there's going to be some kind of judgement then it's none of their business.

4.6.3 Family Sense Making

The 'Family Sense Making' sub-theme referred to participants' understanding of how their family and friends obtained information on WLS and related concerns. All but one

participant discussed this. Some felt that their family made sense of the surgery through the participants directly. Others spoke about family members doing additional research.

> Carrie: My mum, it's just reminding her that it is a long journey, it isn't over after the surgery.

> Joanna: So yeah, my family know everything, all the leaflets we got with the diagrams the other day, my nan's gone through it all, they read through it, they go online, they look up what's happening.

Most participants said that family and friends had anxieties about the surgery. These ranged from concerns about the safety of the procedure and adjustment afterwards, to worries about whether participants were pursuing WLS for the right reasons.

> Gill: Yeah the risk of the surgery [is a worry] because he's never had surgery and he's a wuss anyway.

> Paul: It's a bit scary for them as well because they don't know what it's going to be like afterwards.

> Joanna My partner was a bit, he didn't want me to do it unless it was for myself.

Some participants wondered about how WLS might impact their family members but most had not discussed this directly with the family members themselves.

> Sam: I do wonder how she will feel when she is sitting there with a big pile of food because that's what she eats most nights, is a big pile of food, it's the sort of food that is much better for you then I would put on my plate given free will, it will be lots and lots of vegetables and things like that and she'll chomp and chomp her way through that quite happily but I do

> wonder how she will feel when she's sitting opposite me with her portion of food and I've got a side plate with very little on it.

4.6.4 Family Support

All participants discussed the roles that they thought family and friends would have in supporting them post-surgically and this is captured under the sub-theme of 'Family Support'. Most participants anticipated that those in their system would be supportive in general without specifying what this might look like.

> Stacey: I know my mum would say she will be there for whatever I need and there to support.

Specific types of support anticipated were with childcare.

> Stacey: They've got to be there to look after my children because I won't be able to pick up or lift.

With changing diet.

> Paul: If I go around my mother-in-law's she will make sure that whatever she cooks is helping me with my diet.

Emotional support.

> Jamie: If I fancied a biscuit I would probably phone a friend.

Support with recovery.

> Sam: She'll be supportive and come down and help look after the dog and this, that and the other for the immediate post-surgery.

Support with exercising.

> Gill: I've got one friend I know that will be pushing me to get back to the swimming pool and gym.

And provision of prompts and reminders regarding lifestyle changes.

> Carrie: I think my friend who knows about it will actually keep me going as in he will make sure I'm alright, he's the one who always reminds me to eat and things like that.

Participants also anticipated that family and friends would be there for them should the surgery not go as hoped.

> Gill: They'd be sad for me because obviously they want it to work the same as I do but if it didn't they would be like okay, they'd commiserate, they'd be sympathetic, put up with me crying, screaming, hooting and hollering.

4.6.5 Co-Changing

The 'Co-Changing' sub-theme referred to participants' anticipations that those around them may change aspects of their lifestyle alongside them. Most participants anticipated that others would change their diet.

> Sam: She said if we need to change how we eat or what we eat or whatever, so I don't have any doubts at all that she will do whatever it takes.

Participants also commented on how family members might change their habits generally.

> Paul: They would say exactly the same thing, that they will change their habits in order to help me.

One participant specified that the way the family shop for food would change.

> Joanna: Shopping, there's no colour in our shopping, it's just bland stuff, so that's going to change, we're not going to skip past the fruit and vegetable aisles and we're gonna actually be in that aisle and we're going to buy fruit and vegetables.

In summary, the superordinate theme of 'A Journey in Context' captured how participants' experiences in relation to WLS were contextualised by their social systems.

4.7 Theme 6: Plans and Preparation

Participants spoke about how they were preparing for WLS and life after and this was captured in the overarching theme of 'Plans and Preparation'. Figure 4.7 shows six new sub-themes which fell within this category. The 'Family Support' sub-theme previously presented in section 4.6 also linked with 'Plans and Preparation'. This sub-theme captured participants' expectations of what support they might access from family and friends following surgery, which formed part of their preparation.

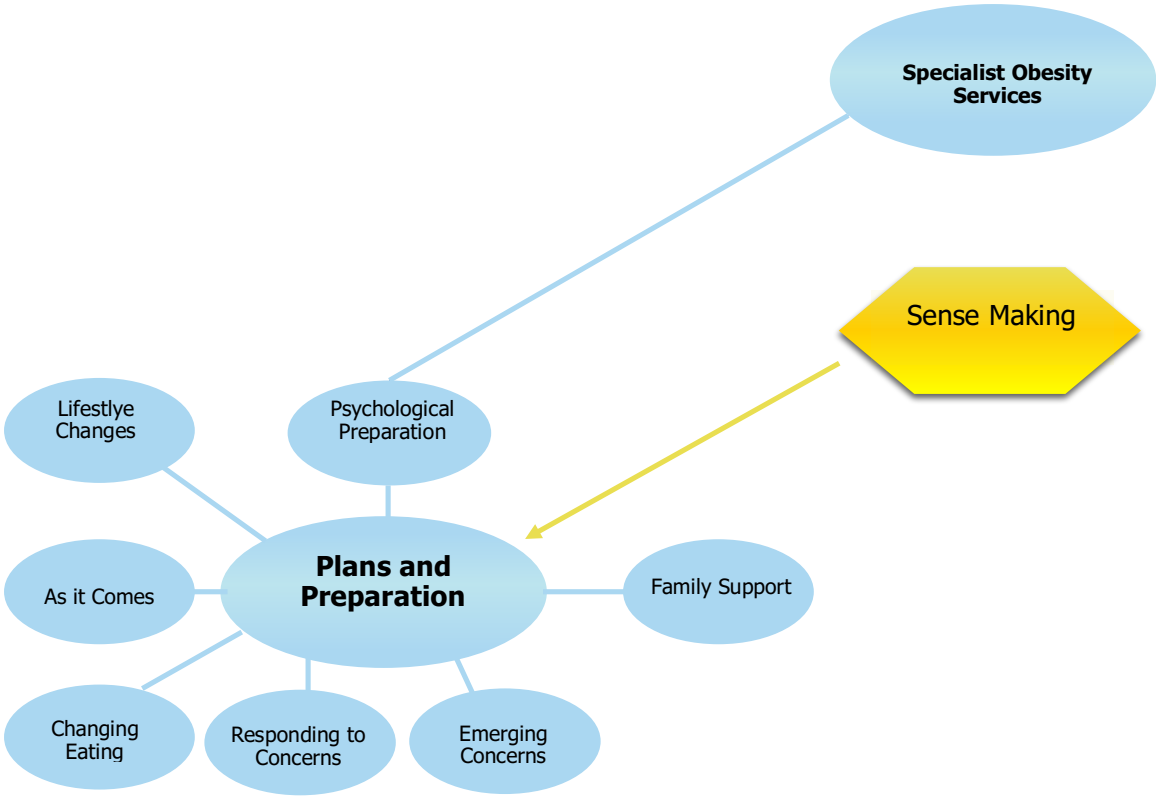


Figure 4.7: Superordinate Theme: 'Plans and Preparation'

4.7.1 Psychological Preparation

The 'Psychological Preparation' sub-them referred to participants' portrayals of their psychological readiness for surgery. Most participants reported feeling confident and prepared for WLS and that they were in the right 'head space'.

> Sharon: At the moment I feel very confident.
>
> Sophie: I feel ready, just like ok let's do this now…
>
> Carrie: …I'm in the right head space…

Some participants, whilst feeling prepared, reported this to a lesser degree.

> Joanna: I think I'm 50-50, I'm mentally prepared for the op.

> Sam: I am 90% there and I understand at least the concept of the changes.

Preparation was grounded in participants' experiences of success during Tier 3 weight management and overcoming challenges, such as dealing with periods of weight gain. Participants said that whilst pre-surgical workup was long, they now appreciated the process as facilitating their readiness for WLS. In this way, the sub-theme of 'Psychological Preparation' also linked with the superordinate theme of 'Specialist Obesity Services'.

> Carrie: I think what has helped me prepare for this, it is a long process and although when you start off you think oh my god this is so far away, you need it. You have to see that you can maintain this because we're talking 2 years later, ok where do you think you're going to be? Well I've already done this for 3 years to a certain degree, I've had to maintain and keep going so it's prepared me.

Some participants described how pre-surgical pathways and their work within this helped to maintain their focus, with participants not wanting their hard work to go to waste.

> Joanna: I've worked my arse off basically to get here and I'm not going to ruin it because a year from now I want to able to look back and say my gosh that's how much I've changed in a year.

Generally, participants described feeling determined and excited for life after surgery.

> Sharon: I don't know, I just sat there one day and said I'm going to do it and that's it.

> Jamie: Since I've had the date and everything it's this big build up to it, it's almost like going on a holiday of a life time.

4.7.2 Changing Eating

The 'Changing Eating' sub-theme captured participants' plans for how their eating would change following WLS. Nearly all participants talked about how the content of the food they ate would be different and that this change had already started at the pre-surgery stage.

> Amy: I sit and think actually, for me now, I'm looking at making more vegetarian options, chicken, meat and fish options rather than chips and burgers.

Most participants anticipated that their portion sizes would be smaller, again with some already making changes in this area prior to the surgery.

> Gill: I'll have to eat to keep me alive but that it will obviously just be smaller portions.

For some participants structure and routine was something which they felt would be important to change both before and after surgery.

> Joanna: I've just kinda got in to my head that I have to eat 3 times a day.

Participants also considered how eating out would change or be challenging following surgery.

> Amy: But no, it's again going with the healthier option, you can go out and eat but it's the alternatives, you can look at the menu and go right, I can have that, I can have that, I can have that and still be sociable, or you say, I'm having the kids portion and that's the way I see it, I sort of think it's just switching things around.

4.7.3 Lifestyle Changes

The 'Lifestyle Changes' sub-theme captured participants' descriptions of non-food related lifestyle changes that they thought would be important following surgery. The majority of participants talked about exercise, being more active and the importance of this.

> Sophie: I wanna take up kettle bells again cos I enjoyed that before, even at this size I could do it and I enjoyed it.

Some participants anticipated that exercising would become more frequent as a result of a reducing body size.

> Paul: But I'm thinking as I lose the weight and I can walk a bit more every day I'll probably come to a point where I can get past that, well I'm hoping anyway.

Over half of participants described developing non-food related ways of coping with emotions such as talking to someone or going for a walk, and that this would be important in enabling them to maintain changes in diet.

> Jamie: Distraction, like I'll go on my phone or I'll go and make a cup of tea just to take your mind off it or I'll start doing something at work that I probably should have been doing anyway before I started thinking about food.

> Joanna: Learning to sort of not turn to food when I'm not feeling myself.

4.7.4 'As it Comes'

This sub-theme was about participants' reports of preferring to take things one day at a time, rather than planning too far ahead. Some participants talked about their preference for this, which was portrayed as a way of coping with or avoiding potentially difficult emotions.

> Amy: I think for me if you go in and think yep, it's the be all and end all and then it doesn't work out the way you're imagining it, you'll be frustrated, so I'm just going to go in and think you know what, let's just take each day as it comes.

They also talked about their expectation that there would be a certain degree of learning as participants went along and this meant that not everything could be planned for.

> Jamie: I suppose with the food, the nurses explained that it's like trial and error, you do try again a bit later so I guess that's something that I'm just going to have to learn to live with really.

4.7.5 Emerging Concerns

The sub-theme of 'Emerging Concerns' captured participants' reports of concerns they had about life after surgery. All participants reported some degree of concern about the unwelcome side effects of surgery such as hair-loss, nausea, dumping syndrome and taking supplements.

> Sam: I am concerned about dumping because I have bowel problems anyway.

> Paul: You read a lot of stuff out there which is a bit concerning sometimes with hair loss and stuff like that.

Most participants also talked about the possibility of developing excess skin, with some expressing concern that excess skin could become a body image concern following surgery.

> Amy: I'm just worried about the excess skin and how it will look, yeah, cus you're always body conscious when you're over weight but to be conscious again when you've got a load of excess skin isn't brilliant either.

Others felt more optimistic that they might be able to reduce the impact of excess skin through pacing weight loss and doing exercise.

> Stacey: Exercise. My brother has built a gym in his garage and he's said that I can use it any time, so I'm just going to try and do as much as I can to reduce the skin.

All participants expressed some level of apprehension about recovery and adjusting to an altered lifestyle after WLS and how this had impacted their planning.

> Gill: I think living on my own is possibly one of my biggest worries, it's not that I don't like living on my own, I actually do, immediately after the operation, the worry of what could happen from the surgery but then I do have a phone so it's not a problem.

Some participants worried about the sustainability of weight loss following surgery and the risk of re-gain and that this informed their commitment to making life-long changes alongside WLS.

> Paul: The thing is with surgery it's a life-long thing that after surgery that's what I need to do. I don't want to go backwards after surgery and become fat again.

Some participants reported feeling worried that others might view them differently as they lost weight or that relationships might change or break down. In this sense, the 'Emerging Concerns' sub-theme also linked to the superordinate theme of 'A Journey in Context' in so far as it included concerns relating to participants' social context of family and friends. Despite expressing an awareness of potential difficulties in this area, generally, participants did not report discussing it with the concerned parties.

> Jamie: You hear a lot, there are 2 ladies at work that have had similar surgeries to this quite a few years ago and both have split up with their partners since then and apparently it's quite common so that's playing on my mind a little bit.

4.7.6 Responding to Concerns

Participants talked about how they might handle emerging concerns and challenges both prior to and following surgery and these descriptions clustered under the sub-theme of 'Responding to Concerns'. Some participants described avoiding researching their concerns, as a way of preventing anxiety from escalating.

> Amy: I'm trying not to think about it so it doesn't get in my head because in a way it's a minor thing, it's major but minor, I'm trying not to think about it.

Participants talked about learning about concerns from previous WLS candidates, either online or face-to-face and some noted how this offered them the opportunity to learn from the mistakes of others.

> Joanna: I've worked hard to get here and I don't want to go back to how I am now and I know it can happen as well because when you're sitting in the waiting room and other ladies and men have had surgery and there was one lady that I was talking to and she'd had a gastric bypass done and she had put on all the weight she had lost back on and I felt like crying for her because I could see the disappointment in herself and but she said that I went through all that to just end up back here like this and I don't want to be like that, I want to be one of these people that know what I done wrong and I've learned from what I've done.

Some participants discussed concerns with their family and friends. The reported advice given was described as 'don't worry' and 'stay positive'. This suggested that some

participants may not have an emotional space in which anxiety might be shared with those in their system.

> Stacey: Just that you're worrying over nothing, that you can't predict what's going to happen and that you just have to deal with it when it happens and not worry about it before because it might never happen.

Participants discussed seeking professional support with their concerns either pre or post-surgically but for some to do this, the extent of the concerns needed to reach a certain threshold.

> Jamie: Yeah, if I had pain or anything like that, I think then I'd ring but you don't want to bother people do you, you know that people are busy so I wouldn't and say I fancy a biscuit, yeah that would definitely but more like family and husband.

With respect to concern about weight re-gain, some participants said that if weight re-gain happened, they would re-assess the situation and try a different approach. This was informed by a sense of focus on achieving their desired goal and that if WLS was not the means to this end, that something else would need to be found.

> Carrie: I've still got to keep going, I've still got to get myself back somehow. Whatever route, I have to get myself there, not just for physical health but for my mental health, I have to get me there.

All in all, participants expressed a range of concerns for life following WLS, as well as different plans and preparations for how these and lifestyle changes would be handled. The depth and degree of planning varied amongst participants, with some preferring to take 'one

step at a time' and others preferring to do the 'groundwork' prior to surgery. Regardless of the depth in preparation, almost all participants reported feeling 'ready' for WLS.

4.8 'Sense Making' As the Golden Thread

The sub-theme of 'Sense Making' refers to participants' sense making of their relationship to eating, weight and self and was initially presented in section 4.2 under the superordinate theme of 'Foundations of Pursuit'. Figure 4.1 shows that 'Sense Making' also linked with the five additional superordinate categories and this is further summarised in Figure 4.8.

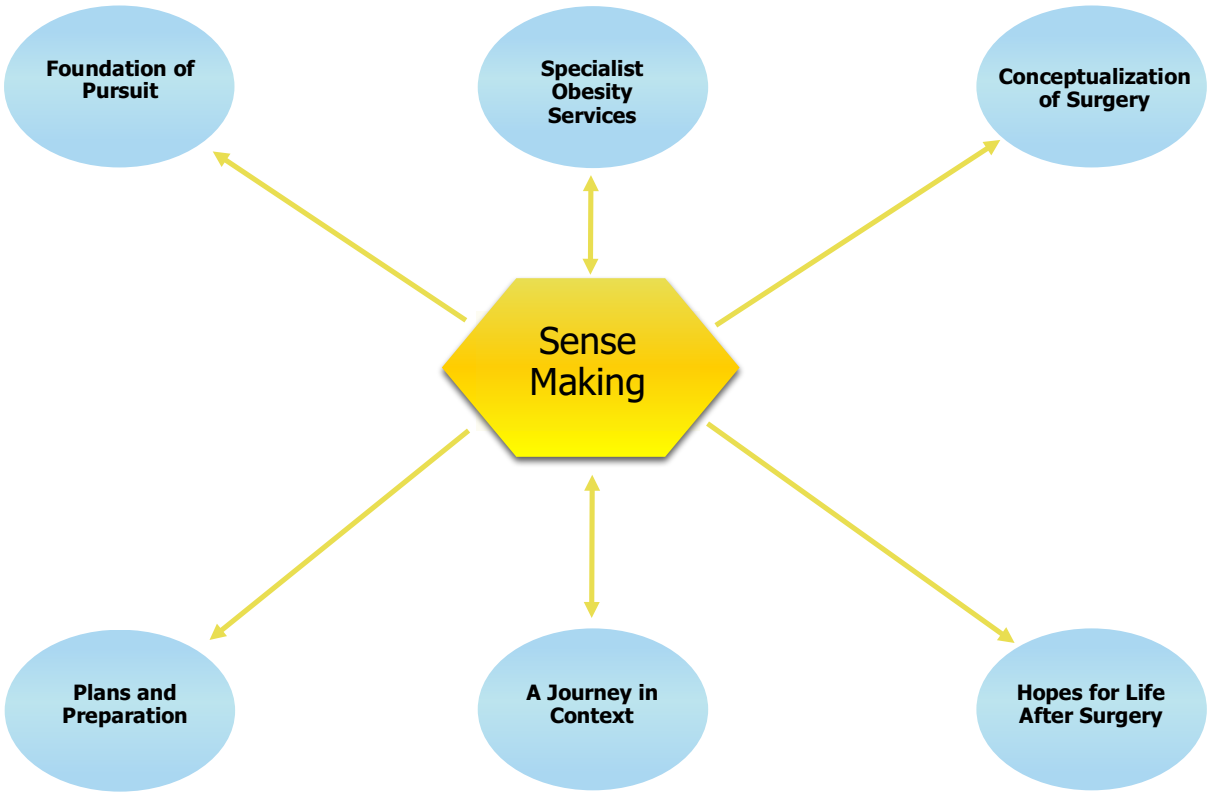


Figure 4.8: Linking the Sub-Theme of 'Sense Making' with Each Superordinate Theme

Participants' sense making seemed to impact their experiences in each superordinate category. Further, in some cases, the relationship between 'Sense Making' and the superordinate categories was reciprocal, with the content and processes captured under some

superordinate themes impacting how participants made sense of their relationship to eating, weight and self. In this way 'Sense Making' acted as a thread running throughout the experiences of participants and informing their decision making. To help illustrate this, a case study of one of the participants (Joanna) is presented below, showing how the sub-theme of 'Sense Making' linked with each superordinate theme.

4.8.1 Joanna: A Case Study of 'Sense Making' and its Links with All Superordinate Themes

The 'Foundations of Pursuit' superordinate theme captured participants' descriptions of how they arrived at the point of pursuing WLS. Joanna described how her decision to pursue WLS was her own idea and that this idea had been grounded in her understanding that she had struggled with weight since childhood.

> Joanna: It was my idea, I wanted it because I've always struggled with my weight, ever since I was a kid.

Prior to pursuing WLS, Joanna reported having done a deal of self-work through attending counselling. This appeared to change her relationship with herself, arriving her at the 'right' time to consider WLS.

> Joanna: …He [ex-partner] thrived off my insecurities and so he made me very very insecure of how I was. And it was only when sorta, I went to see my counselor that she was like 'look you don't need someone like that in your life- you can do this' and so I basically went through a couple of years of just sort of self-loving myself again really. And then I thought no, I'm there mentally now, I know that I can do this and at the end of it I know that what I see in the mirror is how I want to look.

The overarching theme of 'Specialist Obesity Services' referred to participants' experiences within this setting. Joanna described how through attending specialist obesity services she increased her awareness of additional facets of her relationship to food and weight. Specifically, she learned how a lack of structure around food had impacted her struggle to lose weight.

> Joanna: It made me realise that I never had structure with food because I had to work with them for the past 7 months or so on structure of what I eat and at what time.

'Conceptualization of Surgery' captured participants' understanding of WLS and what it may or may not help them to achieve. For Joanna, WLS was seen as a necessity because of repeated failed attempts to lose weight. This appeared to feed into a belief that in the long-run, her relationship with food and weight would remain unaltered without WLS.

> Joanna: To be honest, my Nan said that if I couldn't go through the NHS route my Nan would have paid for me to have it done privately, if I couldn't have weight loss surgery I think that my weight would just go up and down. I do the diets, I stick to it, I lose weight and then I put weight back on, and then I lose weight, I think I would just spend the rest of my life yoyo-ing up and down.

The overarching theme of 'Hopes for Life After Surgery' referred to the hopes and expectations which participants held for life following WLS. For Joanna, her relationship with herself had been greatly impacted by her relationships with others.

> Joanna: Most of mine [difficulties with food] was when my real dad abandoned my mum when she was still pregnant with me, and he divorced my mum, got re-married and had a whole other set of kids and then he got back in touch with my sister, I was only about 4 and

> he denied that I was his, he basically said that I wasn't his and that my mum had had had an affair and it kinda just stemmed from there. It made me feel unloved.

This meant that some of Joanna's hopes for surgery were about building not only an intrinsic sense of achievement and worthiness, but also demonstrating this to others and in some ways protecting herself from miss-treatment by others.

> Joanna: Just being able to do it and actually finally, waking up and being happy to look at myself and being like I've achieved that, to all the people that have negatively put me down, that have said you'll never do it, you'll never get anywhere, to actually sort of say to them, I've done this, this is all me and every step I take will just be like I've done this, you know. Just to be proud of myself every day and to never let myself get sort of bullied by anyone about my weight ever again.

'A Journey in Context' captured how participants' social context of family and friends impacted their experiences of preparing for and sense making around WLS. There was a strong sense of Joanna's family throughout her interview, with clear links to how this had impacted her relationship with food, weight and self.

> Joanna: I got into a horrible relationship and he just said no one else is going to want me, he's the only one and he took pleasure in basically manipulating me and mentally abusing me and yeah he was a feeder, so if we went out for something to eat he would be like you can eat this and eat this.

Similarly, Joanna described how she had learned about her relationship with eating through reports of her childhood by her mother. Joanna adopted these reports and incorporated them within her own sense-making.

> Joanna: And sadly, as my mum said, when I got old enough and started doing a paper round and earning my own money and went out with friends, she had no control of what I was eating. And yeah, just kind of went from there, I never really saw an issue with what I was putting in my mouth.

The overarching theme of 'Plans and Preparations' referred to participants' plans and preparations for WLS and life after. Joanna's sense making of where her difficulties with food lay impacted her preparation for surgery. For instance, developing a meal structure or plans to cope with emotions in non-food related ways.

> Joanna: …Learning to sort of not turn to food when I'm not feeling myself, go out for a walk because I can do it and just do more physical activities…

In summary, the sub-theme of 'Sense Making' not only underpinned Joanna's initial reasons for considering WLS but was woven throughout her experiences in accessing specialist obesity services, her conceptualization of WLS, her hopes and expectations for WLS, her social context and preparing and planning for surgery. The tapestry presented in Joanna's case study is representative of the wider sample of participants' portrayals of 'Sense Making'.

CHAPTER 5: DISCUSSION

This chapter will present a discussion of the results, relating them to existing research and psychological theory relevant to health behaviour change. The clinical implications of the results will be considered, followed by methodological strengths and limitations and finally, future directions for research will be presented.

5.1 Revisiting the Research Question

This research sought to understand the experiences of WLS candidates in the NHS who were awaiting surgery. The results revealed six core themes summarising participants' experiences leading up to surgery, following a semi-linear pattern.

Theme 1 captured what the participants' initial decision to pursue WLS was grounded in, such as their experiences living with obesity, their relationship to eating, weight and self*, and their initial information gathering. Theme 2 focused on participants' experiences of specialist obesity services, from access issues, gaps in services provision, staff rapport, and strengths and challenges during pre-surgical workup. Theme 3 illustrated how participants conceptualized WLS. This covered their understanding of what WLS may be able to facilitate, its limitations, participants' roles within this and their expected trajectories following WLS. Theme 4 identified participants' hopes and expectations for life after WLS. Participants reported a range of aesthetic, practical, health, emotional and relational hopes, as well as anticipating that through WLS they might become "normal". Theme 5 captured the personal contexts of participants and how their family, friends and experiences of WLS stigma impacted their plans and preparations for life after surgery. Finally, Theme 6 described the plans and preparations that participants had for life after surgery with respect to lifestyle changes and coping.

*The word 'self' can mean different things in different contexts. When used throughout this discussion, it refers to the dictionary definition: *'A person's essential being that distinguishes them from others, especially considered as the object of introspection or reflexive action'* (Oxford Dictionary, 2018).

Within each theme, the experiences of participants were impacted by how they made sense of their relationship to eating, weight and self. For Theme 2, 'Specialist Obesity Services' and Theme 5, 'A Journey in Context', the nature of this relationship was reciprocal. Here, how participants made sense of their relationship with eating, weight and self was informed and refined by their experiences within these themes.

5.2 Links with Existing Research

5.2.1 Theme 1: Foundations of Pursuit

Past research found life events as triggers for the decision to pursue WLS, is a common feature amongst WLS candidates who go on to have successful outcomes post-surgically (Ogden & Hills, 2008 & Pfiel et al, 2013). Participants in this study also remarked on key events that triggered their decision to pursue WLS, such as significant illness or milestone birthdays. As the participants in this research were interviewed pre-surgically, it is unknown how this might relate to long-term outcomes. Based on existing research, it could be hypothesised that having identified significant life events, these participants might achieve more successful outcomes following their surgery. This might be usefully explored in a follow up study.

Adding to existing literature with WLS candidates in the NHS, participants in this study reported how their understanding of their relationship to eating, weight and self also impacted their decision to pursue WLS. This included participants' descriptions of what they

formulated to be problematic eating behaviours and descriptions of their relationship to weight. Of particular significance, some participants reported feeling unhappy and dissatisfied with themselves as a result of obesity and that this fuelled their decision to pursue WLS in an effort to attain a more positive sense of self. In contrast, other participants, whilst still having areas that they wanted to improve, reported having improved their self-worth already, through avenues such as psychological therapies, arriving at a place in which they wanted to pursue WLS as an act of care for themselves.

The connection highlighted between weight, eating and self is unsurprising in a sociocultural context, which not only has narrowly defined body ideals (Dittmar & Howard, 2004 & Grammas & Schwartz, 2009) but where negative messages about what it means to be obese are rife (Throsby, 2007). This is important as it may have implications for how candidates experience WLS and their subjective outcomes thereafter. A significant portion of candidates do not achieve sustained weight loss following surgery (Welbourn et al, 2014). Of those who do, a high proportion will go on to experience excess skin which may leave candidates feeling dissatisfied with their aesthetic appearance (Kitzinger et al, 2012 & Mitchell, Crosby & Erteit, 2008). WLS is a serious life changing procedure which in most cases is not reversible. Candidates who embark on WLS purely from a position of being dissatisfied with self rather than as an act of self-care, may find themselves less well equipped with the psychological tools to manage such challenges.

5.2.2 Theme 2: Specialist Obesity Services

Participants in this research accessed obesity services following the implementation of 2013 commissioning guidance (NHS Commissioning Board, 2013), resulting in a more standard and defined care pathway across NHS obesity services. This study was the first study to use

participants from a post-2013 cohort, finding that candidates largely remained happy with the nature and quality of specialist obesity support. This reflects previous research concerned with patient experience of specialist care (Homer et al, 2015 & Lloyd et al, 2017). Participants in this study felt that, whilst the care pathway was long, there was value in its length with it aiding psychological preparation for WLS. This contrasts with past research which reported that participants felt more time was needed in Tier 3 in order to prepare for WLS (Homer et al, 2015). The length of Tier 3 accessed by participants in their study may have been shorter, as the sample used was prior to the standardization associated with 2013 commissioning guidance.

Participants reflected on both difficulty in accessing referrals to specialist obesity services, as well as a persistent fear of being turned down during the process leading up to the surgery. This is similar to other studies, which reported that problems in accessing referrals were grounded in the quality of candidates' relationships with their GP (Homer et al, 2015 & Owen-Smith et al, 2016), as well as a persistent fear of loss with regards to WLS coming to fruition (Homer et al, 2015). In this study, participants generally reported that this fear of loss did not impact how honest they felt they could be with obesity professionals. This contrasts with other research, which reported opposite findings (Homer et al, 2015). It is difficult to know what might account for this difference, particularly as one might hypothesise that a fear of loss would have consequences for honesty levels. It may simply be as participants reported, that they felt specialist staff were 'there to help' and as one participant commented, specialist staff would be 'able to tell' if candidates were being dishonest.

The fear of loss described in this study and others could have consequences for candidates' ability to fully weigh up the pros and cons of surgery. In consumer psychology, fear of loss is

a technique used to encourage consumer behaviour and increase sales (Brennan & Binney, 2008 & Novemsky & Kahnerman, 2005). This approach relies on the assumption that the fear of losing a desired outcome motivates people to secure the outcome, so as to eliminate the fear and perceived risk of loss, at the expense of full consideration of relevant factors. Often WLS candidates have a high emotional attachment to WLS (Engstrom, Oslen & Lonron, 2011). From this context, the fear of loss they experience may impede how able candidates are to fully engage with the different pros, cons and risks of WLS.

The fear of loss may also have consequences for engagement in the requisite lifestyle changes in the longer term. Another technique used in consumer psychology is negative appeal (Brennan & Binney, 2008 & Novemsky & Kahnerman, 2005). Emotional discomfort is purposively created, which can be rectified through engaging with a behaviour desired by the house, not the customer. In the shorter term, candidates who fear losing out on WLS may be more motivated to engage with lifestyle changes required in the NHS. Once surgery has taken place, assuming fear of loss is motivational, this may lead to a reduction in the longevity of lifestyle changes, risking the long-term success of the surgery. Collectively these considerations highlight the importance of playing careful attention to the fear of loss experienced by candidates and how this may be affecting, informed decision making, honesty and lifestyle changes.

Similar to other NHS based studies, participants in this study reported the positive rapport and lack of judgement they experienced from specialist obesity staff (Homer et al, 2015 and Pfiel et al, 2014). Pfiel and colleagues (2014) suggested that staff had a role in providing psychological containment. This idea fits with participants' reports in this research. They spoke about being nervous about WLS and life thereafter, but referred to their faith in

specialist staff and the subsequent support that would follow as soothing their nerves. This research in the context of other studies suggests that less stigma is experienced by candidates, when working with specialist staff. Unfortunately, research indicates that obese patients experience more stigma when working with staff who are not obesity specialists (Homer et al, 2015). It would be useful to understand what factors lead to observable differences in iatrogenic stigma from specialist and non-specialist staff. Presumably there will be factors relating to level of education and knowledge on the complexity of obesity, which account for this.

Finally, in relation to Theme 2, participants highlighted gaps in services provision, particularly with regards to information giving and psychological support both pre- and post-surgically. This is a repeated theme in existing NHS studies (Homer et al, 2015, Lloyd et al, 2017, Ogden et al, 2011, Owen-Smith et al, 2016). Research suggests that higher dissatisfaction with services has been associated with poorer outcomes (Lloyd et al, 2017, Ogden et al, 2011). Conversely, increased psychological support was identified as a key difference reported by candidates who had an unsuccessful WLS, followed by a second successful WLS (Ogden et al, 2011). Collectively the results of this study within the context of previous research highlight the importance of further analyzing and addressing these gaps so as to enhance the WLS candidate experience, and improve outcomes. This is discussed further in section 5.3 which presents the clinical implications.

5.2.3 Theme 3: Conceptualization of Surgery

Replicating previous research (Homer et al, 2015, Ogden et al, 2011 & Pfiel et al, 2014), participants in this study talked about their expectations that the WLS would help them to feel full, reduce the amount of food consumed as well as to accelerate and sustain weight

loss. Overall participants anticipated a reduction in control over what foods that they would be able to tolerate as a result of WLS. Based on their research, Ogden and Hills (2008) suggest that the reduction in available choice around eating as a result of the physical constraints of WLS is a key factor which facilitates outcomes. Collectively and in the context of the past failed weight loss attempts reported by participants, this indicates that candidates may enter surgery with an external locus of control (Rotter, 1976) with regards to the volume and types of foods consumed. These repeated failures might also lead to a sense of learned helplessness (Mairer & Seligman, 1976). Crucially, the addition of WLS, referred to as "a tool" by participants, may reduce learned helplessness by increasing the sense of hope and power that participants having in relation to changing eating, weight and health.

At the same time as anticipating how surgery would impact their eating, participants unanimously reported holding ultimate responsibility for the long-term outcomes of surgery. Additionally, they described questioning whether WLS would act as a panacea for the various health and non-health related difficulties they faced. This helps to shed light on additional cognitive processes involved in WLS, however the depth and ownership of such beliefs is unclear, which may have consequences for health behaviour and outcomes. Ogden and Hills (2008) interviewed participants who had undergone two WLS; an unsuccessful surgery followed by a successful surgery. They found that the level of psychological responsibility participants held increased at their second more successful surgery. The accounts of participants in this study are not based on wisdom yielded from learning through past experience of WLS, as may be the case with Ogden and Hills (2008) sample. Furthermore, during pre-surgical processes, participants in this study may have become socialised into giving the 'right' answers in order to gain access to surgery.

Building on Ogden and Hills (2008), these studies highlight the paradox between handing over control of some aspects of eating to the physical constraints of surgery, whilst retaining responsibility for other overall lifestyle change and ultimate accountability for outcome. More research is needed to understand the quality of candidates' understanding of this paradox and how this is subsequently operationalized in the form of long-term health behaviour change.

5.2.4 Theme 4: Hopes for Life After Surgery

Participants described a range of practical, health, emotional, aesthetic and relational hopes, which correspond with prior research in an NHS context (Homer et al, 2015 & Pfiel et al, 2013). Past research observed "unrealistic" or "high" expectations in WLS candidates (Homer et al, 2015 & Lloyd et al, 2017). In the current study, some participants also demonstrated high hopes. This was the case for participants who expressed significant emotional aspirations for post-surgical life, which in their view would have practical consequences for them living as they wish. For instance, some candidates anticipated that their confidence, body image and relationship to self would improve, and so permit them to go out with existing friends or get married to their long-term partner.

Whilst 'high', whether these hopes are unrealistic or not is difficult to say and doing so is contentious for several reasons. Firstly, based on current research we cannot predict with any accuracy whether these changes will come to fruition for candidates (Wimmleman et al, 2013). Secondly, attaching future happiness to weight loss and aesthetics is precarious. Research suggests that the association between happiness and body type is an illusory correlation, occurring most frequently amongst people with body image disturbance and eating disorder symptoms (Viken, Treat & Bloom, 2005). At the same time, a reduction in

obesity stigma through weight loss may impact happiness. Thirdly, a certain degree of denial or "unrealistic thinking" is perhaps employed by all of us when pursing different things at different times in our life (Kunda,1990). For WLS candidates, when might this go from functional, therefore allowing them to begin, to un-functional and therefore setting them up for failure? Regardless of the difficulties in defining what is unrealistic, it will be important to explore this further. This is particularly significant, as research at the post-surgical stage has found that the discrepancy between what participants hoped for post-surgically and their lived reality is linked with regrets about having WLS (Lloyd et al, 2017).

5.2.5 Theme 5: A Journey in Context

One study, which interviewed NHS WLS candidates following their surgery, found that participants were surprised by the amount of social support they required from those in their network (Owers et al, 2017). This contrasts with the participants interviewed pre-surgically in this study, all of whom spoke about the integral role family and friends would have in supporting them. Participants specified how their family and friends would have a role in assisting them with post-surgical lifestyle changes, either through encouragement, emotional and practical support or through co-changing with the participants themselves. To the author's knowledge, this is not something which has previously been explored with candidates in the NHS prior to WLS.

Owers et al (2017) interviewed candidates post-surgically and found that at this stage in the process, participants felt ill-prepared in managing less supportive family and friends. The sub-theme of stigma and sharing, identified in this research, touches upon this. In this study, there appeared to be a negative association between level of perceived WLS stigma and the level of sharing about WLS. In many ways, the decision not to share with less supportive

family and friends appeared intuitive, possibly offering a layer of protection from additional sources of stress as participants moved closer to the WLS. What we cannot tell from the current study, is the implications of this for participants' post-surgical experiences and whether, like the participants in past research, candidates will be left feeling ill-prepared in managing this post-surgically.

For most, food consumption is beyond functional and operates within each candidates' sociocultural context (Furst et al, 1996). These findings highlight the important role that WLS candidates' social context can play in terms of their preparation and support from within their system. The degree of involvement that family and friends have in candidates' WLS experiences may have implications for adjustment post-surgically. Particularly in cases where family and friends themselves have been ill-prepared for the WLS and what this will mean for how food consumption will change, for instance when eating socially. Hypothetically, the less well informed and educated family and friends are, the less equipped they may be in themselves adjusting to the changes in their loved one, as well as providing support.

5.2.6 Theme 6: Plans and Preparation

Participants spoke of a range of diet and non-diet related lifestyle changes that they felt would be important to implement both pre- and post-surgery. Exercise and increased movement was a plan for most participants in this study, which differs from past research which has reported this to a lesser degree (Pfiel et al, 2014). A key issue was the concern about developing excess skin and how this impacted plans for lifestyle changes. Many participants reported post-surgical plans with a view to reducing, eliminating or handling excess skin, such as exercising, trying to pace weight loss or plans to surgically remove the skin. It may be that this and similar concerns about unwanted factors following surgery

increase the likelihood that lifestyle changes will be successfully implemented. This is something other research has shown candidates use in maintaining focus (Ogden et al, 2011).

To the author's knowledge there is only one study that has asked NHS WLS candidates pre-operatively, about concerns for life after surgery. The study found that candidates were aware of the negative side effects of WLS (Homer et al, 2015). The current study also found that participants had awareness of side effects. Additionally, this study captured how participants used this knowledge to inform intended plans and preparation for life afterwards. What cannot be inferred is the quality of candidates' awareness of side effects and how much the risk of these has been accepted as a likely reality. For instance, candidates acknowledged the risk of excess skin but expressed their belief that this might be managed through exercise. In reality, the rapid rate of weight loss in the immediate months following surgery means that this is unlikely, with most candidates developing excess skin in spite of attempts to prevent it (Kitzinger et al, 2012 & Mitchell et al, 2008). This could be indicative of the earlier mentioned denial and emotional reasoning (Kunda, 1990) which happens as people embark on significant decisions. Again, it is difficult to say how functional or problematic this might be. To shed light on this the participants in this study will need to be re-interviewed post-surgically.

Past research highlighted candidates' experiences of emotionally driven eating post-surgically (Lloyd et al, 2017 & Ogden et al, 2011). Finding alternative ways of coping with emotions is one factor that differs between unsuccessful and successful candidates (Wood and Ogden, 2016 & Wimmelman et al, 2013). In this study, participants had begun to consider the relationship between emotions and food and what alternative strategies they might utilise in coping with emotions. Education on this issue may be important in helping

candidates build an in-depth understanding and awareness of emotionally driven eating, potentially providing a solid platform from which to start using alternative ways of coping. With this in mind, the amount and quality of the pre-surgical work in relation to emotionally driven eating may be particularly important in supporting candidates to achieve successful outcomes following their surgery. This is considered further in section 5.3 where clinical implications are addressed.

Some participants in this research also expressed a preference for taking each day as it comes, rather than planning too far ahead. To date, no other studies have explicitly reported this amongst NHS WLS candidates still at the pre-surgical stage. This might reflect a preferred avoidant way of coping (Westbrook, Kennerly & Kirk, 2011), or it could reflect the idea that not all can be planned for. Research has highlighted that a certain degree of learning through experience is to be expected following WLS (Owers et al, 2017 & Pfiel et al, 2014). This reflects some participants' descriptions in the present study that 'trial and error' would be required to reacquaint one's self with eating and what types of foods and quantities can be tolerated. Whilst learning through experience is to be expected, it is unlikely that this would justify a more general tendency to avoid planning ahead. Giving the serious nature of the procedure and the considerable adjustment that will be required from candidates an 'as it comes' approach may have implications for this.

5.3 Links to Existing Theory

The application of existing theory to the WLS experience will be explored in this section.

5.3.1 Theory of Planned Behaviour and Self-Effiacy

Participants reported intended plans and preparations for WLS and life thereafter. Based on the Theory of Planned Behaviour (Ajzen, 1985) the intentions reported by participants in this study are an indicator that lifestyle changes may be achieved. The model does acknowledge that in some situations, the perceived control candidates believe they have over a behaviour may sever the direct links between intentions and behaviour. This is important in the context of participants' self-reported experiences of setbacks and failures in weight loss. Existing WLS data shows us that many well intended candidates struggle to maintain lifestyle changes post-surgically. This is evident by the number who re-gain weight (Welbourn et al, 2014). Although a starting point, it is unlikely that the high intentions alone that participants reported will be predictive of what follows post-surgically.

Alongside self-reported intentions, most participants conveyed a sense of focus that success would be achieved following WLS. There may be a difference between such statements and the ownership and quality of these as personal beliefs. Nevertheless, this could indicate high self-efficacy (Bandura, 1977), which when measured post-surgically, is associated with higher weight loss (Batsis et al, 2009). If self-efficacy were to be a determinant of success, consideration should be given to what accounts for high self-efficacy. Discussed earlier, participants in this study said that their experiences of success and set-backs during pre-surgical workup had helped increase confidence, possibly indicating improvements in self-efficacy. The perceived complexity of tasks has also been have put forward as potentially influencing self-efficacy (Schunk & Carbonari, 1984). Collectively this indicates that it could be useful to play special attention to the depth of candidates learning with respect to lifestyle changes both prior to and as they progress through post-surgical stages.

5.3.2 Health Belief Model

According to the Health Belief Model (Hochbaum et al, 1950), beliefs about the perceived seriousness of risks to health are key in health behaviour change. Participants in this study expressed concern about physical health and life expectancy. However, these concerns had not been sufficient in participants achieving long-term success through conservative methods of weight management. Under a health belief framework, perceived barriers to change can inhibit action. Participants anticipated that WLS might help them to accelerate and sustain weight loss. Implicitly this indicates that WLS may be seen as reducing barriers to change.

The Health Belief Model prescribes cues to action as an essential ingredient in triggering change and that without them, knowledge will not translate to action. It is essential to consider the range of internal and external cues which candidates may be subject to. WLS increases candidates' interoceptive awareness of digestive sensations (Beck, Mehlsen & Støving, 2012). Internal cues might therefore include feelings of satiety or nausea following surgery which signal to stop eating. Existing outcome data shows that this is not sufficient for all in maintaining lifestyle changes (Welbourn et al, 2014). One explanation is that bodily cues are fleeting. Another is the contradictory role of other internal experiences, such as emotions, which trigger eating post-surgically. External cues such as social support and follow up health appointments are also relevant. These were referred to by participants in the research, who anticipated these factors would help in achieving lasting change.

The Health Belief Model appears conceptually useful with respect to internal and external cues for action. To explore this further, it needs observing post-surgically along with corresponding behaviour change. However, the model is limited in capturing the complex clinical picture of obesity, particularly with regards to variables such as relationship to eating, weight and self, which were significant for the participants in this research. It is also limited

in its application to candidates who have primary aims that are not health focused but emotional or aesthetic. For many participants, whilst improvements in health were hoped for, it was striking the limited space they held in candidates' descriptions of hopes and expectations, perhaps leaving the Health Belief Model redundant.

5.3.3 Stages of Change Model

The results of the study fit with the Stages of Change Model (Prochaska & DiClemente, 1986). Participants reported how the lengthy nature of pre-surgical workup was integral in creating the right 'head space' for change. Within this, participants reflected on their experience of set-backs, such as weight gain, and that overcoming this was useful learning. The Stages of Change Model sees the cycle of contemplation, action and relapse as naturally ongoing, even for those who achieve long-term change. Participants' experiences of set-backs during pre-surgical workup might be helpfully understood within this framework. Making the Stages of Change Cycle and theoretical inevitability of relapse explicit could be helpful in preparing candidates for this and building resilience.

Participants described the process of weighing up pros and cons for WLS. They considered the less welcome side effects of WLS as well as odds for risks associated with WLS. Understood within the contemplation stage of the Stages of Change Model, these processes may be essential in preparing candidates for change. This process might be enhanced by motivational interviewing techniques, which grew from the Stages of Change Model and have been utilised by health professionals in facilitating change ahead of action, or in the case of this study, ahead of WLS (Prochaska & DiClemente, 1986 & DiClememnte & Velasquez, 2002).

5.3.4 Self Determination Theory

Self Determination Theory posits that the more intrinsically rewarding a behaviour is, the more likely that long-term success will be achieved (Ryan & Deci, 2000). It is difficult to know how intrinsic participants' motives were for life following surgery. One participant reported an anticipated sense of pride that they might experience in achieving their WLS goals. Taken as a sign of intrinsic motivation, we can hypothesise that this candidate will successfully maintain lifestyle changes. More participants showed signs of hopes that were extrinsically motivated. For instance, wanting to avoid judgement from others. Here it follows that, by comparison, these participants may be less likely to maintain change. It would be useful to explore this further as participants progress through post-surgical life, observing how this corresponds with sustained lifestyle changes and outcomes.

Under a Self-Determination Theory framework feeling attached and cared for by others facilitates the development of intrinsic reward (Ryan & Deci, 2000). Some participants reported high levels of WLS stigma, feeling less able to share with and be supported by family and friends. These participants might be placed at a disadvantage, being less able to tap into hopes which are intrinsically rewarding, which theoretically may jeopardize success. Furthermore, those candidates who experienced high amounts of stigma from those around them may have internalized this as well as other messages about body ideals (Dittmar & Howard, 2004, Grammas & Schwartz, 2009 & Throsby, 2007). Hopes grounded in these processes might be more extrinsic in origin, further compromising long-term success. This suggests that spending time with candidates to help them consider the origins of their hopes and their social context may be useful.

5.3.5 Body Compassion

This study saw how participants' decisions to access WLS was also grounded in their relationship to self. This has not been reported by past research with WLS candidates in the NHS. Some participants, whilst still having things which they would like to change with respect to their bodies, reported improving their relationship to self, prior to pursuing WLS. In contrast, others expressed dissatisfaction with self in the absence of work through avenues such as therapy. These differences appeared to change the emotional tone of the WLS pursuit, the difference being whether the pursuit was from a place of self-care and compassion or not.

Self-compassion is defined as kindness towards self, particularly during times of distress, enhanced by a mindful awareness of one's own distressing experiences which are seen as part of being human (Neff, 2003). A newly emerging concept in the literature, which marries the construct of self-compassion with that of body image, is the term 'body compassion'. This refers to the multiple faceted relationship that people have with their body, and recent research indicates that this concept can be applied with people to reduce eating disorder behaviours and symptoms (Altman, Linfield & Salmon, 2017a & Altman, Zimmaro & Woodruff-Borden, 2017b). The results of the present study might usefully be considered in light of the concept of body compassion as a possible target for research, assessment and intervention for candidates ahead of WLS.

5.3.6 Acceptance and Commitment Therapy (ACT) Model

Participants described avoiding certain situations as a result of difficult feelings, such as low confidence or feeling socially uncomfortable. Participants hoped that their confidence and feelings of anxiety in social situations would improve post-surgically. Similarly, participants reported reducing challenging emotions, such as depression and boredom, through eating

food. Collectively this suggests that a common feature amongst this sample may have been the avoidance of difficult internal experiences such as certain emotions or beliefs about themselves. ACT labels this experiential avoidance (Hayes, 2004). According to ACT, experiential avoidance may inhibit candidates living a meaningful life. This fits with participants' accounts of putting experiences on hold as a result of not feeling confident enough.

For participants, in their view, WLS seemed to offer an alternative to experiential avoidance. They hoped that through reducing their weight, uncomfortable feelings would dissipate. ACT cannot help to predict whether this will be the case. However, research show that following WLS some candidates do experience improvements in confidence and other aspects of psycho-social functioning but equally, many do not (Coulman, MacKichan & Blazeby, 2017). What ACT does posit is that difficult feelings are inevitable and universal therefore, experiential avoidance is almost always rendered ineffective as a coping strategy in the long-term (Hayes, 2004).

If difficult feelings are inevitable, candidates will still be confronted by these post-surgically. Participants may become disappointed that their subjective outcomes have not been met. If experiential avoidance is a preferred coping strategy, candidates might also find such strategies have been removed. For instance, the freedom to engage in emotionally driven eating can be limited by the physical constraints of the surgery. Experiential avoidance may be a useful concept to explore with WLS candidates. Education on how to become aware of such processes and develop willingness to experience difficult emotions as well as skills in doing this may help.

Participants expressed a range of hopes for life following WLS. In ACT, our personal values are seen as a compass to guide behavioural choices (Hayes, 2004). We cannot say with certainty, how value driven participants' decisions to pursue WLS and subsequent hopes were. Furthermore, this may be clouded by the experience of stigma. As previously discussed in section 5.3.4, in instances where hopes originate from experiences of stigma, this might reflect the internalization of implicit and explicit messages about body ideals and what these represent (e.g. Grammas & Schwartz, 2009 & Dittmar & Howard, 2004), rather than what is intrinsically valued. This is further complicated by the wider systemic issue of obesity stigma, the understandable urge for the victims to want to find personal solutions and where true responsibility for changing this may lie. In spite of this, through an ACT approach, there could be utility in supporting candidates to develop awareness of their personal value system and how this relates to motives for WLS. This may be particularly important for candidates in pursuit of the 'happy life', which in reality may not be on the other side of WLS and therefore leave them feeling dissatisfied with outcomes or even regretting surgery.

5.4 Clinical Implications

Caution should be exercised in reporting clinical implications on the basis of one piece of qualitative research. Equally, the potentially important contribution that this research could make to clinical practice warrants consideration. The clinical implications as they are presented here are tentative and, whilst grounded in this study, are also contextualized by the wider literature and clinical context of obesity services within the NHS.

5.4.1 Emotional Eating

Participants expressed a perceived discrepancy between psychological intervention for people affected by restrictive under-eating, compared to people with problems of over-eating. This is

possibly because many WLS candidates do not meet full diagnostic and access criteria for NHS eating disorder services (Joint Commissioning Panel, 2013), as well as the urgency of risk associated with disorders such as Anorexia Nervosa (NICE, 2017). Despite the potential absence of a diagnosable eating disorder, WLS candidates consistently report challenges in their relationship to eating and are exposed to health risks in the longer-term (Guh et al, 2009). This typically includes emotionally driven eating (Lloyd et al, 2017 and Ogden et al, 2011) and this was the case for participants in this research.

A lack of intervention for WLS candidates with emotionally driven eating may be perceived as a health inequality, contributing further to the inequalities already experienced by obese people (Puhl & Heuer, 2010 & O'Brien et al, 2013). As a tool, WLS addresses the physical components of eating but it may not address other drives to eat such as emotions (Colles, Dixon & O'Brien, 2012). Ways of coping and responding to emotions other than eating could be essential in ensuring the success of many WLS candidates. It is important to consider what psychological intervention could be provided for this and by whom.

In recent years there has been a developing evidence base for psychological intervention targeting emotional eating. Commonly this includes building skills in emotional awareness, acceptance and regulation, following an ACT and dialetic behavioural therapy framework (e.g. Forman, Butryn & Maiasse, 2016, Katterman, Kleinman & Hood, 2014 & Leahey, Crowther & Irwin, 2008). The Five Year Forward Plan for Mental Health Provision in the NHS (Mental Health Taskforce, 2016) recommends increased activity in primary care services and reduced activity in specialist services (Mental Health Taskforce, 2016). This might suggest that psychological intervention of this nature should be accessed in primary care. Given the complexity associated with obesity as well as the seriousness of WLS as an

undertaking, it might be most aptly placed in specialist obesity services. Commissioners, obesity services and NICE should work towards addressing the issue of emotionally driven eating in light of this emerging evidence base and clinical need.

5.4.2 Body Image

Participants in this study highlighted the importance of body image and relationship to self. Many hoped that their body image would improve following WLS, with potential consequences for subjective satisfaction following surgery. Wider literature indicates that the body image issues experienced by WLS candidates have clinical implications for their psychosocial functioning (Giaini et al 2013). Collectively, this highlights a possible unmet need amongst WLS candidates in the NHS.

Body compassion has been demonstrated as a target area for intervention for those wanting to improve body image (Altman et al, 2017a & Altman et al, 2017b). Possible therapeutic approaches which might be suitable for this type of work are compassion focused therapy approaches (Gilbert, 2010) and ACT (Hayes, 2004). Tools from both approaches have been demonstrated as useful for psychological intervention for body image, body compassion and weight management (Forman et al, 2016, Altman et al, 2017a & Altman et al 2017b). WLS candidates who experience difficulties with body image and fear weight regain often experience difficulties with emotionally driven eating too (Colles et al, 2008) and this was the case for some participants in this study. It might therefore be resource effective to combine body image interventions with emotional eating focused intervention. Again, this should be considered by commissioners, obesity services and NICE.

5.4.3 Subjective Outcomes

The commissioning context of WLS in the NHS means that the primary purpose of WLS is to treat obesity associated health conditions (Welbourn et al, 2014). This research indicates that whilst candidates have motives for WLS in line with this, they also have additional hopes such as emotional hopes, aesthetic hopes and relational hopes. It is important to consider the possible ethical implications of what may be a disparity between the primary aims of WLS from a commissioning perspective, and the primary aims of some WLS candidates. This means that obesity professionals may be faced with a dilemma in how they manage candidates' expectations, whilst supporting them in achieving all of their WLS hopes, not simply physical health improvement.

Whether the full range of hopes which many candidates have for WLS are actualised might impact subjective satisfaction. There is a risk that some candidates may have good objective outcomes, which inform commissioning targets, but poor subjective outcomes. Furthermore, subjective dissatisfaction could impact post-surgical coping, with consequences for long-term objective outcomes. In the financial context of budgets cuts, stretched NHS services and increasing obesity, there is no clear solution as to how candidates' subjective hopes might be better addressed. As a starting point, it would be useful for specialist obesity services to collect data on subjective outcomes to inform service development and commissioning.

5.4.4 NHS Specialist Obesity Pathways

Participants reported that the pathway to WLS was long, with different milestones to be achieved. Most came to appreciate this process as helping them to psychologically prepare for WLS. Whilst this study was not a review of obesity service pathways, this feedback is potentially useful when reviewing the nature of Tier 3 and 4 provisions. A potential area for improvement is how the mapping of service pathways is communicated to patients.

Participants in this study reported feeling unclear about what the process was from referral to WLS and that this might be more clearly illustrated. This is something that might be easily addressed through providing written information.

Accessing referrals to WLS was a key issue discussed by the participants. Similar to past research reporting the roles of GPs (Owen-Smith et al, 2016), this study highlighted variable experiences of participants' discussion about WLS with their GPs. It is difficult to ascertain what explains this variation and why one GP might decline to refer a potential candidate whilst another GP might make the referral. One possibility is that participants originally tried to access WLS prior to the introduction of the 2013 commissioning guidance (NHS Commissioning Board, 2013). In this case, the introduction of new commissioning guidance has been useful in increasing equitable access. Candidates may not be aware of this, which may feed further into any fear of loss reported by participants. Again, educating candidates on the evolving funding criteria and care pathways may therefore be warranted.

Another possibility is that GPs vary in their understanding of WLS and beliefs around obesity, weight loss and how this 'should' be achieved. Whilst further research is needed to explore this, it may be useful for specialist obesity services to consider their referring pool of GPs and whether education regarding WLS and associated issues is required. In doing so this would provide the opportunity to challenge beliefs amongst GPs that have the potential to contribute to obesity and WLS stigma and restrict access to obesity services, as well as improving the sign-posting of obesity services within community NHS settings.

5.5 Methodological Considerations

5.5.1 Participant Pool and Sample Size

A total of 37 participants registered interest in the research, however the final sample size was 11. Whilst adequate for a comprehensive TA, this may limit the generalisability of this research. One recruitment challenge was the short amount of time in between which potential participants became aware of the opportunity to partake in the research and their actual surgery date. As this study aimed to capture candidates' views prior to surgery, this meant that many willing participants were unable to meet with the researcher within the required time frame. Another reason was that the recruitment site covered a large geographical area, which meant that some interested participants were travelling long distances. As this issue became more apparent, an ethics amendment request was submitted to offer potential participants the opportunity to be interviewed over the telephone as an alternative to travelling to the research site. Unfortunately, the amendment was not processed within the required time frame and so this option was not made available to participants.

5.5.2 Participant Demographics

All but one participant identified as white British and all but two participants were female. Whilst the majority of candidates pursuing WLS in the NHS are from a white British background and more likely to be female, there are obvious limitations to the lack of diversity in the sample of this study. The results may not be representative of people who are from different ethnic backgrounds. Ethnicity is closely linked with culture, which significantly impacts the way food is consumed (Furst et al, 1996). The participant in this study who identified as black British Caribbean made reference to her Caribbean heritage, how this impacted the way food was consumed in her family, and challenges that this might pose for her in the context of WLS. These included the types of foods eaten and the understanding of family members about why this might need to change. One participant

cannot speak for all people with Caribbean heritage and as such it is difficult to say how such experiences might be similar or different for others.

Similarly, with gender, the overall findings of this study may not be representative of how men experience pursuing WLS. This is a salient issue given the gendered nature of concerns relating to body image and societal body ideals. Whilst recent years have seen an increase in such issues affecting males as well as females (Barlett, Vowels, & Saucier, 2008), the body image experiences of men accessing WLS may differ to women. This could have implications for how male candidates relate to self and weight what this means for their experience of WLS. For instance, is excess skin as much of a worry to male candidates as female candidates?

5.5.3 Research Context and Timing of Data Collection

This study was conducted in an NHS setting. There are relatively few studies capturing the experiences of NHS WLS candidates and even fewer that look specifically at pre-surgical candidates. Given the unique context of the NHS, the results of this study may not generalise to those accessing WLS privately or abroad. Equally, research in other settings may not apply to NHS WLS candidates. As such the context and timing of data collection in this study is a particular strength, contributing usefully to furthering our understanding of how candidates experience pursuing WLS in the NHS.

To ensure sample homogeneity, participants in this study were recruited once assessed by the multidisciplinary team as suitable candidates for WLS. A potential limitation of this is that through the pre-surgical assessment, participants may have been socialised into what is expected of them as WLS candidates. This may have impacted the descriptions portrayed by

participants during their research interviews. Steps were taken to assure participants that their interviews would be anonymized and that members of the professional team would not have knowledge of the answers they had personally given. Nevertheless, the possibility that participants may have given desirable answers at the expense of honesty cannot be ruled out.

5.5.4 A Qualitative Approach

This study benefited from a qualitative methodology to learn about the experiences of a group of NHS candidates at a time point in their WLS journey where little research has been completed. In light of the themes that have emerged, particularly with regard to subjective outcomes and emotionally driven eating, it would have been useful to have the addition of some quantitative measures. This might have permitted comparison of qualitative themes between different groups e.g. high emotionally driven eaters versus low emotionally driven eaters. Participants in this study will have the opportunity to be followed up post-surgically. With participant consent, some quantitative measures could be accessed through their clinical records to enhance the qualitative research process and track change over time.

5.5.5 Tool of Analysis

A mixed inductive and deductive TA was used. This broad approach can mean methodological challenges in terms of clarity on the specific steps in the analytical process and development of the coding frame. The analytical steps taken during this research have been made explicit throughout this thesis. Furthermore, additional precautions have been taken to help ensure the integrity of the story told from the analysis, such as professional validation of the thematic map. For this study, a mixed thematic approach enhanced the analytical process. An initial deductive approach meant that based on existing theoretical and clinical knowledge, the data could be analysed with a specific lens. This process was then

enriched and expanded on by data driven codes and themes via the inductive approach, ensuring that the different facets of participants' experiences were captured.

5.6 Areas for Future Research

5.6.1 Longitudinal Research

When this project was designed, it was with the intention of following participants on a longitudinal basis. This will be useful in capturing participants' experiences, sense making and behaviours as they unfold without the impact of hind sight. It may be helpful for future stages in longitudinal research to consider how they will track candidates' objective and subjective outcomes and whether there is any difference in qualitative themes between high satisfaction and low satisfaction groups, possibly aiding this through the introduction of quantitative measures.

5.6.2 Research on Specialist Obesity Staff

One of the outcomes of this study has been the integral role of specialist obesity professionals in the journeys of WLS candidates. It would be useful to explore the staff perspective on this. Questions may include their views on what might be missing from service provision and their experiences of working with WLS to manage expectations which do not align with commissioning goals. The results of research with obesity professionals might be usefully triangulated with research using WLS candidates themselves.

5.6.3 Research on Psychological Interventions

There is limited psychological intervention for WLS candidates, particularly as most do not meet the threshold for diagnosable eating disorders, despite exhibiting disordered eating behaviours. Research investigating psychological interventions addressing issues of disordered eating within an obese sample would add to the evidence base, in turn improving our understanding of best practice.

Based on the current study but also within the context of the wider literature and clinical accounts, many WLS candidates struggle with their relationship to their body with implications for confidence, body image, depression, anxiety and quality of life. This too warrants further research exploring psychological interventions along with the impact of such interventions on outcomes for WLS. Building this evidence base is crucial in reducing the current disparities in access to psychological therapies for this service-user group.

5.7 Concluding Remarks

This study sought to understand how candidates arrive at the point of pursuing WLS, their hopes and expectations for life after, and their plans and preparations, with a specific focus on NHS WLS candidates prior to surgery. In doing so it has found that for many, the pursuit of WLS goes beyond improving health conditions associated with obesity. Candidates each have a personal understanding of their relationship to weight, eating and self and their motives for surgery and subsequently plans and preparations are grounded in this.

REFERENCES

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. *Action Control* (pp. 11-39). Springer: Berlin Heidelberg.

Altman, J. K., Linfield, K., Salmon, P. G., & Beacham, A. O. (2017a). The body compassion scale: Development and initial validation. *Journal of Health Psychology*, 1-11.

Altman, J. K., Zimmaro, L. A., & Woodruff-Borden, J. (2017b). Targeting Body Compassion in the Treatment of Body Dissatisfaction: A Case Study. *Clinical Case Studies*, 16(6), 431-445.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. DAOL Discourse Analysis Online. Last accessed online 27/09/17 at URL: https://dspace.lboro.ac.uk/dspace-jspui/bitstream/2134/633/4/DA%20means%20doing%C2%A0analysis.pdf

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1 (3), 385-405.

Armstrong, S. N., Anderson, M., Le, E. T., & Nguyen, L. H. (2009). Application of the Health Belief Model to bariatric surgery. *Gastroenterology Nursing*, 32(3), 171-178.

Backholer, K., Wong, E., Freak-Poli, R., Walls, H. L., & Peeters, A. (2012). Increasing body weight and risk of limitations in activities of daily living: a systematic review and meta-analysis. *Obesity Reviews*, 13 (5), 456-468.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*, 84 (2), 191 - 215.

Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, 44 (9), 1175-1184.

Bandura, A. (1997). Chapter 7: Health Functioning, pp 259-313. *In* Self-efficacy: The Exercise of Control. Macmillan: USA.

Batsis, J. A., Clark, M. M., Grothe, K., Lopez-Jimenez, F., Collazo-Clavell, M. L., Somers, V. K., & Sarr, M. G. (2009). Self-efficacy after bariatric surgery for obesity. A population-based cohort study. *Appetite*, 52 (3), 637-645.

Barlett, C. P., Vowels, C. L., & Saucier, D. A. (2008). Meta-analyses of the effects of media images on men's body-image concerns. *Journal of Social and Clinical Psychology*, 27(3), 279-310.

Beck, N. N., Mehlsen, M., & Støving, R. K. (2012). Psychological characteristics and associations with weight outcomes two years after gastric bypass surgery: postoperative eating disorder symptoms are associated with weight loss outcomes. *Eating Behaviors*, 13(4), 394-397.

Bocchieri, L. E., Meana, M., & Fisher, B. L. (2002). Perceived psychosocial outcomes of gastric bypass surgery: A qualitative study. *Obesity Surgery*, 12 (6), 781-788.

Boyatzis, R. E. (1998). Transforming qualitative information: Thematic analysis and code development. California: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

Brennan, L., & Binney, W. (2010). Fear, guilt, and shame appeals in social marketing. *Journal of Business Research*, 63(2), 140-146.

Brown, I., & Gould, J. (2013). Qualitative studies of obesity: a review of methodology. *Health*, 5(8C), 69-80.

Centre for Disease Control & Prevention. (2015). About Child and Teen BMI. Last accessed 01/08/2018 at URL: https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

Chang, V. W., & Christakis, N. A. (2002). Medical modelling of obesity: a transition from action to experience in a 20th century American medical textbook. *Sociology of Health & Illness*, 24(2), 151-177.

Charmaz, K. (2008). Constructionism and the Grounded Theory Method. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research* (pp.397-412). New York, US: The Guildford Press.

Colles, S. L., Dixon, J. B., & O'brien, P. E. (2008). Grazing and loss of control related to eating: two high-risk factors following bariatric surgery. *Obesity*, 16(3), 615-622.

Cooper, C. (2010). Fat studies: Mapping the field. *Sociology Compass*, 4(12), 1020-1034.

Cordain, L. Eaton, S. B., Sebastian, A., Mann, N., Lindeberg, S., Watkins, B. R., O'Keefe, J. H. & Brand-Miller, J. (2005). Origins and evolution of the Western diet: health implications for the 21st century. *The American Journal of Clinical Nutrition.* 81 (2), 341-354.

Coulman, K. D., MacKichan, F., Blazeby, J. M., & Owen-Smith, A. (2017). Patient experiences of outcomes of bariatric surgery: a systematic review and qualitative synthesis. *Obesity Reviews*, 18(5), 547-559.

Courneya, K. S., Plotnikoff, R. C., Hotz, S. B., & Birkett, N. J. (2001). Predicting exercise stage transitions over two consecutive 6-month periods: A test of the theory of planned behaviour in a population-based sample. *British Journal of Health Psychology*, 6(2), 135-150.

Critical Appraisal Skills Programme (2018). CASP: Qualitative Checklist. Last accessed 22/05/2018 at URL: https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-Download.pdf

Crook, M. A. (2003). The Caldicott report and patient confidentiality. *Journal of Clinical Pathology*. 56, 426-428.

da Silva, S. S. P., & da Costa Maia, Â. (2012). Obesity and treatment meanings in bariatric surgery candidates: a qualitative study. *Obesity Surgery*, 22(11), 1714-1722.

Department of Health. (1999a). Patient and public involvement in the new NHS. London: Department of Health.

Department of Health. (1999b). Research and development for a first class service. London: Department of Health.

DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. *Motivational interviewing: Preparing People for Change*, 2, 201-216.

Dittmar, H., & Howard, S. (2004). Thin-ideal internalization and social comparison tendency as moderators of media models' impact on women's body-focused anxiety. *Journal of Social and Clinical Psychology*, 23(6), 768-791.

Dixon, J. B., Laurie, C. P., Anderson, M. L., Hayden, M. J., Dixon, M. E., & O'brien, P. E. (2009). Motivation, readiness to change, and weight loss following adjustable gastric band surgery. *Obesity*, 17(4), 698-705.

Elder, K. A., & Wolfe, B. M. (2007). Bariatric surgery: a review of procedures and outcomes. *Gastroenterology*, 132(6), 2253-2271.

Elliott, R., Fischer, C.T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Wiklund, M., Olsén, M. F., Lönroth, H., & Forsberg, A. (2011). The meaning of awaiting bariatric surgery due to morbid obesity. *The Open Nursing Journal*, 5, 1.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5 (1), 80-92.

Flaxman, P. E., Blackledge, J. T. & Bond, G. W. (2011). Acceptance and Commitment Therapy. Routledge: East Sussex.

Furst, T., Connors, M., Bisogni, C. A., Sobal, J. & Falk, L. W. (1996). Food choice: a conceptual model of the process. *Appetite*, 26 (3), 247-266.

Ganley, R. M. (1989). Emotion and eating in obesity: A review of the literature. International *Journal of Eating Disorders*, 8(3), 343-361.

Gariepy, G., Nitka, D., & Schmitz, N. (2010). The association between obesity and anxiety disorders in the population: a systematic review and meta-analysis. *International Journal of Obesity*, 34(3), 407.

Gatineau, M., & Dent, M. (2011). Obesity and Mental Health. Oxford: National Obesity Observatory.

Gee, J. P. (2004). An introduction to discourse analysis: Theory and method. Routledge.

Gianini, Loren M., Marney A. White, and Robin M. Masheb. (2013). Eating pathology, emotion regulation, and emotional overeating in obese adults with binge eating disorder. *Eating Behaviors* 14, 309-313.

Gibbons, L. M., Sarwer, D. B., Crerand, C. E., Fabricatore, A. N., Kuehnel, R. H., Lipschutz, P. E., & Wadden, T. A. (2006). Previous weight loss experiences of bariatric surgery candidates: how much have patients dieted prior to surgery? *Obesity*, 14 (S3).

Gilbert, P. (2010). Compassion focused therapy: Distinctive features. Routledge.

Glaser, B. G. & Strauss, A. L. (1967). The Discovery of Grounded Theory: Strategies, for Qualitative Research. Chicago: Aldine.

Grammas, D. L., & Schwartz, J. P. (2009). Internalization of messages from society and perfectionism as predictors of male body image. *Body Image*, 6 (1), 31-36.

Guest, G.S., MacQueen, K. M., & Namey, E. E. (2012). Applied thematic analysis. Thousand Oaks: Sage Publications.

Guh, D. P., Zhang, W., Bansback, N., Amarsi, Z., Birmingham, C. L., & Anis, A. H. (2009). The incidence of co-morbidities related to obesity and overweight: A systematic review and meta-analysis. *BMC Public Health*, 9 (1), 1.

Gustavsson, S., & Westling, A. (2002, June). Laparoscopic adjustable gastric banding: complications and side effects responsible for the poor long-term outcome. In Seminars in laparoscopic surgery, 9 (2), 115-124. Sage CA: Thousand Oaks, CA: Sage Publications.

Hancock, J., Jackson, S., & Johnson, A. (2016). The Reasons for Disclosing (or Not) Laparoscopic Adjustable Gastric Banding Surgery and the Impact on Long-Term Weight Loss.

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy*, 35(4), 639-665.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1-25.

Harper, D. (2012). Choosing a Qualitative Research method. In Harper, D. & Thompson, A. R (Eds). Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.

Hochbaum, G., Rosenstock, I., & Kegels, S. (1952). Health belief model. United States Public Health Service.

Homer, C. V., Tod, A. M., Thompson, A. R., Allmark, P. & Goyder, E. (2016). Expectations and patients' experiences of obesity prior to bariatric surgery: a qualitative study. *British Medical Journal,* 6(2), e009389.

Javadi, M., & Zarea, K. (2016). Understanding thematic analysis and its pitfall. *Journal of Client Care*, 1(1), 33-39.

Joffe, H. (2012). Thematic analysis. *In* Harper, D. & Thompson, A. R (Eds). Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners (pp. 209-23).

Joint Commissioning Panel. (2013). Guidance for Commissioners of Eating Disorder Services. Last accessed 07/05/18 at URL: https://www.jcpmh.info/resource/guidance-commissioners-eating-disorder-services/

Katterman, S. N., Kleinman, B. M., Hood, M. M., Nackers, L. M., & Corsica, J. A. (2014). Mindfulness meditation as an intervention for binge eating, emotional eating, and weight loss: A systematic review. *Eating Behaviors*, 15, 197-204.

Keys, A., Fidanza, F., Karvonen, M. J., Kimura, N., & Taylor, H. L. (1972). Indices of relative weight and obesity. *Journal of Chronic Diseases*. 25 (6–7), 329–43.

Kirk, S. F., Penney, T. L. & McHugh, T. L. (2010). Characterizing the obesogenic environment: the state of the evidence with directions for future research. *Obesity Reviews*, 11 (2), 109-117.

Kitzinger, H. B., Abayev, S., Pittermann, A., Karle, B., Bohdjalian, A., Langer, F. B. & Frey, M. (2012). After massive weight loss: patients' expectations of body contouring surgery. *Obesity Surgery*, 22 (4) 544-548.

Kluever Romo, L. & Dailey, R. M. (2014). Weighty dynamics: Exploring couples' perceptions of post-weight-loss interaction. *Health Communication*, 29 (2), 193-204.

Kunda, Z. (1990). The case for motivated reasoning. *Psychological Bulletin*, 108(3), 480.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense of interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102 – 120. doi:10.1191/1478088706qp062oa

Leahey, T. M., Crowther, J. H., & Irwin, S. R. (2008). A cognitive-behavioral mindfulness group therapy intervention for the treatment of binge eating in bariatric surgery patients. *Cognitive and Behavioral Practice*, 15(4), 364-375.

LeMont, D., Moorehead, M. K., Parish, M. S., Reto, C. S., & Ritz, S. J. (2004). Suggestions for the pre-surgical psychological assessment of bariatric surgery candidates. *American Society for Bariatric Surgery*, 129.

Loaisa, A. J., Carrillo, V. J. B., Coll, D. G. C., & Gimeno, E. C. (2015). Psychosocial effects of surgery and physical activity in bariatric patients: a systematic review. *European Journal of Human Movement*, 35, 12-33.

Lloyd, F. M. M., Hewison, A., & Efstathiou, N. (2017). "It just made me feel so desolate": Patients' narratives of weight gain following laparoscopic insertion of a gastric band. *Journal of Clinical Nursing*, 27(3-4), 732-742.

Luppino, F. S., de Wit, L. M., Bouvy, P. F., Stijnen, T., Cuijpers, P., Penninx, B. W., & Zitman, F. G. (2010). Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. *Archives of General Psychiatry*, 67(3), 220-229.

Lustig, R. H., Schmidt, L. A. & Brindis, C. D. (2012). Public health: the toxic truth about sugar. *Nature*, 482, 27-29.

Lynch, A. (2016). "When the honeymoon is over, the real work begins:" Gastric bypass patients' weight loss trajectories and dietary change experiences. *Social Science & Medicine*, 151, 241-249.

Maier, S. F., & Seligman, M. E. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General*, 105(1), 3.

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, 13 (6), 522-525.

Martin, L. M., Espel-Huynh, H. M., Marando-Blanck, S., Evans, B. C., Forman, E. M., Butryn, M. L., & Herbert, J. D. (2017). Trusting homeostatic cues versus accepting hedonic cues: A randomized controlled trial comparing two distinct mindfulness-based intervention components. *Journal of Contextual Behavioral Science*, 6(4), 409-417.

Mays, N. B. & Pope, C. C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, 320, 49-52.

McCormick, B., Stone, I., & Corporate Analytical Team. (2007). Economic costs of obesity and the case for government intervention. *Obesity Reviews*, 8, 161–164.

McLaren, L. (2007). Socioeconomic status and obesity. *Epidemiologic Reviews*, 29(1), 29-48.

McLeod, J. (2001). Qualitative research in counseling and psychotherapy. London: Sage

Mental Health Taskforce. (2016). The Five Year Forward View for Mental Health. Last accessed 07/05/2018 at URL: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Mitchell, J. E., Crosby, R. D., Ertelt, T. W., Marino, J. M., Sarwer, D. B., Thompson, J. K., ... & Howell, L. M. (2008). The desire for body contouring surgery after bariatric surgery. *Obesity Surgery*, 18(10), 1308.

Nash, M., & Warin, M. (2017). Squeezed between identity politics and intersectionality: A critique of 'thin privilege'in Fat Studies. *Feminist Theory*, 18(1), 69-87.

National Institute of Clinical Excellence. (2014). *Obesity: Identification, Assessment & Management* (CG189).

National Institute for Health and Clinical Excellence. (2017). Eating Disorder Recognition and Treatment. Last accessed 17/05/2018 at URL: https://www.nice.org.uk/guidance/ng69/resources/eating-disorders-recognition-and-treatment-pdf-1837582159813

National Obesity Forum. (2009). National Obesity Forum Obesity Model. Last accessed 22/05/2018 at URL: http://www.nationalobesityforum.org.uk/media/PDFs/NOFobesitystrategynewformat.pdf

National Statistics. (2015). Health Survey for England 2014. Last accessed 22/05/2018 at URL: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2014

Neff, K. D. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2, 85–101.*

Newson, L. & Flint, B. (2011). Applied Psychology and Obesity Management. *Obesity in the Uk: A Psychological Perspective*: British Psychological Society.

NHS Choices. (2015). Britain: 'the fat man of Europe'. Last accessed 07/11/16 at URL: http://www.nhs.uk/Livewell/loseweight/Pages/statistics-and-causes-of-the-obesity-epidemic-in-the-UK.aspx

NHS Choices. (2016). *Treating Obesity*. Last accessed 25/10/16 at URL: http://www.nhs.uk/Conditions/Obesity/Pages/Treatment.aspx

NHS Choices, (2017). Weight loss surgery: types. Last accessed 15/12/2017 at URL: https://www.nhs.uk/conditions/weight-loss-surgery/types/

NHS Commissioning Board, (2013). Clinical Commissioning Policy: Complex and Specialised Obesity Surgery. London. Last accessed 15/12/17 at URL: https://www.england.nhs.uk/wp-content/uploads/2016/05/appndx-6-policy-sev-comp-obesity-pdf.pdf

NHS England. (2016). Commissioning Guidance to support devolution to CCGs of Adult Obesity surgical services in 2016/17. NHS England Specilaised Commissioning: London. Last accessed 04/02/2018 at URL: https://www.england.nhs.uk/wp-content/uploads/2016/05/devolved-services-ccg-guid-obesity.pdf

Novemsky, N., & Kahneman, D. (2005). How do intentions affect loss aversion? *Journal of Marketing Research*, 42(2), 139-140.

Nuttall, F. Q. (2015). Body mass index: obesity, BMI, and health: a critical review. *Nutrition Today*, 50(3), 117.

O'Brien, K. S., Latner, J. D., Ebneter, D., & Hunter, J. A. (2013). Obesity discrimination: the role of physical appearance, personal ideology, and anti-fat prejudice. *International Journal of Obesity*, 37(3), 455-460.

Ogden, J. (2003). Some problems with social cognition models: a pragmatic and conceptual analysis. *Health Psychology*, 22(4), 424.

Ogden, J., Avenell, S., & Ellis, G. (2011). Negotiating control: patients' experiences of unsuccessful weight-loss surgery. *Psychology & Health*, 26(7), 949-964.

Ogden, J., & Hills, L. (2008). Understanding sustained behavior change: the role of life crises and the process of reinvention. *Health*. 12(4), 419-437.

Oliveira, D. M. D., Merighi, M. A. B., & Jesus, M. C. P. D. (2014). The decision of an obese woman to have bariatric surgery: the social phenomenology. *Revista da Escola de Enfermagem da USP*, 48(6), 970-976.

Ortiz, S. E., Kawachi, I., & Boyce, A. M. (2017). The medicalization of obesity, bariatric surgery, and population health. *Health*. 21(5), 498-518.

Owen-Smith, A., Donovan, J., & Coast, J. (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study. *Journal of Public Health*, 39(1), 163-169.

Owers, C., Halliday, V., Saradjian, A., & Ackroyd, R. (2017). Designing pre-bariatric surgery education: The value of Patients' experiences. *Journal of Diabetes Nursing*, 21(4), 119-125.

Oxford English Dictionary (2017). Last accessed online 03/08/2017 at URL: https://en.oxforddictionaries.com/definition/obesity

Oxford Dictionary (2018). Last accessed 14/05/2018 at URL: https://en.oxforddictionaries.com/definition/self

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In *Treating Addictive Behaviors* (pp. 3-27). Springer US.

Park, J. (2016). Self-determination and motivation for bariatric surgery: a qualitative study. *Psychology, Health & Medicine*, 21(7), 800-805.

Pfeil, M., Pulford, A., Mahon, D., Ferguson, Y., & Lewis, M. P. (2013). The patient journey to gastric band surgery: a qualitative exploration. *Bariatric Surgical Practice and Patient Care*, 8(2), 69-76.

Pfeil, M., Crozier, K., Pulford, A., Ferguson, Y., Mahon, D., & Lewis, M. (2014. Living with a Gastric Band: A Qualitative Study. *Healthcare*, 2 (1), 47- 59.

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: important considerations for public health. *American Journal of Public Health*, 100 (6), 1019-1028.

Riessman, C. K. (2005). Narrative analysis. University of Huddersfield.

Ritchie, J., Lewis, J, McNaughton., Nicholls, C., & Ormston, R. (2003). Qualitative Research Practice. (2nd Ed.). London: Sage Publications.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological monographs: *General and Applied*, 80(1), 1.

Rubin, H. J., & Rubin, I. S. (2011). Qualitative interviewing: The art of hearing data. London: Sage.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68.

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative research. *Qualitative Health Research*, 13 (7), 905-923.

Sarafino, E. P. (2006). Health Psychology: Biopsychosocial Interactions. Wiley: London

Schunk, D. H., & Carbonari, J. P. (1984). Self-efficacy model. Behavioral Health: A handbook of health enhancement and disease prevention.

Scott, K. M., Bruffaerts, R., Simon, G. E., Alonso, J., Angermeyer, M., de Girolamo, G., ... & Kessler, R. C. (2008). Obesity and mental disorders in the general population: results from the world mental health surveys. *International Journal of Obesity*, 32(1), 192-200.

Smith, J. A., & Osborn, M. (2004). Interpretative phenomenological analysis (pp. 229-254). The British Psychological Society and Blackwell Publishing Ltd.

Sogg, S., & Gorman, M. J. (2008). Interpersonal changes and challenges after weight-loss surgery. *Primary Psychiatry*, 15 (8), 61-66.

Spencer, L. & Ritchie, J. (2012). In pursuit of quality. *In* Harper, D. & Thompson, A. R (Eds). Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners (pp. 227-242).

Starks, H. & Brown-Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, 17, 1372-1380.

Throsby, K. (2007). "How could you let yourself get like that?": Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine*, 65(8), 1561-1571.

Throsby, K. (2008). Happy re-birthday: Weight loss surgery and the new me'. *Body & Society*, 14(1), 117-133.

Tack, J., & Deloose, E. (2014). Complications of bariatric surgery: dumping syndrome, reflux and vitamin deficiencies. *Best Practice & Research Clinical Gastroenterology*, 28(4), 741-749.

Thompson, R. A & Harper, D. (2012). Introduction. *In* Harper, D. & Thompson, A. R (Eds). Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners (pp. 3-9).

Tweed, A., & Charmaz, K. (2012). Grounded theory methods for mental health practitioners. Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners, 131-146.

Van Amsterdam, N. (2013). Big fat inequalities, thin privilege: An intersectional perspective on 'body size'. *European Journal of Women's Studies*, 20(2), 155-169.

Viken, R. J., Treat, T. A., Bloom, S. L., & McFall, R. M. (2005). Illusory correlation for body type and happiness: Covariation bias and its relationship to eating disorder symptoms. *International Journal of Eating Disorders*, 38(1), 65-72.

Wallston, B. S., Wallston, K. A., Kaplan, G. D., & Maides, S. A. (1976). Development and validation of the health locus of control (HLC) scale. *Journal of Consulting and Clinical Psychology*, 44(4), 580.

Wardle, J., & Cooke, L. (2005). The impact of obesity on psychological well-being. *Best Practice & Research Clinical Endocrinology & Metabolism*, 19(3), 421-440.

Weineland, S., Arvidsson, D., Kakoulidis, T. P., & Dahl, J. (2012). Acceptance and commitment therapy for bariatric surgery patients, a pilot RCT. *Obesity Research & Clinical Practice*, 6(1), e21-e30.

Weineland, S., Hayes, S. C., & Dahl, J. (2012). Psychological flexibility and the gains of acceptance-based treatment for post-bariatric surgery: six-month follow-up and a test of the underlying model. *Clinical Obesity*, 2(1-2), 15-24.

Welbourn, R., Small, P., Finlay, I., Screela, A., Somers, S., Mahawar, K., Walton, P. & Linsman, R. (2014). Second Registry Report: United Kingdom Bariatric Surgery Registry.

Wells. (2011). Narrative inquirey: Pocket Guides to Social Work Research. Oxford University Press: London.

Westbrook, D. Kennerley, H., & Kirk, J. (2011). An introduction to cognitive behaviour therapy: Skills and applications. Sage: London.

Wimmelamnn, C. L., Dela, F., & Mortensen, E. L. (2013). Psychological predictors of weight loss after bariatric surgery: A review of the recent research. *Obesity Research & Clinical Practice*, 8 (4), 299-313.

Wood, K. V., & Ogden, J. (2015). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study. *Journal of Health Psychology*, 21(11), 2447-2456.

World Health Organdiation, (2017). Obesity and Over Weight: Key Facts. Last accessed 22/05/2018 from URL: http://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

World Health Organisation, (2003). Controlling the global obesity epidemic. Last accessed 14/12/17 from URL: http://www.who.int/nutrition/topics/obesity/en/

Wysoker, A. (2005). The lived experience of choosing bariatric surgery to lose weight. *Journal of the American Psychiatric Nurses Association*, 11(1), 26-34.

APPENDIX A

Systematic Literature Review Process

The systematic literature review followed on from the introduction and overview of the relevant theory presented in chapter 1. The following steps were involved:

Step one: Identify topic for systematic literature review

Based on chapter 1, the focus of the systematic literature review was on the processes impacting and informing candidates' decision to have weight loss surgery, as well as their preparation and planning for life following surgery. As the NHS is a unique context for weight loss surgery with specific criteria guiding commissioning and referrals, UK based research was focused on.

Step two: Identify inclusion and exclusion criteria

Inclusion and exclusion criteria were chosen to focus the scope of the review on the topics of interest and are presented in Table A1.

Table A1: *Inclusion and Exclusion Criteria for Systematic Literature Review*

Inclusion Criteria	Exclusion Criteria
Research on adults aged 18 or over who are having or have had weight loss surgery.	None NHS based research.
Research that attempts to understand why candidates pursue weight loss surgery.	Research on candidates who are having/ had privately funded weight loss surgery.
Research that attempts to understand candidates' knowledge, understanding and preparation for weight loss surgery and life afterwards.	Research on adolescents.
Research that attempts to understand candidates' hopes and expectations for weight loss surgery.	
Research that attempts to understand how weight loss surgery candidates plan and prepare for lifestyle change.	

Step three: Identify search concepts

A number of different search terms were experimented with to gain a sense of what yielded the highest number of results. To ensure that studies were not missed, different synonyms were substituted. For instance, the word "hope" was substituted for the word "expectation". Final search terms and combinations are listed in table A2.

Table A2: *Search Terms for Systematic Literature Review*

	"Bariatric surgery"	"Weight loss surgery"
Decision	*N* = 1077	*N* = 79
Preparation	*N* = 347	*N* = 34
Expectation	*N* = 202	*N* = 29
Experience	*N= 2858*	*N= 181*

Step four: Identify search sources

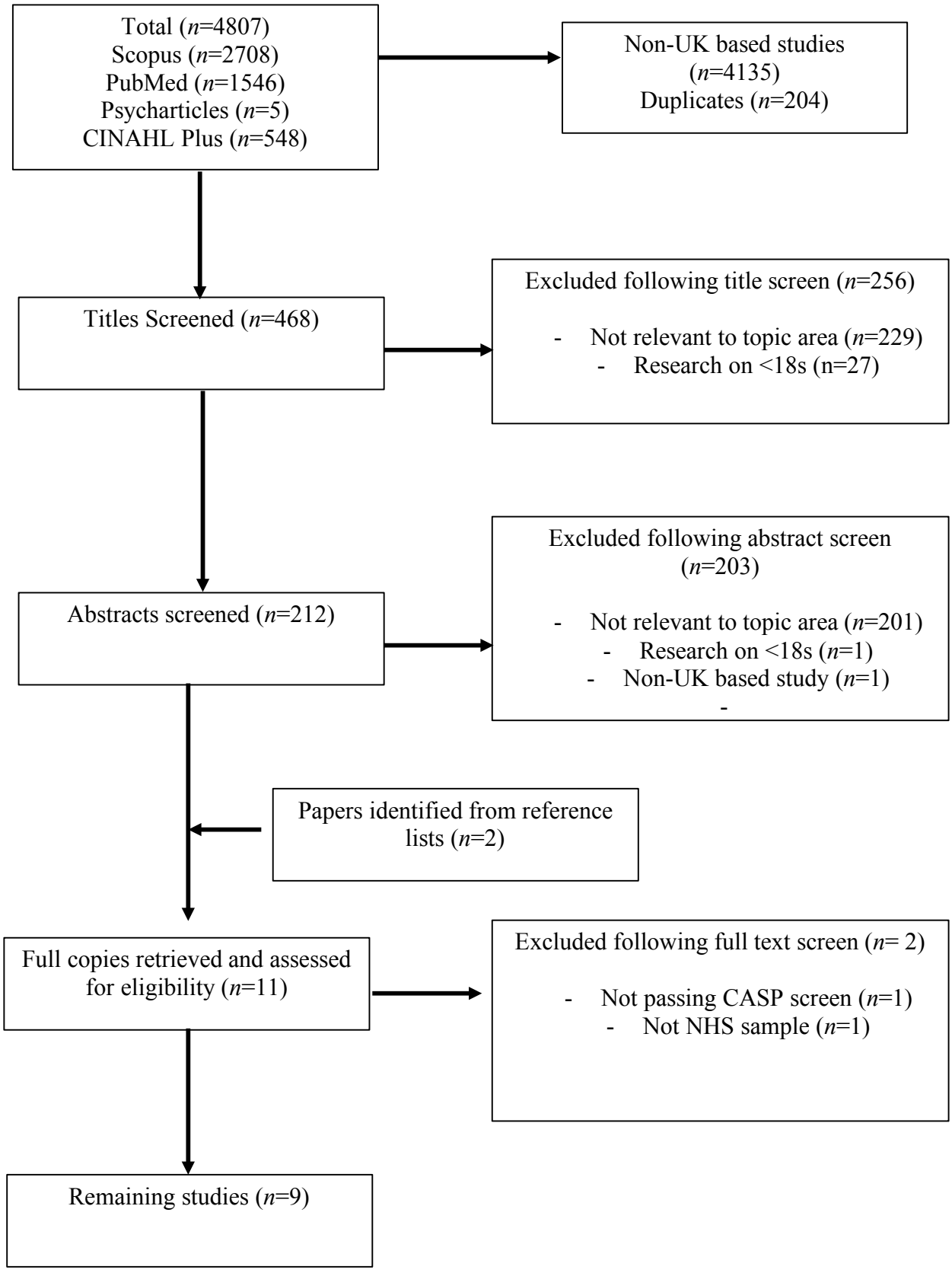
The below sources were selected for the systematic literature review. These were chosen with a view to capturing a broad range of psychological and medical literature pertaining to the topics of interest.

- Scopus
- PubMed
- Psycharticles
- CINAHL Plus

Step five: Identify and screen articles

The sources identified in step four were searched using the terms outlined in step three. The process of article selection and exclusion is outlined in Figure A below. As part of the review process, the reference list of any studies identified for full copy retrieval were also scanned for potentially relevant articles. In this instance, two further studies were identified (Ogden & Hills, 2008 & Throsby, 2008), although only one of these made the final systematic review (see step 7 for further details on this).

Figure A: Flow Diagram of Systematic Review Process



Step six:

The quality of studies included in the systematic review was evaluated against two sets of criteria. All studies identified for inclusion in the systematic review were qualitative and so criteria for assessing the quality of qualitative research was used. The first set of criteria was the Critical Appraisal Skills Programme (CASP) qualitative research screen. This consists of a series of tick box questions, allowing for a swift and initial evaluation of each study:

- Was there a clear statement of the aims of the research?
- Is a qualitative methodology appropriate?
- Is it worth continuing?
- Was the recruitment strategy appropriate to the aims of the research?
- Was the data collected in a way that addressed the research question?
- Has the relationship between researcher and participants been adequately considered?
- Have ethical issues been taken into consideration?
- Was the data analysis sufficiently rigorous?
- Is there a clear statement of findings?
- How valuable is the research?

The results of the CASP initial screen are presented in the review table in Appendix B. If the CASP screen highlighted studies without clear aims, inappropriate use of qualitative methodology or any other significant methodological issues, these studies would have been excluded further from the systematic review, in this case two studies (Throsby, 2008 & Hancock, Jackson & Johnson, 2016).

In the case of Throsby's (2008) study, upon inspection of the paper, it was less a research study and more a narrative account based on the discourse analysis of other research. It provides a potentially useful insight into the socio-political discourses which underpin weight loss surgery. In addition, it aided my own pre-emptive thinking around how weight loss surgery candidates might experience their bodies within the context of their pursuit of weight loss surgery. For example, it highlighted the many paradoxes that emerge through weight loss surgery such as the pursuit of an extraordinary measure in the pursuit of having a more ordinary body or the need to both listen to the body and at the same time control it. These were all ideas which impacted my thinking as I designed the research interview schedule.

Throsby's (2008) paper was not presented as a traditional research study, making systematic evaluation difficult. From the information available it was not possible to determine the ratio of NHS to privately funded candidates used in the research underpinning Throsby's (2008) paper. With this and the violation of CASP criteria, the paper was therefore excluded. Similarly, it could not be determined whether an NHS based sample was used in Hancock et als (2016) study and nor was it clear whether some key methodological issues had been addressed. For instance, there was no reference to ethics. This study was therefore also excluded from the final systematic literature review.

Step seven

Each study included in the final systematic review was evaluated against questions and criteria for assessing qualitative research outlined by Mays and Pope (2000) (see appendix C for review table). These questions and criteria were chosen as they are specific to qualitative research in health care settings, as in the present study, and are outlined below:

Table A3: *Questions & Criteria for Evaluating Qualitative Research in Health Care Settings (Mays & Pope, 2000)*

Question/ criteria	**Description**
Worth or relevance	Was the study worth doing? Has it contributed usefully to knowledge?
Clarity of research question	Was the research question clear either at the beginning of the study or by the end? Was the researcher able to set aside their preconceptions?
Appropriateness of design	Would a different method have been more appropriate?
Context	Is the context/ setting described allowing for the reader to relate the findings to other settings?
Sampling	Did the sample include the full range of possible cases or settings so that conceptual generalisations could be made? Were appropriate efforts made to obtain data by extending the sample that might contradict or modify the analysis?
Data collection & analysis	Were the data collection and analysis procedures systematic? Is enough information available so that someone else could repeat each stage in the analysis? Did the analysis incorporate all observations? Did the analysis identify categories and concepts which capture and explain key processes and observations? Was it possible to follow the thread between the data and explanations for the data? Did the researcher search for disconfirming cases?
Reflexivity	Did the researcher self-consciously assess the likely impact of the methods used on the data obtained? Was sufficient data included in the accounts of the study to allow the reader to assess whether analytical criteria had been met?

Step Eight

After each study had been evaluated, a summary of the main features and findings of each study was created and put into a review table (see appendix D).

APPENDIX B

Table B1: *Systematic Literature Review CASP Initial Screening*

	Clear aims?	**Qualitative methods appropriate?**	**Appropriate recruitment strategy?**	**Data collection method addresses research issue?**	**Relationship between researcher and participants adequately considered?**	**Ethical issues considered?**	**Data analysis sufficiently rigorous?**	**Findings clear?**	**How valuable is the research?**
Homer et al (2016). Expectations and patients' experiences of obesity prior to bariatric surgery.	✓	✓	✓	✓	?	✓	✓	✓	✓
Owers et al (2017). Designing pre-bariatric surgery education: the value of patient experience.	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Clear aims?	Qualitative methods appropriate?	Appropriate recruitment strategy?	Data collection method addresses research issue?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Findings clear?	How valuable is the research?
Owen et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study.	✓	✓	✓	✓	?	✓	✓	?	✓
Pfeil et al (2013). The patient journery to gastric band surgery: A qualitative exploration.	✓	✓	✓	✓	?	✓	✓	✓	✓

	Clear aims?	Qualitative methods appropriate?	Appropriate recruitment strategy?	Data collection method addresses research issue?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Findings clear?	How valuable is the research?
Throsby (2008). Happy re-birthday: Weight loss surgery and the 'new me'.	?	✓	✓	✓	?	?	?	✓	✓
Pfeil et al (2014). Living with a gastric band: A qualitative study.	✓	✓	✓	✓	?	✓	✓	✓	✓
Ogden et al (2011). Negotiating control: Patients' experiences of unsuccessful weight loss surgery.	✓	✓	✓	✓	?	✓	✓	✓	✓

	Clear aims?	Qualitative methods appropriate?	Appropriate recruitment strategy?	Data collection method addresses research issue?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Findings clear?	How valuable is the research?
Wood & Ogden (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study.	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Clear aims?	Qualitative methods appropriate?	Appropriate recruitment strategy?	Data collection method addresses research issue?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Findings clear?	How valuable is the research?
Lloyd et al (2017). It just made me feel so desolate: Patients' narratives of weight gain following laparoscopic insertion of gastric band.	✓	✓	✓	✓	?	✓	✓	✓	✓
Ogden & Hills, (2008). Understanding sustained behaviour change: The role of life crises and the process of reinvention.	✓	✓	✓	✓	?	✓	✓	✓	✓

	Clear aims?	Qualitative methods appropriate?	Appropriate recruitment strategy?	Data collection method addresses research issue?	Relationship between researcher and participants adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Findings clear?	How valuable is the research?
Hancock et al, (2016). The reasons for disclosing (or not) laparoscopic adjustable gastric banding surgery and the impact on long-term weight loss	✓	✓	✓	✓	?	?	?	✓	✓

✓Yes ? = Can't Tell X = No

APPENDIX C

Table C1: *Systematic Literature Review Detailed Study Evaluation Based on Mays and Pope criteria (2000)*

	Worth/ relevance	**Clarity of research question**	**Appropriateness of design**	**Context**	**Sampling**	**Data collection & analysis**	**Reflexivity**
Homer et al (2016). Expectations and patients' experiences of obesity prior to bariatric surgery.	This study was one of the first of its kind in the UK and has made a worthwhile contribution to forming a platform of evidence which can be built upon in improving weight loss surgery services in the NHS.	Clear research aims were stated from the onset: (1) To understand the experiences and expectations of people seeking weight loss surgery in England. (2) To identify implications for behavioural and self-management interventions. The researchers were not explicit about any preconceptions that they may have held, therefore it	Given the exploratory nature of the research aims and that they were centered on understanding the experiences of weight loss surgery candidates, a qualitative design was appropriate. In this instance an alternative design would not have been more appropriate.	The context of the study is adequately described in terms of time, location and relevant commissioning guidance at the time. This permits the reader to understand how the findings of the study may or may not be generalised to other settings.	Information was provided on the age, gender, relationship status, self-reported physical comorbidities and employment status of participants. On the whole, the sample was representative of the population who access weight loss surgery in the UK. Only 4 men participated in the study, the authors acknowledge the low number	The data collection and analysis of this study were sufficiently described and would allow for study replication. A clear narrative to the themes was provided along with supporting quotes. The authors also reported on contradictory results. For example, some participants reported X	The authors do not explicitly assess the impact of the methods on data collection, nor do they state their position with regards to epistemology or pre-existing ideas. Despite this, there is an implicit sense of the authors positioning and thinking around methodological considerations, such as with their decision to include modified photovoice methodology to help generate

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
		cannot be ascertained whether the researchers were able to set these aside and/or reflect on these.			relative to women whilst contextualizing this in the fact that less men have weight loss surgery as a whole. No information was collated on the ethnic background of participants.	whilst others said Y.	discussion during research interviews and triangulate data.
Owers et al (2017). Designing pre-bariatric surgery education: the value of patient experience.	This study contributed to an understanding of what candidates felt unequipped to manage post-surgically.	The research aims were stated early on: To use qualitative research to inform the design of a pre-surgical intervention.	A qualitative method was appropriate, however the researchers may have found additional benefits in using a focus group rather than 1-1 interviews.	The context of this study is adequately described in terms of NHS service and time. Limited however, is information on the pre-surgical support and preparation that the participants would have received at the	Appropriate sampling methods were used and the characteristics of the sample were reported to be representative of the weight loss surgery population.	Data collection and analysis is appropriate and adequately described. However, only information pertaining to themes that the researchers had not anticipated was reported in any detail in this write up.	The researcher briefly reflects on their position as a doctor within the NHS service which potential participants have previously accessed. The write up is grounded in the researchers' clinical positioning

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
				time of their surgery. This makes it difficult to compare this sample with the current research.			within a bariatric NHS service. Whilst this may add to the clinical applications of the research there is no explicit discussion as to the potential biases that may occur as a result of this.
Owen et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study.	The study was useful in shedding light on and understanding weight loss surgery candidates' experiences in liaising with their GP in the pursuit of weight loss surgery.	The aim of the research were clear. However, based on how information was presented in the introduction, I was left wondering whether the authors held a particular political position or pre-conceived ideas and whether this did	Whilst there is definite utility in employing a qualitative longitudinal design to understand patient experiences as they move towards weight loss surgery, a longitudinal design was not necessary to answer the research aims/ question. The findings from a	The context is adequately described in terms of NHS service and time. More information on how many times patients had accessed their GP with regards to weight management/ associated health problems would	The sampling methods used were appropriate in light of the research question, however a lack of information was reported on the ethnicity of participants. The sampling approach taken for interviewing clinicians	Data collection and analysis procedures were clearly reported. Based on what was reported both seem systematic and would allow for replication.	The study lacked information which might evidence reflexivity. In addition contradictory results were not reported so it is difficult to know whether this is simply because none were found or if these were excluded.

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
	Unfortunately, the research did not expand this understanding to other areas of the pre-surgical pathway which may be useful in understanding patient decision making, planning and preparation.	or did not impact data collection and interpretation.	longitudinal point of view were reported only sparingly.	have added to the research and of been useful in terms of understanding the context.	seemed excessive relative to their rationale for interviewing clinicians and given that almost nothing was reported on the outcomes of these interviews.		
Pfeil et al (2013). The patient journery to gastric band surgery: A qualitative exploration.	This study was both relevant and worthwhile. It was the 1st NHS based study and one of the 1st world wide to interview weight loss surgery candidates pre-operatively to understand their views and experiences of people preparing	The research aims are clearly defined and presented early on in the write up of the research: To explore the views and experiences of obese people preparing for gastric band surgery.	The chosen design and method was appropriate to the research question and it is unlikely that another approach would have improved on the chosen design.	The context and setting for the research is adequately described, including a sense of professional support in preparing for surgery. This enables the reader to gain a sense of how the findings may or may not be generalised.	Appropriate sampling methods were used. The researchers decided to restrict the sample to weight loss surgery candidates who were having gastric band only so as to ensure homogeneity, however this also might	Data collection and analysis was described and reported in a systematic way allowing for the replication of research. Clear information on validity checks was included. Different and contradictory	The authors clearly state their epistemological position however there is limited explicit information on prior assumptions and how this may impact the research. There is some evidence of reflection throughout the research process,

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
	for weight loss surgery.				significantly impact the generalisability of any findings, including to people having other types of weight loss surgery.	results are reported.	for instance considering the fear of loss candidates may have around surgery and how this may impact the data collection and their relationship to the researcher.
Pfeil et al (2014). Living with a gastric band: A Qualitative study.	This study was both relevant and worthwhile. Following on for a previous study (Pfeil et al, 2013), this study is the first NHS based study to utilise a qualitative, longitudinal design to help us better understand the experiences of weight loss surgery candidates, all of	The research aims are clearly defined: To illuminate the patient experience of weight loss surgery.	The chosen design and method was appropriate to both the research question and tracking the evolution of experience over time as it unfolds, rather than retrospectively.	The context and setting for the research is adequately described, including a sense of the post-operative support that candidates were able to access.	As per their previous study (Pfeil et al, 2013) which is linked to this one, appropriate sampling methods were used. The researchers decided to restrict the sample to weight loss surgery candidates who were having gastric band only so as to ensure	Data collection and analysis was described and reported in a systematic way allowing for the replication of research. Some validity checks are discussed. Different and contradictory results are reported.	Although to a certain degree information on the reflexivity of the research team can be gleamed from their previous paper (Pfeil et al, 2013), there is less evidence of this in this paper and therefore cannot be assumed. The analytical accounts did hold a detailed

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
	which may be useful in continually improving both services and outcomes for this group of people.				homogeneity, however this also might significantly impact the generalisability of any findings, including to people having other types of weight loss surgery.		narrative which is supported by quotations from the data, including contradictory positions. Within the analytical accounts, the authors discuss the inclusion of themes which correspond to the conviction in which participants presented the themes, rather than the quantity of participants/ data.
Ogden et al (2011). Negotiating control: Patients' experiences of unsuccessful	This was a worthwhile study that has contributed to understanding mechanisms of change for	The research aims were clear: The study aimed to explore patients' experience of weight loss	The qualitative approach taken in this study and the tool of analysis (IPA) was appropriate given that the study was	The context is described to the extent that we know that all but 1 participant received their surgery in the	With respect to demographics, the sample was generally representative of the population of people accessing	The analysis was clearly described and appears to be systematic. Information is provided on the	Whilst the method and analysis is suitable and is reported as undertaken in a systematic way,

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
weight loss surgery.	patients who have unsuccessful weight loss surgery, followed by a second weight loss surgery.	surgery that had been considered unsuccessful.	concerned with the patients' experience of a particular phenomena. The methodology may have been improved by interviewing participants at the actual time of the experiences rather than retrospectively as they may lead to biases in thinking due to learning that takes place in line with hind sight.	NHS. Little information is given on the nature of support either pre or post operatively. This could make it difficult to generalise from one NHS setting to another.	weight loss surgery on the NHS. Most participants in the research had a gastric band as their first surgery. This may make comparisons with candidates that have a bypass or sleeve as their first surgery difficult and/or may have influenced the results of the study.	steps taken by the authors to ensure the quality and integrity of the analysis. Data analysis is well supported with quotes from the data and contradictory results are presented.	less information is provided on the reflexivity of the authors, any pre-existing beliefs they may have held, their epistemological positioning and how these factors may have impacted the findings.
Wood & Ogden (2016). Patients' long-term experiences following obesity surgery with a focus on eating	The study was useful in exploring the long-term consequences of obesity surgery as viewed by the patients. It also shed light on	The research aims were clear from the onset and the authors reflected on their beliefs as researchers as they went into the research.	The qualitative design chosen was the most appropriate but may have been added to by introducing some quantitative approaches along	The context is described in terms of recruitment (from a support group), length of time from surgery and which	The sample was largely representative of the weight loss surgery population and included people who were both happy and	Data analysis was clearly described and done systematically. Quality checks were explained and quotes from data were	Reflexivity is demonstrated throughout this paper, such as the relationship between the researcher and the participants and the

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
behaviour: A qualitative study.	some of the different processes that successful versus unsuccessful patients go through.		side e.g. a measure of emotional eating.	participants were NHS funded versus private funding. It may have been useful to have additional contextual information on the type of support and intervention that participants had accessed from health services.	unhappy with their outcome.	presented to support findings. Differences between participants were also presented and discussed.	researchers prior experiences and beliefs.
Lloyd et al (2017). It just made me feel so desolate: Patients' narratives of weight gain following laparoscopic insertion of gastric band.	This study was useful in contributing to our understanding of failed weight loss surgeries within the context of the NHS. However, Ogden et al (2011) completed a very similar	There was a clear research question and aim from the onset. It is difficult to ascertain the impact of any pre-conceived ideas/ beliefs as these were not explicitly discussed or reflected upon.	The qualitative design was appropriate as was the inductive thematic analysis. However the authors were keen on giving a constructivist, narrative account and it was not clear why narrative analysis was not used.	The context is well described. We know the NHS context and what type of surgery patients will have received. There are details provided on the post-operative support which was available to patients.	A good attempt was made to recruit participants who are representative of the weight loss surgery population, however the resulting sample was all female. The authors chose to focus	Data collection and analysis is clearly described and was done in a systematic fashion. Information is provided on quality checks. Differences in experiences and results are reported.	The researchers considered the epistemological and ontological positioning and how this impacted their decisions with respect to method and analysis. There was less clear reflection on the

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
	study prior to this one.			However, no information is available on the length, depth and quality of pre-surgical work up.	on patients who had a gastric band procedure. Whilst allowing for homogeneity, it may make comparisons with patients who are having other types of bariatric surgery difficult.		researchers themselves and how they specifically influenced data collection and analysis.
Ogden & Hills, (2008). Understanding sustained behaviour change: The role of life crises and the process of reinvention.	This study was useful in understanding which factors contribute to long term health behaviour change and the cognitive experiences of people who successfully achieve this.	There was a clear research aim from the onset. It is difficult to ascertain the impact of any pre-conceived ideas/ beliefs as these were not explicitly discussed or reflected upon.	The qualitative thematic approach used was appropriate and suitable for the research aims. As there are existing theories, research and possibly measures with relevant to health behaviour change the addition of a quantitative component may	The context is described is as far as where participants were recruited from and that this is a UK based study. No other information is provided on the support and services which the weight loss surgery patients within the	This study sort to purposively use a heterogeneous sample so as to understand if and how long term health behaviour change happens across different samples and people. For those members of the sample who had	Most steps of the data analysis are described, however it is not explicitly stated whether an inductive or deductive approach is taken, although it appears deductive. It is also difficult to work out what quality checks were under taken.	There is limited evidence of reflexivity throughout the write up of this research.

	Worth/ relevance	Clarity of research question	Appropriateness of design	Context	Sampling	Data collection & analysis	Reflexivity
			have added further to the study. It was not clear whether this was considered.	sample used may have accessed.	weight loss surgery, all had sustained weight loss for 3-4 years. No information is provided on the type of surgery participants had.		

APPENDIX D

Table D1: *Systematic Literature Review Study Summaries*

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
Homer et al (2016). Expectations and patients' experiences of obesity prior to bariatric surgery. 2 NHS, Tier 4 weight loss surgery teams in the North of England.	N = 18 Participants were in a Tier 4 weight management service for people accessing weight loss surgery. 16/18 participants had completed Tier 3 weight management, 2/18 had been referred into Tier 4 directly from primary care. Apart from one participant, at the time of the research interviews, no participants had a date for surgery and were at the stage of meeting with their surgeon. No participants had accessed weight loss surgery before.	Study aimed to: (1) Understand the experiences and expectations of people seeking weight loss surgery in England. (2) To identify implications for behavioural and self-management interventions. Addressed these aims using a qualitative approach of semi-structured interviews analysed thematically and triangulated with data from photovoice methodology (participants choose/ take a photo to discuss at their research interview).	Found that negative experiences of obesity and repeated failed weight loss attempts informed decision to have weight loss surgery. Authors reported unrealistic expectations of weight loss surgery, described as "transformative" in the pursuit of "normality". Participants reported positive experiences of weight management professionals but that they thought that Tier 3 intervention could be expanded and improved upon.	A methodologically sound study that makes some key and initial contributions to understanding patient experience of weight loss surgery in the NHS. Study conducted prior to implementation of current commissioning guidance in which Tier 3 services have been expanded and improved. Study leaves unanswered questions around how prepared patients felt going into their weight loss surgery. Due to the stage in which participants were interviewed in their Tier 4 pathway, the study cannot capture further experiences of candidates as they progress on the Tier 4 pathway during their pre-surgical workup.

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
Owers et al (2017). Designing pre-bariatric surgery education: the value of patient experience. An NHS Tier 4 weight loss surgery service in the North of England.	N = 12 Participants were 12 patients who had received weight loss surgery from an NHS service in the North of England between 2001 and 2012. Specific details were not provided on the sample but it was described as spanning a range of ages, ethnicities and genders and was said to be representative of the weight loss surgery population.	The study aimed to use qualitative interviews with patients who have previously had weight loss surgery to inform the design of a psychosocial, health related quality of life, pre-operative educational course to help candidates in planning and preparing for surgery. Semi-structured interviews were undertaken with participants and analysed thematically.	Participants reported feeling unprepared for the side effects of surgery such as excess skin or malabsorption. Participants reported that they required additional support both professionally and within their personal life following surgery to help with adjustment to life style changes and challenges following surgery. Participants also reported feeling surprised by the negative reactions of others to the weight loss surgery and that this had led to feelings of guilt and shame.	A suitable methodology for gathering information to inform pre-operative intervention. Provides insight into aspects of post-operative life that candidates may not feel prepared for or expect. Study only reported on aspects of post-operative life that the researchers had not already considered including in the pre-operative education intervention. As a result, a wealth of potentially useful information was not reported in the write up of this research. The research was done with candidates who accessed surgery as long as long as 17 years ago. Their experiences of pre-operative preparation may not correspond to those of candidates in services today.

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
				As participants were interviewed post-surgically, their experiences may have been impacted by hind sight and retrospective recall. Obesity and weight loss surgery stigma is still persistent, however in recent years there have been social movements targeting the stigmatization of people in larger bodies. In addition, weight loss surgery is increasing. This may or may not have consequences for current candidates' experiences of sharing their weight loss surgery with others.
Owen-Smith et al (2016). Experiences of accessing obesity surgery on the NHS: a qualitative study.	N = 22 patients Ages range from 23-60 and 7/22 were male, most were in employment and information on ethnicity was not reported. The study also interviewed clinicians working within weight management, although the outcome of this is not	This study aimed to investigate how patients experienced accessing referrals for obesity surgery. The study took a longitudinal qualitative approach using semi-structured interviews, with participants interviewed every 6 months over a 2 year period and	The study replicated the finding of those before it in describing the repeated weight loss attempts punctuating candidates' journeys towards accessing weight loss surgery. The study highlights frustrations that candidates experience in interacting with	This study was useful in shedding light on access issues via primary care in accessing weight loss surgery, which in turn can aid understanding of what candidates may experience in their journey towards weight loss surgery.

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
NHS sites in the South West of England.	clearly reported. The rationale for interviewing clinicians was to develop an understanding of the prioritization framework for referrals. N = 11 clinicians. Participants were recruited between 2012 – 2013.	then once more at 3 years following their initial interview. Data was analysed using an inductive, constant comparative approach, *"broadly in line with the principles of grounded theory"*.	their GPs in the pursuit of referrals for weight loss surgery. Patients felt that more psychological intervention was required.	However, the study does not provide information of patients experiences once they have been accepted on to pre-operative pathways. For example, how did they experience pre-surgical work up? Did it help them prepare for their surgery? Did it impact their decision? The study also interviewed 11 clinicians but failed to report on the contents of these interviews, potentially excluding useful and important information. The reporting on the longitudinal components of the research were not clear and the attrition rates were not clearly documented.
Pfeil et al (2013). The patient journey to gastric band surgery: A qualitative exploration.	N = 23 Participants were 19 women and 4 men who were due to undergo gastric band surgery. All participants had completed a preparatory programme to demonstrate readiness for surgery.	The study aimed to explore the views and experiences of obese people preparing to undergo gastric and surgery leading up to the time of their surgery. The study followed a realist epistemology, although upon	The research found that participants psycho, social and physical experiences of living with obesity created a desire to change that was grounded in multiple failed attempts to lose weight. The study found that participants expected the	The study was the first NHS based study to interview participants pre-operatively. Study conducted prior to implementation of current commissioning guidance in

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
2 NHS Tier 4 weight loss surgery sites in the South of England.	Participants were recruited during June 2011 – March 2012. Age ranged 29-65 years. All participants were white British, authors reported that no potential participants were of any other ethnic origin.	description and definition this position seemed more critical realist rather than realist. The study took a qualitative approach using in-depth interviews and inductive thematic analysis.	surgery to control appetite which in turn would enable them to achieve their weight loss goals. The study attempted to provide a model pertaining to the patients' journey to gastric band surgery.	which Tier 3 services have been expanded and improved This research included a clear description of the validity checks taken to ensure the integrity of the qualitative research. This study was limited to patients having gastric band surgery only and so may not apply to candidates having other types of weight loss surgery. This study used an inductive thematic approach and attempts to produce a theoretical model of the patients' journeys to gastric band surgery. A grounder theory approach may have been more appropriate.
Pfeil et al (2014). Living with a gastric band: A Qualitative study.	N = 20. Consenting participants were re-interviewed 12-18 months after their surgery (August 2012 – February 2013). Age ranged 29-65	The study aimed to illuminate the experiences of candidates having gastric band surgery with a focus on the post-operative stage.	The study's key findings related to how candidates began to exercise choice over what they ate, how they rediscovered aspects of their life such as being more	This study was useful in following patients longitudinally to learn about their unfolding weight loss surgery journey which removed any

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
2 NHS Tier 4 weight loss surgery sites in the South of England.	years. Participants included 2 men and 18 women. All of whom had gastric band surgery. All participants were white British, authors reported that no potential participants were of any other ethnic origin.	A longitudinal qualitative design was used with in-depth interviews and an inductive thematic approach.	physically able and that none regretted their decisions. Of particular relevance to the current research, the research highlighted how all candidates felt that continued professional support from specialist nurses was essential to them anticipating, adjusting to and overcoming challenges as they moved along their weight loss surgery journey.	potential bias caused by retrospective recall. An inductive approach allowed for the analysis to be driven by the data, however as the study was a follow-up of candidates who had been interviewed pre-operatively, it may have benefited from a mixed inductive and deductive approach, with information from the pre-surgical research informing the deductive aspects of the analysis. This study was limited to patients having gastric band surgery only and so may not apply to candidates having other types of weight loss surgery.
Ogden et al (2011).	N = 10	The study aimed to explore patients' experiences of	The key findings of the research focused on the issue	A major strength of this study is in the sample of

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
Negotiating control: Patients' experiences of unsuccessful weight loss surgery. The setting for the research was a *'London based clinic'* and *'patient support group'*.	9/10 of the participants accessed weight loss surgery on the NHS, the one remaining participant was privately funded. All participants had had at least one weight loss surgery, the first of which had been reported as unsuccessful by the participants. First surgery procedures were as follows: LAGB=7, gastric bypass=1, roux-en-Y=2. Second surgery procedure were as follows: gastric bypass =3, sleeve gastrectomy=2, pouch revision=2. Participants had the primary surgeries between 1-10 years ago.	weight loss surgery that was deemed unsuccessful. A retrospective qualitative design was used. In-depth interviews were completed and IPA analysis undertaken.	of control in weight loss surgery with failed surgeries characterised by a battle for control over eating and successful surgery handing over control to their restricted stomachs. Of relevance to the present research, the study highlighted that unsuccessful surgery involved a neglect in attending to the psychological components of eating such as emotional hunger and that attending to this was important for success. The study also touched on the idea of experiential learning or learning as experiences unfold which might indicate that not all can be planned/ prepared for. For successful surgeries were also grounded in behavioural changes with regards to	patients that have experience both unsuccessful and successful weight loss surgery, allowing for a qualitative comparison of what changes between the two. However, the retrospective nature of the design makes it difficult to capture processes as they unfold which may be important in informing the timing of information sharing and intervention by health professionals. The sample was also heavily weight towards participants who had a gastric band as their primary surgery. Gastric bands are known to be less successful than other types of weight loss surgery and so this may impact both the nature of the results and their generalisability.

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
	The year of the interviews is not stated but all will have taken place 2011 or earlier. The age range of participants was 38-56, 9/10 considered themselves white British, 1.10 considered themselves British Caribbean.		eating and that this was often facilitated by health professionals.	
Wood & Ogden (2016). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study. The setting for this study was London based support group.	N = 10 8/10 participants were NHS funded and the remaining two were privately funded. 4/10 = gastric band. 6/10 = gastric bypass. Based on demographics provided the sample seemed representative of the weight loss surgery population, although only 1 participant was male.	The study aimed to explore patients' experiences 8 or more years after surgery with a focus on eating behaviour. A cross sectional, qualitative design using in-depth interviews and IPA was used.	The key findings were that candidates who saw their surgery as successful reported a decline in emotional eating, an increasing in alternative and adaptive ways of coping, that food had become more functional and their lives and that they had in some way reinvented themselves, all relative to those participants who did not experience the surgery as a success. 6/10 participants experienced their surgery as a success and escribed developing	This study is useful in helping us to understand the mechanisms of change which might differentiate successful candidates from unsuccessful candidates. Limitations are the cross sectional design and lack of quantitative data to support and build on the qualitative findings. The study cannot help us understand exactly how and when these changes in fold during the course of

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
	Participants had undergone weight loss surgery at least 8 years ago.		alternative ways of coping such as going for a walk and engaging in activities such as exercise.	the weight loss surgery journey.
Lloyd et al (2017). It just made me feel so desolate: Patients' narratives of weight gain following laparoscopic insertion of gastric band. The setting for this study was a NHS obesity service in the West Midlands.	N = 10 All participants had undergone a gastric band between 2009-2012. Data was collected in 2014. All participants had experienced a plateau in weight loss or gained weight. All participants were female, aged between 43-69. 2 participants were non-white and 8 participants were white British. An attempt was made to recruit male participants, however no participants who registered and interest and met inclusion criteria were male.	The study aimed to understand the experiences of patients who had not maintained weight loss 2 years or more following surgery. The study was specifically interested in participants own accounts and so the chosen qualitative methodology was appropriate. Data was collected using semi-structured interviews and data was analysed thematically using an inductive approach. The authors stated that a thematic approach would be flexible enough to encompass an overall narrative approach.	The key findings of the research focused on the regrets that patients had about their surgery and that this regret was grounded in their long term expectations not having been met. Participants spoke about difficulty in dealing with the side effects of the medication. Patients reported receiving a lack of support and that the pre-operative support and preparation was either insufficient or unavailable.	The study helps contributes to our understanding of what challenges patients face following surgery and contextualises this within an NHS support system. Due to the focus on female patients who had had gastric band surgery only, it may be difficult to generalise to other weight loss surgery candidates who are having other types of surgery. Participants in this study also accessed surgery prior to the implementation of current commissioning guidance on weight loss surgery. This means that their Tier 3 and pre-operative pathways may

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
				not have been as extensive as is currently provided in the NHS.
Ogden & Hills, (2008). Understanding sustained behaviour change: The role of life crises and the process of reinvention. This is a UK, London based study.	The overall sample was n = 34, 12 of which we people who had undergone weight loss surgery. The type of surgery is not specified, all is known is that the weight loss had been sustained for 3-4 years. It also is not clear whether participants had surgery on the NHS. All is known is that participants were recruited from a London based obesity clinic. Only one male participant had weight loss surgery. Other participants included those who had lost weight through conservative methods (n=12) and those who had stopped smoking (n=10).	This study aimed to explore whether factors exist that relate to long term health behaviour change and the cognitions that relate to this. The study purposely sought a heterogenous sample. Semi-structured interviews were used and analysed thematically.	Key findings were that sustained behaviour change was triggered by life crisis realting to health, relationships and life milestones. Three sustaining conditions for long term change were identified (1) the function of the unhealthy behaviour is disrupted (2) the choice to carry out the unhealthy behaviour had been reduced (3) they bought into a behavioural understanding and approach to their problem.	This study was useful in exploring what sustains health behaviour change and provides interesting theory as to how this could be applied the a weight loss surgery population. However, limited information is available on the participants in this study who had weight loss surgery. We therefore do not know whether they are representative to the weight loss surgery population within the NHS.

Title/ Location	Participants	Aims & Methodology	Summary of Key Findings	Main Strengths & Limitations
	In total, 12 males and 22 females took part in the study with an age range of 25-54. No information on ethnicity is provided.			

APPENDIX E

Evaluation of This Study

Table E1: *An Evaluation of the Present Study Based on Mays and Pope's (2000) Criteria for Evaluating Qualitative Research in a Healthcare Setting*

Worth/ relevance	This study was worthwhile. Firstly, there is a low number of studies exploring candidates' experiences of accessing WLS on the NHS. Secondly, there are even fewer studies which have explored this in candidates who accessed surgery after the introduction of 2013 commissioning guidance. This is important as this impacted the nature of access to surgery as well as pre-surgical workup. Thirdly, to date there is only one study which has explored what helped candidates to prepare for surgery and life afterwards. This was a retrospective study and so may be impacted by hindsight. This study addresses this question whilst candidates are still at the pre-surgical stage.
Clarity of research question	The research question was clearly stated and created based on the funneling of information presented during the introduction and systematic literature review: To explore the experiences, expectations and preparations of candidates awaiting WLS in the NHS. The research has been transparent on pre-conceived ideas as discussed in the introduction and research diary. In being transparent, the researcher has demonstrated how they have set aside their own pre-conceived ideas e.g. personal beliefs about WLS as an extreme treatment of last resort whilst being open to candidates' experiences of WLS as a positive thing and presenting this during the results.
Appropriateness of design	The study was with an under researched group, therefore a qualitative approach made sense. The study did however acknowledge the usefulness of previous studies and theoretical knowledge, this coupled with the critical realist position meant that a deductive thematic approach was suitable. A deductive approach however does not allow for new data driven questions and information to be generated by the research. A mixed deductive and inductive approach was chosen on this basis. This allowed for complete transparency on the deductive and inductive aspects of analysis.
Context	The context for the research is described with respect to the NHS, commissioning guidance and WLS pathways. Further details on the nature of pre-surgical provision for participants in this research are in Appendix K. Collectively this should enable the reader to understand how this research may or may not be applicable to other NHS services of healthcare and WLS privately and beyond the UK.
Sampling	The sample is representative of a WLS population. It is however limited with regards to diversity and size. The researcher attempted to address this through increasing recruitment opportunities and applying for an ethical amendment to allow for data collection over the telephone, but was unsuccessful in doing so within the required time frame.

Data collection & analysis	The method is clearly justified and described. The detail and description illuminates the analytical steps taken allowing for replication, with quality checks to ensure coding accuracy.
Reflexivity	The epistemological position and researcher assumptions are made transparent. The author evidences reflexivity in the research diary, as well as during the method section with consideration of issues of power and the researchers thin privilege.

APPENDIX F

Ethical Approval from the University of Hertfordshire

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Dr B Mason and Ms J Clayton
Department of Psychology and Sports Science
School of Life and Medical Sciences

29 November 2017

Dear Dr Mason and Ms Clayton

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: A Qualitative Study Looking at The Hopes and Expectations of Weight Loss Surgery Candidates
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Barbara Mason
NAME OF INVESTIGATOR (Student): Ms Jennifer Clayton
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGR/NHS/02684

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission to the Health Research Authority (HRA) NHS Research Ethics Committee (REC) and I must also be notified of the outcome. It is also essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as it is received. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

APPENDIX G

Ethical Approval from the Health Regulatory Authority

NHS
Health Research Authority

Dr Barbara Mason
Doctorate in Clinical Psychology Programme,
University of Hertfordshire,
Health and Research Building, College Lane Campus,
Hatfield, Hertfordshire,
AL10 9AB

Email: hra.approval@nhs.net

06 October 2017

Dear Dr Mason

Letter of HRA Approval

Study title:	**The working title for this piece of research is as follows: A Qualitative Study Exploring The Hopes and Expectations of Candidates for Weight Loss Surgery**
IRAS project ID:	**224510**
Protocol number:	**LMS/PGR/NHS/02684**
REC reference:	**17/EE/0318**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

IRAS project ID	224510

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

IRAS project ID	224510

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **224510**. Please quote this on all correspondence.

Yours sincerely

Beverley Mashegede (on behalf of Joanna Strickland)
Assessor

Email: hra.approval@nhs.net

APPENDIX H

Ethical Approval from Local Research and Development Departments

NB: This research took place in one research site only, however, due to a service level agreement between the employing trust of psychological staff members and the trust providing Tier 3 and 4 obesity service, approval from two local R&D departments was required.

From: Hardy Diana (RC9) Luton & Dunstable Hospital TR <Diana.Hardy@ldh.nhs.uk>
Sent: 22 November 2017 16:45
To: 'j.m.senior@herts.ac.uk'; Mason, Barbara (b.l.mason@herts.ac.uk); 'research-sponsorship@herts.ac.uk'
Cc: Jophy B Bindumol (RC9) Luton & Dunstable Hospital FT; Ramsden Rebecca (RC9) Luton & Dunstable Hospital FT; Jennifer Clayton (jen.clayton@outlook.com); Rassool Sara (RC9) Luton & Dunstable Hospital TR
Subject: IRAS 224510 Confirmation of Capacity and Capability at Luton and Dunstable University Hospital NHS Foundation Trust

Dear Professor Senior,

Re: **IRAS 224510 Confirmation of Capacity and Capability at Luton and Dunstable University Hospital NHS Foundation Trust**

Full Study Title: **A Qualitative Study Exploring the Hopes and Expectations of Candidates for Weight Loss Surgery**

This email confirms that **Luton and Dunstable University Hospital NHS Foundation Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on a date to be agreed when you, as Sponsor, give us the green light to begin.

I would like to take this opportunity of informing you that should any amendments be made to the study, e.g. Protocol, Information Sheet, Consent Form, etc. it is your responsibility to inform not only the Health Research Authority / Research Ethics Committee but also the Research & Development Department of these changes. I would also like to inform you that, as part of the monitoring process, at the end of your study we require documented evidence that the findings of the study are published.

I confirm that the student, Mrs. Jennifer Clayton, cannot commence on the Luton and Dunstable Hospital (L&D) site until she has been issued with an L&D Trust Honorary Contract which I understand is in the process of being arranged by the Obesity Centre.

I should be grateful to receive a follow up on the progress of the study in six months and attach a form for this purpose. Thereafter, please update me on progress at six monthly intervals.

NOTE TO PRINCIPAL INVESTIGATOR: You are required to recruit the first participant within 30 days of this confirmation email.

If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Dr. Christopher M. Travill
Director of Research & Development
Luton and Dunstable University Hospital NHS Foundation Trust
Lewsey Road
Luton LU4 0DZ

Contact:
R&D Manager - Diana Hardy
Tel: - 01582 718243

From: Young Pauline (R1L) Essex Partnership <Pauline.Young@eput.nhs.uk>
Sent: 13 October 2017 18:29
To: Jennifer Clayton
Cc: b.l.mason@herts.ac.uk; Ramsden Rebecca (RC9) Luton & Dunstable Hospital FT
Subject: REC Reference: 17/EE/0318, IRAS Project ID: 224510, hopes and expectations for weight loss surgery

Hi Jen

This email confirms that **Essex Partnership University NHS Foundation Trust (EPUT)** has the capacity and capability to deliver the above referenced study. Please find attached the statement of activities sheet with local information duly completed by us as confirmation that we are ready for you to proceed with this study.

We are ready now for you to go ahead with starting this study and look forward to you as sponsor beginning recruitment.

If you wish to discuss further, please do not hesitate to contact me.

Best regards

Pauline

Pauline Young
Interim Head of Research
& Community Services Research Delivery Lead
Essex Partnership University NHS Foundation Trust (EPUT)
☎·**Mobile: 07939 008588** **pauline.young@eput.nhs.uk**
www.eput.nhs.uk

APPENDIX I

GP Letter

[redacted]

Dear [GP details],

RE: Participation in research on weight loss surgery

Name: **DoB:**

We are writing to inform you that the above patient has agreed to take part in our research study on candidates who are awaiting weight loss surgery.

Aims of research:
To learn about how candidates conceptualise weight loss surgery and arrive at their decision to pursue it and what their hopes and expectations are.

What is required from your patient:
They will have attended a semi-structured interview in which we discuss their decision to pursue weight loss surgery as well as their hopes and expectations for the surgery.

Research team:

Chief Investigator	Dr Barbara Mason Senior Clinical Tutor & Clinical Psychologist, University of Hertfordshire AL10 9AB Tel: 01707 286322 Email: b.l.mason@herts.ac.uk
Main researcher (research student)	Jennifer Clayton Trainee Clinical Psychologist DClinPsy University of Hertfordshire AL10 9AB Tel: 07[redacted] Email: j.clayton2@herts.ac.uk
Sponsor	Professor John Senior Pro-Vice Chancellor Pro-Vice Chancellor's office, University of Hertfordshire AL10 9AB

Field supervisor Dr [redacted]
Clinical Psychologist
[redacted]
Email: [redacted]

Research study reference numbers:
IRAS Number: 224510
SPONSORS Number: LMS/PGR/NHS/02684

If you require any additional information or have any queries, please do not hesitate to contact us.

Yours Sincerely,

Jennifer Clayton
Trainee Clinical Psychologist
Main Researcher

APPENDIX J

Transcription Agreement

University of Hertfordshire

Doctorate in Clinical Psychology

University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

X ('the discloser')

And

***Transcription service* ('the recipient')**

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:……

Name:……

Date:……

INVESTOR IN PEOPLE

APPENDIX K

Pre-Surgical Provision

Participants in this study followed the below pre-surgical pathway.

Referral:

- Participants were referred to tier 3 weight management services by their GP.
- Access criteria for tier 3 was as follows:
  - BMI> 35 and one or more obesity associated health condition e.g. type 2 diabetes
  - BMI> 40

↓

Enter Tier 3 Wight Management Services

- Lasts for 12 months
- Specialist MDT support to develop weight loss programmes which are individually tailored to candidates needs
- Candidates are required to attend group sessions targeting lifestyle changes
- Most candidates are trialed on the "milk diet". This is a low-calorie diet consisting of the following:
  - Daily allowance: You MUST HAVE the following:
    - 4 pints of semi skimmed milk
    - 2 pints (1 litre) of other fluid
    - 1 multivitamin and mineral tablet (e.g. Sanatogen A-Z Complete or Centrum Advance)
    - 1 salty drink e.g. stock cube, Bovril (1 teaspoon in hot water), marmite (1 teaspoon hot water)
  - Allowed Drinks: at least 2 pints (1 litre) of the following:
    - No added sugar or diet variety soft drinks
    - Tea or coffee using milk from allowance (you can use a sweetener but must not use sugar)
    - Water
    - Flavoured water (providing it doesn't contain sugar – check the label)
  - Allowed extras:
    - Sugar free jelly- 1 sachet a day
    - Sugar free chewing gum- maximum 3 pieces a day
- After 12 months, candidates who sustain 5% loss of excess body weight qualify for onward referral to tier 4 weight loss surgery services.

↓

Enter Tier 4 Weight Loss Surgery Services

- Candidates undergo MDT assessment to check for any additional support needs or contra-indications for surgery.
  - Meet with Nurse
  - Meet with Dietician
  - Meet with Clinical Psychologist
- Candidates who are able to proceed towards surgery following MDT assessment meet with the surgeon and anesthetist.
- 2 weeks prior to surgery candidates attend a Nurse led information group to help prepare them for surgery.
- 2 weeks prior to surgery candidates must commence the milk diet. This is to shrink the liver ahead of surgery for safety reasons

APPENDIX L

Study Protocol

RESEARCH PROTOCOL

STUDY TITLE
A qualitative study exploring the hopes and expectations of weight loss surgery candidates

PROTOCOL VERSION NUMBER AND DATE
Version 2, 07/09/2017

RESEARCH REFERENCE NUMBERS

IRAS Number:	224510
SPONSORS Number:	LMS/PGR/NHS/02684

KEY CONTACTS

Chief Investigator	Dr Barbara Mason Senior Tutor, University of Hertfordshire AL10 9AB Tel: 01707 286322 Email: b.l.mason@herts.ac.uk
Main researcher (research student)	Jennifer Clayton Trainee Clinical Psychologist DClinPsy University of Hertfordshire AL10 9AB Tel: 07983385339 Email: j.clayton2@herts.ac.uk
Sponsor	Professor John Senior Pro-Vice Chancellor Pro-Vice Chancellor's office, University of Hertfordshire AL10 9AB
Field supervisor	Dr Rebecca Ramsden Clinical Psychologist Luton and Dunstable Obesity Service Email: Rebecca.Ramsden@ldh.nhs.uk

LIST OF CONTENTS

TRIAL FLOW CHART

Stage	Description	Relevant document
1	Participants made aware of eligibility to participate in study by obesity service staff and participant information form provided. If interested in taking part, a registration of interest form is completed.	• Participant information sheet • Registration of interest form
2	Research student contacts interested participant. Brief checklist completed to confirm inclusion criteria met. Discusses research with potential participants, verbal consent taken and interview date made.	• Recruitment initial screening questionnaire
3	Written consent taken prior to starting research interview. Demographic questionnaire completed followed by research interview. Participants made aware of who they can contact if they have questions or concerns. Participants asked if they consent to being contacted about taking part in a second phase of the research following surgery (separate ethics application made with respect to phase 2).	• Participant information sheet • Consent form • Demographics questionnaire
4	Participants GP is informed that they have taken part in the research.	• GP letter

STUDY PROTOCOL

1 BACKGROUND

Obesity Prevalence

The term obesity is used to refer to those individuals who have a body mass index (BMI) above 30. Obesity is often referred to as an epidemic (NHS Choices, 2015) and this is supported by existing statistical data. According to the World Health Organisation (WHO, 2016), global rates of obesity have more than doubled since the 1980s, with 13% of the world population now classified as obese. Alarmingly, the figures are more worrisome when looking specifically at the United Kingdom (UK), with 25.6% of the UK population estimated to be obese (Health Survey for England, 2014).

The Implications of Obesity

Psychological, physical, social and financial difficulties are each interlinked with obesity and are discussed in more detail below. Collectively, these difficulties highlight that there is a clear case for the need to better understand obesity, and how individuals can be supported to reduce their weight.

The National Obesity Observatory (NOO) report a bidirectional association between mental health difficulties such as anxiety and depression, and obesity (Gatineau & Dent 2011). Although it can vary slightly dependent on culture, there is also a considerable stigma surrounding obesity, and there is evidence to show that obese individuals are subject to multiple prejudices and discrimination (Pull & Brownell, 2011). Physically, individuals with obesity are more at risk of health conditions, such as diabetes and cancer. Furthermore, some health conditions can increase the risk of further weight gain and mortality (Guh, Zhang & Bansback, 2009). The annual cost of obesity and its associated health conditions is estimated at 6 to 7 billion pounds per year. This figure includes costs to the health service, sick benefits and loss of earnings (McCormick & Stone, 2007).

Why is Obesity Increasing?

Individuals who develop obesity consume more calories than they expend, however, the reasons why this is happening are complex and still not fully understood. Genetic variability and individual biology is thought to play a role (Newson & Flint, 2011). Some people, no matter what they consume, do not seem to gain weight. In contrast, others gain weight with ease. Furthermore, the rates of metabolic disorders and other health conditions which can increase the risk of weight gain, are higher amongst individuals who develop obesity (UK Bariatric Surgery Registry, 2014).

Our social environment might also be implicated. We do not consume foods within a vacuum. Rather, eating is a social activity, as even when done alone, we do so in a wider context. Research has shown that culture, family and societal values are influenced by marketing and the wider media, and that they form a foundation from which we make food choices (Furst, Connors & Bisogni, 1996). Thus, our culture and the way that our food is sold to us plays an important role in what we do and do not eat.

Over the past one hundred years, the provision of food has also changed drastically. Our environment can be described as obesogenic, in that the abundance of convenient food available to us, makes the environment a fertile breeding ground for obesity (Kirk, Penney & McHugh, 2010). The chemical composition of the food available to us has also changed (Cordain, Eaton & Sebastian, 2005). Substances which are irresistible to humans, such as sugar, are increasingly present in foods (Lustig, Schmidt & Brindis, 2012). It seems that food is being designed in a way which, on a biological level, taps into our evolutionary tendency to consume calorific food.

Despite the complex factors underlying obesity, the responsibility for change is placed within individuals. This means that it is the people who develop obesity who ultimately are required to make a change to their behaviour in order to lose weight and improve health. Current interventions for obesity are briefly discussed in the next section.

Interventions for Obesity

Diet and exercise interventions for obesity are offered within the National Health Service (NHS). Typically, this is provided within the context of Tier 3 weight management clinics, taking on the form of year long programmes focused on changes to diet, exercise and lifestyle. An example of this is the Tier 3 service provided by Luton and Dunstable Weight Management Service, the centre in which the current project will take place. In addition to diet and exercise interventions, medications to enhance weight loss such as Orlistat are also offered (NHS Choices, 2016).

Once an individual has exhausted all alternative routes provided by the NHS, they are able to pursue weight loss surgery (NHS Choices, 2016). Surgery is offered within Tier 4 weight management clinics, such as that provided by Luton and Dunstable Obesity Service.

Weight Loss Surgery: Key Facts

In the NHS, weight loss surgery is offered as a treatment for severe obesity, which poses a significant risk to a person's health and potentially, their life (NHS Choices, 2016). Specifically, candidates are required to satisfy the following criteria:

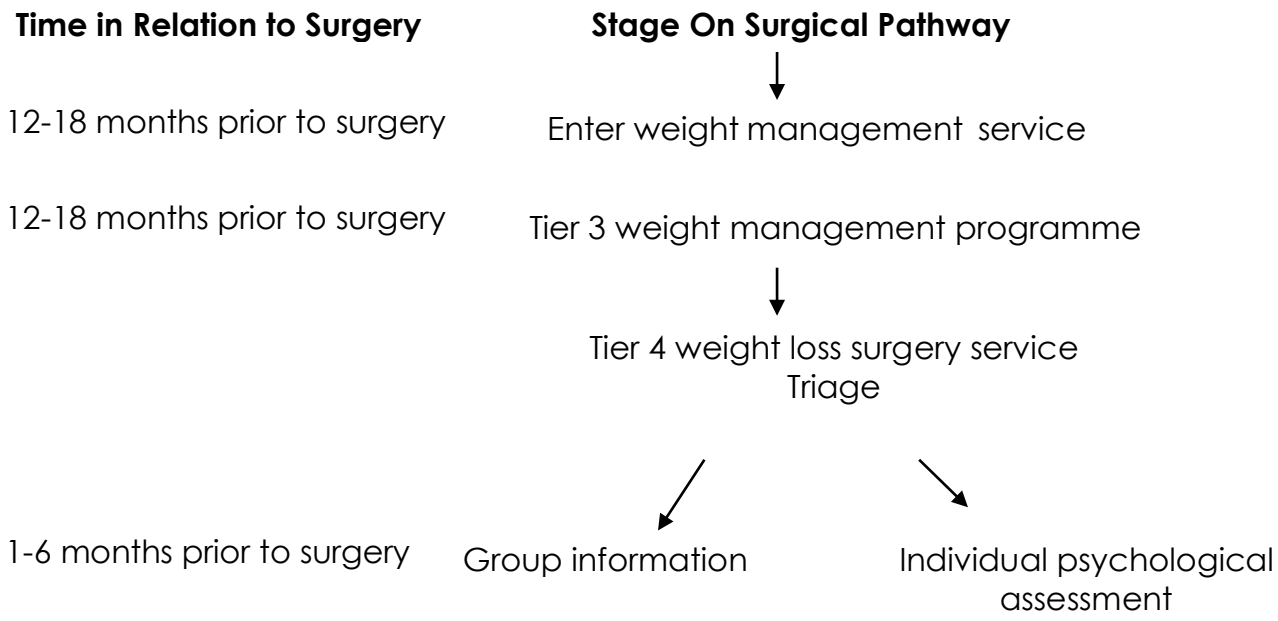
VI. Have a BMI of 40 or more, or between 35 and 40 and another serious health condition, that could be improved with weight loss, such as type 2 diabetes or high blood pressure.
VII. All appropriate non-surgical measures have been tried, but the person hasn't achieved or maintained adequate, clinically beneficial weight loss.
VIII. The person is fit enough to have anaesthesia and surgery.
IX. The person has been receiving, or will receive, intensive management as part of their treatment.
X. The person commits to the need for long-term follow-up.

Weight loss surgery usually takes one of the following forms, all of which are offered under the Tier 4 Luton and Dunstable Obesity Clinic from which this study intends to recruit:

- Laparoscopic Gastric Band.
- Laparoscopic Sleeve Gastrectomy.
- Laparoscopic Gastric Bypass.
- Laparoscopic Duodenal Switch.

Each type of surgery involves some level of stomach restriction or bypass, that significantly limits the amount of calories candidates are able to consume. As a result, the surgery requires that candidates make a significant life style change. Regardless of the surgery type, the below pathway is followed by candidates who have surgery under the care of Luton and Dunstable Obesity Service.

Pre Surgery Work Up:



Weight Loss Surgery: Outcomes

Outcomes with regards to weight loss are routinely reported by the UK Bariatric Surgery Registry (2014); One year following surgery, on average, candidates lose 58.4% of the excess weight that they are required to lose, in order to reach what is considered a healthy BMI. At three years post surgery, this figure rises slightly to 59.6%. In other words, on average, after having weight loss surgery, candidates still have 40% of their excess body weight left to lose in order to reach a healthy BMI range.

According to the UK Bariatric Surgery Registry, the aim of weight loss is actually secondary to that of reducing other physical health problems (2014). The registry report a multitude of comorbid conditions associated with obesity such as arthritis, hypertension, diabetes and sleep apnoea. In addition, it reports that weight loss surgery can be successful in reducing such conditions and improving functional status (2014).

Candidates also experience changes in social and psychological outcomes. A recent review of the literature found that candidates reported improved health related quality of life, improved depression and anxiety, improved self esteem and improved social relationships. However, such improvements were positively correlated with weight loss and in many cases at least a moderate weight loss was required before candidates began to experience improvements in other areas (Loaisa, Carrillo & Coll, 2015).

In addition to these positive changes, candidates may also experience challenges after weight loss surgery. As changes (or a lack of) in weight occur, candidates are required to navigate adjustments in their self concept and image. The resulting tensions which can arise from this process can be difficult (Bocchieri, Meana & Fisher, 2002). Even when the desired weight loss is achieved, candidates can be left with excess skin, which can cause skin conditions and functional difficulties (Kitzinger, Abayev & Pittermann, 2012).

Candidates may also experience changes in their social relationships. On the one hand this may be positive, for instance, reduced social stigma and discrimination or increased sexual interest from a romantic partner. On the other hand, some candidates struggle as they find themselves being exposed to new situations (Sogg & Gorman, 2008). Candidates might also experience unwelcome challenges in their relationships, if partners struggle to adjust to their relative changing and perhaps assuming a new role within the family system (Kluever Romo & Dailey, 2014).

Thus the outcomes of weight loss surgery are so much more than the amount of weight loss achieved. Candidates can experience a host of physical, psychological and social changes that are not always necessarily anticipated, or welcomed. In addition, for most candidates, there is significant room left to improve outcomes.

Psychological Predictors of Weight Loss

Whilst it is common practice to assess psychological factors with candidates who are pursuing weight loss surgery, there is no consensus in the literature on which psychological factors predict outcome, or may be contraindicative of weight loss surgery. One of the most recent reviews looking into this (Wimmelmann, Dela & Mortensen, 2013), concluded that there is no clarity on which factors might predict outcome. Perhaps unsurprisingly, the only conclusive finding that they reported was that post surgical eating behaviour and binge eating predicts weight loss irrespective of pre surgical factors (Wimmelmann, Dela & Mortensen, 2013).

Possibly reflecting the insufficient evidence, NICE guidance is vague on which psychological factors should be considered during pre surgical assessment (NICE, 2014). Psychological assessment undertaken within the Luton and Dunstable Obesity Service, can be described as similar to that recommended by Dziurowicz-Kozlowska, Wierzbicki and Lisik (2006), who urge that the following factors are assessed:

- Motivations and expectations for pursuing surgery.
- How well formulated candidates' ideas are around changing habits surrounding diet and health.
- knowledge of the surgery and the underlying weight loss mechanisms.
- Mental health and psychological wellbeing.
- Family context and access to social support.
- The candidates' narrative of developing obesity and history of attempts to combat this.
- Lifestyle, eating behaviours and functions of eating.
- Awareness of the need for permanent modifications to habits.
- Degree of preparation made for lifestyle change.

Key Themes in the Weight Loss Surgery Literature:

There are many qualitative pieces of research which have retrospectively explored with candidates, their experiences of weight loss surgery. From these pieces of research, a number of useful themes have been identified.

Firstly, candidates discuss the importance of viewing the surgery as a tool to be worked with, rather than a cure in which they are a passive agent to (Geraci, Brunt & Marihart, 2014). There is a paradox in that, at the same time as not being a passive agent, there is a sense that candidates need to relinquish some degree of control to the processes underlying the surgery. For example, not aiming to cheat the surgery by chewing food to a pulp so that higher quantities of food might be consumed (Ogden, Avenell & Ellis, 2011).

Secondly, weight loss after surgery is viewed as an evolving trajectory over many years, rather than there being a pre-determined end point. This is best captured by Lynch (2016). Based on her interviews with candidates, she identified 3 post surgical stages. During the first 12 months following surgery, candidates will find weight loss effortless, losing weight without trying. Lynch entitles this "the honeymoon" phase. Following this, candidates enter in to a "stabilization" phase, in which weight loss plateaus despite candidates having not reached their weight loss goals. From here a "work begins" phase starts. During this period candidates need to adjust to the slowed weight loss, moving towards a position of acceptance that weight loss will not be as rapid. Furthermore, they will need to develop new habits and behaviours which enable them to continue losing weight.

The third and final theme worth highlighting here, is the need for candidates to become aware of any unhelpful eating behaviours and habits, and subsequently develop new ones. For example, food may move towards serving a physical function, rather than an emotional one. More successful candidates will develop new coping strategies for dysphoric emotions

(Wood & Ogden, 2015, Hillersdal, Christensen & Holm, 2016 & Natvik, Gjengedal & Moltu 2014). In addition, they develop a greater awareness of their habits which surround food. For instance, in the first few months following weight loss surgery, it is not physically possible for candidates to consume the type and volume of foods they did prior to surgery. Yet despite this, candidates might notice that they have a habit of regularly checking their fridge and cupboards (Lynch, 2016).

Mindfulness, Values, Food and Weight Loss

Whilst not explicitly discussed in the weight loss surgery literature, an additional theme worth mentioning is that of values. The Food Choice Process Model provides a framework to describe how food choices are made based on a person's life experiences and underlying values (Connors, Bisogni & Devine, 2001). Confusingly, the values which underpin food choices may vary at any given time. For instance, at one point of time an individual might value convenient and time effective options, and at another time focus on the underlying nutritional and health benefits of food. Thus values are key to the food choices we make and this is something which could be useful to consider for candidates on weight loss surgery pathways.

A common psychological framework utilised for individuals adjusting to change and/ or health conditions is Acceptance and Commitment Therapy (ACT, e.g. Nordin & Rorsman, 2012). This approach utilises mindfulness to enable people to develop awareness of their physical and emotional experiences, as well as develop skills in sitting with the more difficult experiences which according to ACT, are inherent to being human. It also helps people to develop explicit awareness of their underlying values. ACT assumes that when we live in alignment with our values we thrive, and so after developing awareness, ACT encourages people to make behavioural choices in accordance with their value system (Flaxman, Blackledge & Bond, 2011).

Taking into consideration both the Food Choice Process Model and ACT, it seems that mindfulness skills, the underlying value systems of weight loss surgery candidates, along with the values which underpin their weight loss surgery goals, may be integral in whether the process is deemed a success or not. In line with this, there is emerging research which has piloted ACT based interventions for candidates who have weight loss surgery. Preliminary results suggest that the interventions have been useful in improving the management of emotional eating and psychological flexibility (Weineland, Arvidsson & Kakoulidis, 2012).

Making Health Behaviour Changes

According to the Theory of Planned Behaviour (Ajzen, 1985) intentions are what predict behaviour and intentions are usually determined in advance of voluntary behaviours. The theory expands further in explaining three factors which influence our intentions. First is our attitude regarding the behaviour. This refers to whether we see the behaviour as a good or bad thing and whether we think the behaviour will be rewarding. Second, are the opinions of others. This might be the individuals in our day to day life or more broadly the opinions held within the larger culture. Third and finally, is whether we believe that we will be successful in executing the behaviour (Sarafino, 2006). In may be helpful to consider such relevant health behaviour change theory within the context of weight lost surgery.

2 RATIONALE

We have seen that there has been a vast amount of research which has tried to identify which factors predict outcomes following weight loss surgery. Despite this, the research is contradictory and insufficient and so no clear consensus or conclusions can be drawn.
There has also been a wealth of qualitative studies which have interviewed candidates months and years following their surgery, to glean an insight in to their weight loss journey. This has shown that candidates feel behaviour change is key. What it does not show us however, is *how* candidates make changes to their behaviours in relation to food and weight, nor how they make the decision to pursue weight loss surgery and how they conceptualise the weight loss surgery itself.
Most commonly, existing qualitative research has also followed a retrospective design and, as a result, is confounded by the power of hindsight. Whilst the wisdom yielded by hindsight is undoubtedly valuable in the screening and tailoring of advice for future weight loss surgery candidates, it does not show us *how* candidates' beliefs, anticipations and behaviour in relation to weight loss surgery evolve over time and in relation to outcomes.
It is clear there is a need for research that can track clients in vivo to help get a unique insight into candidates' journeys along weight loss surgery pathways and how this might vary with their subjective outcomes. Such a piece of longitudinal research which follows candidates in their journey through weight loss surgery pathways would help capture the complexities involved in psychological and physical change during weight loss surgery.
This project aims to act as phase 1 of a qualitative longitudinal piece of research which is concerned with how candidates for weight loss surgery reach their decision to pursue surgery, their hopes and expectations for the surgery and what, if any, plans they have begun to make with respect to health behaviour changes alongside the weight loss surgery. Please note that a separate ethical application and protocol will be written for further phases of the longitudinal study.

3 OBJECTIVES AND OUTCOME MEASURES/ENDPOINTS

3.1 Primary objective

To learn about how candidates conceptualise weight loss surgery and arrive at their decision to pursue it and what their hopes and expectations are.

3.2 Secondary objectives

To learn about candidates experiences of the pre-surgical pathway.

4 TRIAL DESIGN

The research will follow a within subjects, qualitative design. Qualitative interviews will be carried out with weight loss surgery candidates prior to their weight loss surgery. The research will be approached from a critical realist stance, because, based on the existing literature, there are certain themes that are anticipated to emerge from the research.

4.1 Recruitment of participants

A purposive sampling approach will be used. Participants will be recruited from the Luton and Dunstable Weight Management Service. All participants will have competed the Tier 3 weight management programme and be at the Tier 4 pre weight loss surgery stage.
Patients will be asked by the Obesity Service multidisciplinary team (MDT) whether they would like to be contacted about the research. At this time a participant information sheet will be provided and patients asked whether they are happy to be contacted by the researcher. If so, patients will be asked to complete an expression of interest form which will be stored securely with the Field Supervisor who is a Clinical Psychologist based in the Obesity Service. The Field Supervisor will store the registration of interest paperwork in a locked filing cabinet in their office at the Obesity Service.
The Main Researcher will arrange to collect this information from the Field Supervisor, at which time the Field Supervisor will also provide the relevant contact information for those potential participants who have registered an interest.
Potential participants will subsequently be contacted by the main researcher over the telephone. At this time there will be further opportunity for questions about the research and the participant information sheet will be discussed verbally. If the patient still wishes to proceed, a date for the research interview will be arranged.
On the day of the interview the participant information sheet will be re-visited and at this point informed consent will be documented using the consent form.

4.1 Interview process

Participants will be invited to attend a research interview. The research interview will last approximately 1 hour. The interview will be semi-structured and participants will be asked questions about their experiences leading up to their decision to pursue weight loss surgery as well as their hopes and expectations for after the surgery.

5 STUDY SETTING

The research will take place in a private, quiet room at an NHS setting within or close to Luton and Dunstable Hospital. Two locations which have been identified as suitable for conducting the study are the Obesity Service at Luton and Dunstable Hospital and the Disability Resource Centre in Dunstable. These locations were selected as they both have appropriate accessible rooms.

6 ELIGIBILITY CRITERIA

6.1 Inclusion criteria

- Be awaiting weight loss surgery with the Luton and Dunstable Obesity Service.
- Be aged 18 or over.
- Not yet had weight loss surgery.
- Have the mental capacity to make the decision to take part in the research.
- Have good working knowledge and use of the English language.

6.2 Exclusion criteria

Of prospective candidates, those candidates who are not able to attend a research interview at a site in or near to Luton and Dunstable Hospital will not be able to participate in the research. This reflects a resource issue, in that the research student who will be conducting the interviews will be unable to travel to different parts of the country.

7 CONSENT

Informed consent will be taken by the research student who will also be undertaking the research interviews. Whilst informed consent will be viewed as an ongoing process during participants' involvement with the research, there are two key stages in which consent will be formally visited.

Firstly, the research student will contact those candidates who register an interest in taking part in the research. At this time the research can be discussed, along with the participant information sheet and any questions candidates have about the research. If at this stage candidates wish to take part, initial verbal consent will be taken over the phone and a date for the research interview will be arranged.

On the day of the research interview and prior to commencing it, the research student will re-visit the participant information sheet and again address any questions that the participant may have. If the participant still wishes to take part in the research, written consent will be taken at this time, with copies for the participant, researcher and patient records with the Obesity Service.

Participants will also be asked whether they are happy to be contacted regarding future research at the post-surgery stage. A separate consenting procedure and study protocol will be in place for this. It will be made clear that there is no obligation for them to do so.

Consent is an ongoing process and participants will be informed of their rights to withdraw from the research, without explanation, up until 2 weeks after their research interview is completed. A two week cooling off period was chosen to allow time for participants to process the information they have received and provided.

As part of the inclusion criteria for this research participants are required to have the mental capacity to consent to participating in the research and as such, no issues around capacity are anticipated. The rationale for this is in ensuring the homogeneity of the sample.

8 ASSESSMENT AND MANAGEMENT OF RISK

The research team have considered that the pathway to pursuing weight loss surgery can be lined with difficult experiences which might lead to feeling of distress. In addition, given the personal nature of the research interviews, it cannot be ruled out that risk issues may arise. The following procedures are in place with respect to the management of risk.

Immediate Risk:

With respect to "immediate risk", this refers to situations in which there is an immediate risk to the participant's health as they are unable to keep themselves safe, such as intent of life threatening self harm. Under these unlikely circumstances, if the research interview is taking place at the Luton and Dunstable Hospital, the participant will be escorted by the researcher to A&E, which is located within the same base. If the research interview is taking place at Disability Resource Centre, then the researcher will call 999 in assisting the participant to access A&E. This is in line with the policy and procedure which would be followed by staff within the Luton and Dunstable Hospital Obesity Service.

Distress During Research Interview:

The researcher has over 10 years of clinical experience working with individuals with physical and mental health problems and as such is skilled in working with people experiencing distress as it presents in the room. There may be situations where participants experience distress for which they would like to access further support.

The researcher has close links with the Obesity Service. In the event that distress, upset or concerns arise with respect to the weight loss surgery, the researcher can signpost participants to the Obesity Service. This is in line with the clinical protocol which currently operates in the Obesity Service, in which they provide all candidates with details of who they can contact for help and advice Monday-Friday, 9am-5pm.

During the research interviews, if distress arises in relation to issues not related to weight loss surgery and this requires additional support, candidates will be advised tocontact their GP.

Safeguarding Issues:

In the unlikely event that a safeguarding issue arises, the researcher will make a safeguarding alert through the appropriate local authority. In doing so the participant's GP and health team within the Obesity Service will be updated. Again, this is in line with the current clinical protocols in place within the Obesity Service.

9 DATA ANALYSIS

9.1 Sample size

Amongst the literature there is no consensus of what is an adequate sample size for a qualitative piece of research, rather, participants are continuously recruited until "saturation" is achieved, whereby no additional themes emerge from interviewing new participants (Fugard & Potts, 2014). The required sample size is therefore difficult to determine prior to commencing the research.

Based on recommendations by Fugard & Potts (2014) and Johnston and colleagues (2010), an estimation initial of 20 participants has been proposed. This is based on existing theoretical and clinical knowledge around weight loss surgery and the number of themes which are anticipated to emerge.

9.2 Data analysis

Thematic analysis will be used to analyse data gathered from the interviews, following the approach described by Braun & Clarke (2006). As the questions are based on the existing literature, it is anticipated that certain theory-lead themes may emerge in the data; however new themes may also emerge. As such, both an inductive (data lead) and a deductive (theory lead) approach to coding will be taken.

Using a thematic analysis approach, data will be analysed qualitatively using codes. The codes will then be sorted into broader themes. Alongside the data analysis, memos will be written by the researcher regarding the processes by which codes and themes are formed. NVivo, a computer programme, will be used to aid this process.

To ensure the validity of themes, some data will be analysed a second time by the Chief Investigator.

10 DATA HANDLING

10.1 Data handling and record keeping

To contact prospective participants, contact details will be provided to the research student by the field supervisor within the Obesity Service for those people who have registered their interest in participating and given their consent for their contact details to be accessed. These details will be stored in a password protected document on the research student's university drive. This will be permanently deleted from the research student's university drive when the study is complete.
Data will be stored in two locations. (1) On the research student's university drive. This is a cloud drive, password protected and accessible by the research student only. It also benefits from additional firewall protection as provided by the University of Hertfordshire. (2) A back up copy of the data will be stored on the Chief Investigator's university drive. Again this is password protected, accessible only by the Chief Investigator and benefiting from additional firewall protection provided by the University of Hertfordshire.
All audio recordings and transcriptions will be provided with a code name and identifiable information changed.
Code names will be linked to participant information on a password protected electronic document stored on the research student's university drive.
The details of participants who consent to being contacted about future research will be retained by the Chief Investigator who will store these electronically on a password protected document on their university drive. Only the Chief Investigator will have access to this information. All other identifiable information will be destroyed once the study is completed.
After completion of the study, anonymised transcripts will be archived electronically by the Chief Investigator on the university drive. These will be destroyed after five years in accordance with university policy. Once the study has completed the research student will destroy all copies of study data which have been stored on their university drive.

9.2 Access to Data

With the exception of during transcription, only the research team outlined in this application will have access to the data. A transcription service will have access to anonymised audio recording for transcription purposes. A confidentiality agreement will be in place with the transcription service and the service will delete the data following the research team's receipt of the transcribed data.

11. REFERENCES

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. Action control (pp. 11-39). Springer Berlin Heidelberg.

Bocchieri, L. E., Meana, M., & Fisher, B. L. (2002). Perceived psychosocial outcomes of gastric bypass surgery: A qualitative study. Obesity Surgery, Vol. 12, No. 6, pp. 781-788.

Connors, M., Bisogni, C. A., Sobal, J. & Devine, C. M. (2001). Managing values in personal food systems. Appetite, Vol. 36, No. 3, pp. 189-200.

Cordain, L. Eaton, S. B., Sebastian, A., Mann, N., Lindeberg, S., Watkins, B. R., O'Keefe, J. H. & Brand-Miller, J. (2005). "Origins and evolution of the Western diet: health implications for the 21st century." The American journal of clinical nutrition, Vol. 81, No. 2, pp. 341-354.

Dziurowicz-Kozlowska, A. H., Wierzbicki, Z., Lisik, W., Wasiak, D., & Kosieradzki, M. (2006). The objective of psychological evaluation in the process of qualifying candidates for bariatric surgery. Obesity surgery, Vol. 16, No. 2, pp. 196-202.

Flaxman, P. E., Blackledge, J. T. & Bond, G. W. (2011). Acceptance and Commitment Therapy. Routledge: East Sussex.

Furst, T., Connors, M., Bisogni, C. A., Sobal, J. & Falk, L. W. (1996). Food choice: a conceptual model of the process. Appetite, Vol. 26, No. 3, pp. 247-266.

Geraci, A. A., Brunt, A. & Marihart, C. (2014). The work behind weight-loss surgery: A qualitative analysis of food intake after the first two years post-op. ISRN obesity, 2014.

Gatineau, M., & Dent, M. (2011). Obesity and Mental Health. Oxford: National Obesity Observatory.

Guh, D. P., Zhang, W., Bansback, N., Amarsi, Z., Birmingham, C. L., & Anis, A. H. (2009). The incidence of co-morbidities related to obesity and overweight: A systematic review and meta-analysis. BMC Public Health. Vol. 9, No. 1, pp. 1.

Hillersdal, L., Christensen, B. J. & Holm, L. (2015). Patients' strategies for eating after gastric bypass surgery: a qualitative study. European Journal of Clinical Nutrition. Vol. 10, pp. 523-527.

Kirk, S. F., Penney, T. L. & McHugh, T. L. (2010). Characterizing the obesogenic environment: the state of the evidence with directions for future research. Obesity Reviews, Vol. 11, No. 2, pp. 109-117.

Kitzinger, H. B., Abayev, S., Pittermann, A., Karle, B., Bohdjalian, A., Langer, F. B. & Frey, M. (2012). After massive weight loss: patients' expectations of body contouring surgery. Obesity Surgery, Vol. 22, No. 4, pp. 544-548.

Kluever Romo, L. & Dailey, R. M. (2014). Weighty dynamics: Exploring couples' perceptions of post-weight-loss interaction. Health Communication, Vol. 29, No. 2, pp. 193-204.

Loaisa, A. J., Carrillo, V. J. B., Coll, D. G. C., & Gimeno, E. C. (2015). Psychosocial effects of surgery and physical activity in bariatric patients: a systematic review. European Journal of Human Movement, Vol. 35, pp.12-33.

Lustig, R. H., Schmidt, L. A. & Brindis, C. D. (2012). Public health: the toxic truth about sugar. Nature, Vol. 482, pp. 27-29.

Lynch, A. (2016). "When the honeymoon is over, the real work begins:" Gastric bypass patients' weight loss trajectories and dietary change experiences. Social Science & Medicine, Vol. 151, pp. 241-249.

McCormick, B., Stone, I., & Corporate Analytical Team. (2007). Economic costs of obesity and the case for government intervention. Obesity Reviews. Vol. 8, pp. 161–164.

National Institute of Clinical Excellence. (2014). Obesity: Identification, Assessment & Management (CG189).

Natvik, E., Gjengedal, E., Moltu, C. & Råheim, M. (2014). Re-embodying Eating Patients' Experiences 5 Years After Bariatric Surgery. Qualitative Health Research, 1049732314548687.

Newson, L. & Flint, B. (2011). Applied Psychology and Obesity Management. Obesity in the Uk: A Psychological Perspective: British Psychological Society.

NHS Choices. (2015). Britain: 'the fat man of Europe'. Last accessed 07/11/16 at URL: http://www.nhs.uk/Livewell/loseweight/Pages/statistics-and-causes-of-the-obesity-epidemic-in-the-UK.aspx

NHS Choices. (2016). Treating Obesity. Last accessed 25/10/16 at URL: http://www.nhs.uk/Conditions/Obesity/Pages/Treatment.aspx

Nordin, L. & Rorsman, I. (2012). Cognitive behavioural therapy in multiple sclerosis: a randomized controlled pilot study of acceptance and commitment therapy. Journal of rehabilitation medicine, Vol. 44, No. 1, pp. 87-90.

Ogden, J., Avenell, S., & Ellis, G. (2011). Negotiating control: patients' experiences of unsuccessful weight-loss surgery. Psychology & health, Vol. 26, No. 7, pp/ 949-964.

Puhl, R., & Brownell, K. D. (2011). Bias, discrimination, and obesity. Obesity Research. No. 9, Vol. 12, pp. 788–805.

Sarafino, E. P., & Smith, T. W. (2014). Health psychology: Biopsychosocial interactions. John Wiley & Sons: USA.

Sogg, S., & Gorman, M. J. (2008). Interpersonal changes and challenges after weight-loss surgery. Primary Psychiatry, Vol. 15, No. 8, pp. 61-66.

Weineland, S., Arvidsson, D., Kakoulidis, T. P. & Dahl, J. (2012). Acceptance and commitment therapy for bariatric surgery patients, a pilot RCT. Obesity Research & Clinical Practice, Vol. 1, No. 6, e21-e30.

Wimmelamnn, C. L., Dela, F., & Mortensen, E. L. (2013). Psychological predictors of weight loss after bariatric surgery: A review of the recent research. Obesity Research & Clinical Practice, Vol. 8, No. 4, pp. 299-313.

Wood, K. V., & Ogden, J. (2015). Patients' long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study. Journal of Health Psychology, 1359105315578304.

APPENDIX M

Research Poster

University of Hertfordshire UH

Are You Having Weight Loss Surgery?

We are looking for participants to take part in a research study looking at the hopes, expectations and experiences of candidates awaiting weight loss surgery.

What Does The Research Involve?

You would meet with a Researcher at an NHS site in or near [redacted].
The Researcher will talk with you for around 1 hour about your expectations and hopes for your weight loss surgery.

How To Take Part In The Research

If you are interested in taking part, please ask for further information at your Pre-Surgery Information Group or from a member of the Psychology Team.

Version 2 07.09.17

APPENDIX N

Participant Information Sheet

Participant Information Sheet

We are looking for participants to take part in a research study looking at the hopes, expectations and experiences of candidates who are awaiting weight loss surgery.

Below is the information we think you will need to decide whether you would like to take part. If you are interested, please complete a registration of interest form at the end of this information sheet and pass to a member of staff running your information group.

Project title:
A Qualitative Study Exploring the Hopes and Expectations of Candidates for Weight Loss Surgery.

Why are we doing this research?
We hope that talking to candidates awaiting weight loss surgery will help us to better understand their hopes and expectations of weight loss surgery as well as what influenced them in their decision to choose to have surgery. We hope that this will enable us to better understand when is the right time for candidates to pursue weight loss surgery.

The information learned will contribute to improving the assessment and support provided for weight loss surgery candidates.

Do I have to take part in the study?
No, taking part is voluntary. If you decided to take part, you are able to change your mind about this without giving a reason.

What do I need to do if I take part?
You would meet with a Researcher. During the meeting the Researcher will spend about 1 hour talking with you about your hopes and expectations for weight loss surgery as well as about your experiences leading up to your decision to pursue surgery and why now.

Where will the research interview be held?
The interview will take place at the ***** and ***** Hospital or at the Disability Resource Centre in *****. If you decide to take part in the research, a precise location can be confirmed, to fit with room availability and the time and place most convenient for you.

Who is the Researcher I will meet with?
You will meet with Jennifer Clayton, who is a Trainee Clinical Psychologist at the University of Hertfordshire. As part of her doctoral training, Jennifer has chosen to do research focusing on people's experience of weight loss surgery.

Who else is in the research team?
Jennifer will be working closely with Dr Barbara Mason, who will be supervising this piece of research. Barbara is a Clinical Psychologist and Senior Clinical Tutor at the University of Hertfordshire. Barbara also has worked in the Obesity Service at ***** and ***** Hospital.

Dr Rebecca Ramsden, Clinical Psychologist from the Obesity Service at ***** and ***** Hospital will also work closely with Jennifer and Barbara on this research.

If I take part in the research what happens to the information I tell you and the results of the study?

Like all health professionals, the research team are bound by confidentiality. This means that the information you share with us will not be discussed outside of the research team and will be stored securely at all times.

The only time that we might have to share information about you, is if we were to learn information which meant that you or someone else was at risk of harm. Whilst uncommon, under these circumstances, if we did need to share the information, the purpose would be to help ensure the safety of you or others and we would always aim to explain to you who we will share information with and why, more information is included about this in the next question.

The research interview with you will be audio recorded. After your interview this audio recording will be transcribed using a confidential transcription service. Any personally identifiable information such as your name will be removed so that the transcribed interviews will be anonymous. Once transcribed, the audio recording of your interview will be destroyed and the written transcription will be stored electronically and will be password protected. Only the research team will have access to this.

When the research has been completed, Jennifer will write up the findings as a part of her studies at university. The findings will also be written for publication in an academic journal. In this article, and in the work for the university, there may be quotes included from the interviews; however these will be carefully selected and anonymised to protect the identity of those who provided the quotes. The findings will also be shared with the ***** and ***** obesity service. Here too, information will be anonymised to protect the confidentiality of individual participants.

If during your interview you say something which you do not want to be used, you can ask for this information to be removed from the data.

What happens if I become distressed during the research interviews?
We understand that it is a big decision to have weight loss surgery, that candidates may have had difficult experiences leading up to their surgery and that they might also feel worried about what may happen during or following the surgery.

The researcher, Jennifer, has over 10 years clinical experience working with people with physical and mental health conditions in the NHS. If you become distressed, upset or worried about the weight loss surgery during you interview, she can support you to link in with the professionals you have been working with from the Obesity Service for support with this.

In the event that other issues not related to the weight loss surgery arise during the research interview that causes you distress or upset, we would recommend that you contact your GP who will be able to help you access the support you need. Whilst very unlikely, if you were to feel so distressed that you experienced thoughts of wanting to hurt yourself or end your life and you felt that you were going to act on these thoughts, Jennifer would support you to access A&E.

Will the study affect the assessment and intervention I receive from the clinical team working with me in relation to my weight loss surgery?

No, the clinical team will continue to work with you as they would do so if you were not taking part in the study.

Will my GP be informed that I am taking part in the research?
Yes, we will write to your GP to let them know that you have taken part in the research. Your GP is the person that holds all the information on your involvement with the NHS and this includes NHS based research.

What else might happen?
There is also a second phase to the study where we would like re-interview people at least 6 months after their surgery to explore their experiences and view about the surgery a while after it has been done.

We would like to ask people if they agree to being contacted after their surgery to discuss taking part in the second phase of the study.

Will I get paid for taking part?
Participation is voluntary so you will not get paid or be reimbursed for your travel costs.

Who has reviewed this study?
This study is being completed as part of Jennifer's doctorate training in clinical psychology at the University of Hertfordshire. The University of Hertfordshire have reviewed this project and are sponsors for the project to take place in the NHS.

This study has also been reviewed by the University of Hertfordshire and has been approved by the NHS ethics committee (Health Research Authority).

For audit purposes to ensure research is carried out in line with ethical standards, the information that you provide as part of this research may be accessed by NHS Trusts and regulatory authorities.

Who do I contact if I need more information or have any questions?
If you would like further information or have any questions you can contact the Researcher or their supervisor using the contact details below:

Researcher:
Jennifer Clayton
Trainee Clinical Psychologist
Tel: 01707 286 322
Email: j.clayton2@herts.ac.uk

Research Supervisor:
Dr Barbara Mason
Clinical Psychologist
Tel: 01707 28 6322
Email: b.l.mason@herts.ac.uk

Interested in taking part?

Register your interest below

Simply complete and give to a clinical member of staff who is running your information group. The research team will then get in touch with you.

Name: ……

Please circle yes or no:

I am interested in taking part in the research:	YES	NO
I am happy for the researcher to access my contact details from the obesity service:	YES	NO
I am happy for the researcher to contact me about the research:	YES	NO

APPENDIX O

Brief Screening Questionnaire

Recruitment: Initial Screening Questions

To be used by the researcher in her initial telephone contact with potential participants who have opted in to being contacted about the research. These questions will serve as a guide for the researcher, and can be followed up with other questions or discussion as required.

Thank you for your interest in taking part in this research study. I need to ask a few questions to check whether you are able to participate in the study. We can then discuss the information about the study in more detail and I can answer any questions you might have. If you'd like to take part, we can go on to discuss the practical arrangements for meeting.

1. *Is this your first weight loss surgery?*

2. *If you take part in the study, will you be able to meet with a researcher in or near* [redacted]

3. *What stage of your pre-surgery process are you at?*
    a. *Have you attended the pre-surgery information group with the psychologist, dietician and nurse? OR*
    b. *Have you met individually with a psychologist, dietician and nurse?*
    c. *Have you met with the anesthetist yet?*
    d. *Have you met with the surgeon yet?*

4. *Have you read the information about the study? Do you have any questions?*

5. *Are you happy for us to contact you about potential research in the future?*

APPENDIX P

Demographics Questionnaire

DEMOGRAPHIC INFORMATION
Please answer the below questions using the space provided.

How old are you?	
Do you identify yourself as male or female? (Please circle/tick)	**Male** **Female** **Prefer not to say**
What type of surgery are you having?	
What is your employment status? (Please circle/tick)	**Employed full-time** **Employed part-time** **Unemployed** **Retired** **Student** **Long term sick** **Homemaker** **Unpaid voluntary work**
What is your relationship status? (Please circle/tick)	**Single** **Married/ Civil Partner** **Divorced/ Person whose Civil Partnership has been dissolved** **Widowed/ Surviving Civil Partner** **Separated**
What is your highest qualification?	
What is your ethnicity (Please circle/tick)	**White:** White British White Irish White other (Please specify below) background **Asian & Asian British:** Indian Pakistani Bangladeshi Any other Asian background (Please specify below) **Other Ethnic Groups:** Chinese Any other ethnic group (Please specify below) **Mixed:** White & Black Caribbean White & Black African White & Asian Any other mixed (Please specify below) **Black & Black British:** Caribbean African Any other Black background (Please specific below)

APPENDIX Q

Interview Schedule

RESEARCH SCHEDULE

- **To be completed following written consent and completion of demographic questionnaire.**
- **Allocate 1 hour to complete the interview.**

1. Thank you for taking part in the research, what made you decide to take part?

2. When do you first remember considering weight loss surgery?
   Possible prompts:
   a. Was it your idea or someone else's?
   b. Did any life events influence your decision?
   c. What made now the right time?
   d. Did you feel any other options were available to you?

3. How did you experience being assessed for weight loss surgery?
   a. did you have any concerns?
   b. what was helpful about it
   c. was there anything unhelpful about it?
   d. did you feel able to be open and honest?
   e. did it help with your decision to have surgery?
   f. did it make you have any doubts about surgery?

4. How would you describe your relationship to eating?
   Possible prompts:
   a. What triggers eating?
      i. Feeling hungry?
      ii. Habit
      iii. Emotions (boredom, sadness, stress, loneliness, happiness)
      iv. Family and friends
   b. How do you feel after you have eaten?

5. How do you think surgery will change how you eat?

6. What things do you value most in life? Do you think any of these things will change or improve after weight loss surgery?

7. Imagine you've had the weight loss surgery; imagine your life 2 years from now - what does it look like?
   Possible prompts:
   a. Where do you live?
   b. Who is in your life?
   c. How do you spend your time?
   d. Do you work? If so where?
   e. How is your physical health?
   f. How are you feeling emotionally?
   g. How do you feel about yourself?
   h. How do you feel about your body?
   i. What does your body look like?
   j. What are your relationships like?

8. What makes these differences [insert differences] important to you?

9. Let's pretend you weren't going to have the weight loss surgery. When you imagine your life 2 years from now, what does it look like?

10. Who are the important people in your life? Have you spoken to them about the weight loss surgery?
    Possible prompts:
    a. What do they say/think/ feel about the weight loss surgery?
    b. How do you expect this will impact your relationship with (key person)?
    c. How do you think this will affect the other relationships in your life?

11. What do you think the impact of you having surgery might be on your family?
    Possible prompts:
    a. How do you think it might impact your lifestyle as a family?
    b. Do you think it will change meal times?

12. How do you think your friends/ family might support you following the weight loss surgery?
    Possible prompts:
    a. If they were here what do you think they might say about this?

13. How do you think your friends and family will react if the surgery doesn't go as hoped (i.e. you don't lose weight)?

14. Are there any changes that you anticipate following surgery that you don't want, or feel worried about in any way?
    Possible prompts:
    a. Have you made any plans on how to manage this?
    b. What do think will be the most difficult changes to make?
    c. What do you anticipate the biggest challenge will be?

15. Have you spoken to anyone about your worries?
    Possible prompts:
    a. What did they say?
    b. Did they give you any advice?
    c. Professional advice?
    d. People that have had surgery?
    e. Advice from other sources e.g. internet?

16. How much do you think the changes after surgery will be down to you and how much will be down to the physical impact of the surgery?
    Possible prompts:
    a. Which parts do you think you have control over?

17. What if anything, do you think will be required from you following the weight loss surgery?
    Possible prompts:
    Eating? Lifestyle? Self-care?
    a. Do you think this might change over time?
    b. Have you thought about how you will achieve this?
    c. Do you have any worries about achieving this?
    d. Do you think you will need any help with this? From whom?
    e. How confident do you feel about being able to make the changes required after surgery?
    f. Do you feel prepared?

- **Complete interview by thanking the participant for there time.**
- **Ensure that they understand who and where to go to for further information and support.**
- **Before the participant leaves check with them whether they would like any information removing from their interview and remind the participant of the two week period in which they are able to withdraw from the study.**

APPENDIX R

Table R1: *Creation of Semi-Structured Interview Schedule*

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
Description of the sample characteristics	**Demographics** o Age o Ethnicity o Gender o Type of weight loss surgery (if known) o Employment status o Relationship status o Highest qualification	Requested using brief written questionnaire at the start of the interview.	As for Time A – demographics to be collected at the start of the interview.
• Anchor questions to open the interview & orientate the ppt • Health belief model, Becker & Rosenstock • Theory of planned behaviour, Ajzen, 1985 • Stages of change, Diclemente et al, 1991	**Opening 'warm-up' question** **What factors influenced their decision to pursue weight loss surgery?** o Life circumstances? o Crucial events? o Views of significant others? o Societal norms? o Threats? (of not losing weight) o Perceived benefits o How did they get the idea?	Thank you for taking part in the research, what led you to decide to take part? What lead you to decide to pursue surgery as a means to lose weight? o Own idea / advice of others? When do you first remember considering weight loss surgery? Has there been any particular aspect or events in your life that influenced your decision to pursue weight loss surgery? o Perceived benefits?	How have things been since the weight loss surgery? Looking back, how do you feel about your decision to have weight loss surgery?

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
	○ When did they first consider weight loss surgery? ○ Readiness for change • Capturing the quality of choice- An active choice to support positive change or a reactive choice / last option?	○ Feared negative consequences of not losing weight? Do family and friends have a view on weight loss surgery? How has this influenced your decision? What do you think has made now the right time?	
• S/U feedback that family and friends are key. • Theory of reasoned action, Ajzen & Fishbein, 1980- Social pressures surrounding the health behaviour influence the likelihood of change. • Interpersonal and relationship changes, Sogg & Gorman, 2008 • Self-efficacy, Schunk & Carbonari, 1984- likelihood of help from	**<u>Family & social relationships:</u>** • Who are the important people in their life, do they know about the surgery and what do they think, say and feel about it? • How do they think weight loss surgery will impact the other people in the home? • How do they anticipate weight loss will impact their intimate relationships? • How to they anticipate weight loss will impact their wider social relationships?	Who are the important people in your life? Have you spoken to them about the weight loss surgery? ○ What do they say/think/ feel about the weight loss surgery? What do you think the impact of you having surgery might be on your family? ○ Impact of lifestyle/eating changes If you lose a lot of weight, how do you think your family and friends will feel about this? ○ How do you expect this will impact on your relationship with your (husband/wife/partner)? ○ How do you think this will affect your wider friendships and relationships?	How do the important people in your life think things have been since the surgery? Do family / friends think it has been successful? Has the surgery impacted the people in your life too? In what ways? How have others reacted to your weight loss so far?

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
others impacts self efficacy over health behaviour change.	• How do they think weight loss surgery will impact any social engagement they currently have around eating? • How well supported do they feel? Perceived social support.	And if you don't lose a lot of weight …? How much is eating currently a social occasion for you? o Do you anticipate this changing after surgery? o How do you imagine this will be for you? for your friends and family? How do you think your friends/ family might support you following the weight loss surgery? o What do you think your friends/family would say about this?	Husband/wife/partner? Family? Friends? Other people? Is this what you expected? Has eating with others changed, if so how? Have the people in your life supported you with the process, if so how?
• S/U feedback that fear of an undesired outcome if they do not change is important to consider. • Health belief model, Becker & Rosenstock- high perceived seriousness of not changing and high susceptibility to this	**<u>Desired outcomes (hopes), pros & cons of change & relationship with values</u>** • What are candidates' desired outcomes for surgery? o Improvement in health conditions o Weight loss o Improvement in psychological wellbeing	Imagine you've had the weight loss surgery; imagine your life 2 years from now - what does it look like? o Where do you live? o Who is in your life? o How do you spend your time? o Do you work? If so where? o How is your physical health? o How are you feeling emotionally? o How do you feel about yourself? o How do you feel about your body?	What do you recall as having been your hopes for surgery? o Have these materialized? o Have they changed? What have the actual outcomes been so far?

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
increases chances of successful change. • Theory of planned behaviour, Ajzen, 1985 – Higher prediction of reward following change = increased chances of success. • Stages of change, Diclemente et al, 199- the balance of pros vs cons of changing will impact chance of success. • ACT, Flaxman at al 2011 & Food choice process model, Connors et al 2011- making choices in accordance with values can improve psychological outcome.	○ Improvement in activities of daily living ○ Improvement in quality of life ○ Improvement in relationships ○ Other changes to aesthetic appearance • What do candidates believed will happen if they do not change? How much have they considered this? What are their biggest fears? • Why are the undesired outcomes of not having weight loss surgery and the desired outcomes of weight loss surgery important to them, why these things?	○ What does your body look like? ○ What are your relationships like? Let's pretend you weren't going to have the weight loss surgery. When you imagine your life 2 years from now, what does it look like? What things do you value most in life? Do you think any of these things will change or improve after weight loss surgery? When you imagine your life after weight loss surgery and the ways in which it will look different, what makes those differences important to you? Do you think those differences are important to anyone else? If so, what makes them important to those/ that person/ people?	What else (if anything) has changed since the surgery? ○ body image ○ self confidence ○ intimate relationships ○ social relationships ○ occupational / activities What other impacts has it had on your life? Is this different to what you expected? Which changes/impacts have felt most important to you?

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
• S/U feedback that these things are less considered until following the surgery. • Theory of planned behaviour, Ajzen, 1985 and reasoned action, Ajzen & Fishbein, 1980 – How likely they think they will succeed/ fail in getting what they want influences chances of success. • The stages of change model, Diclemente et al, 1991, cons of change will influence the level of behaviour change • WL as an evolving trajectory- no end point, Lynch, 2016. • Development of new coping strategies, Wood & Ogden, 2015, Hillersdal et al, 2016, Natvik et al, 2014. • Self-efficacy, Schunk & Carbonar, 1984- effort	**<u>Fears, concerns and challenges relating to the surgery and life afterwards</u>** • Do they anticipate any undesired outcomes or have any fears and worries about the surgery and lifestyle changes following surgery.	Do you have any worries about the weight loss surgery? o The surgery itself? o The recovery? o Ongoing impact? o The outcome? Are there any changes that you anticipate following surgery that you don't want or feel worried about in any way? What do you anticipate as being the biggest challenge for you following weight loss surgery? o Have you made any plans on how to manage this? o What eating habits do you anticipate you will need to change? o What do think will be the most difficult changes to make? Have you spoken to anyone (particularly people who have had surgery) about your worries? o What did they say? o Did they give you any advice?	What do you recall as your fears about having surgery? o Have they materialized? o How have you managed this? Have there been any other undesired outcomes? o How have you managed this? What have been the biggest challenges /barriers? What are the anticipated challenges ahead? What do you know now that you wish you had known before?

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
required and complexity of task will influence change, having a positive prototype can help.			

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
• A tool to be worked with not a cure, Geraci et al, 2014. • But relinquishing some control to the tool, Ogden et al, 2011. • WL as an evolving trajectory- no end point, Lynch, 2016. • Development of new coping strategies, Wood & Ogden, 2015, Hillersdal et al, 2016, Natvik et al, 2014.	**<u>Behaviour change following surgery</u>** • Do candidates think that they will need to change their behaviours and how are they planning to achieve this? • Self efficacy • Locus of control (internal vs external)?	What if anything, do you think will be required from you following the weight loss surgery? o Do you think this might change over time? o Have you thought about how you will achieve this? How? o Do you have any worries about achieving this? o Do you think you will need any help with this? From whom? o How confident do you feel about being able to make the changes required after surgery? How much do you think the changes are down to you and how much will be down to the physical impact of the surgery? o Which parts do you feel you have control over?	Looking back what have you had to change? How much do you think the changes have been down to you and how much down to the physical impact of the surgery? What have you struggled to change? Anticipated changes in the future? How confident do you feel about making these? What was the process like for you? How did they experience the surgery? Immediate recovery period? Time since?

UNDERPINNING THEORY / RESEARCH / RATIONALE	AREAS TO COVER	QUESTIONS & PROMPTS	EXPECTED FOLLOW-UP QUESTIONS AT TIME B.
• Stages of change model, Diclemnte et al 1991, preparation stage states that people should consider specifically what is required from them in increasing their chances of success			

APPENDIX S

Participant Consent Form

Participant Consent Form

Title of the Research: A Qualitative Study Exploring the hopes and Expectations of Candidates for Weight Loss Surgery.

Researcher: Jennifer Clayton (Trainee Clinical Psychologist)

Supervisors: Dr Barbara Mason (Clinical Psychologist) and Dr [redacted] (Clinical Psychologist)

Please read each statement and circle yes if you agree.
Please also write your initials in each check box as indicated.

Phase 1 of the research	Please write initials in the empty boxes below	
I have read the information sheet provided and have had the chance to ask any questions that I have, which were answered by the researcher.	**Yes** **No**	
I understand that I can withdraw at any time without giving a reason, until 2 weeks after the interview has been completed.	**Yes** **No**	
I understand that I can choose not to answer any questions asked during the interview.	**Yes** **No**	
I understand that my research interview will be audio recorded and that the audio recording of my interview will be destroyed once it has been transcribed.	**Yes** **No**	
I understand that talking part will not affect the treatment that I receive from the Obesity Service.	**Yes** **No**	
I understand that the information I provide will be stored confidentially and in accordance with data protection rules.	**Yes** **No**	
I understand that the information I provide will be used by Jennifer Clayton for her doctorial thesis. The information will be anonymised (meaning that my name and other identifying details will be removed). Anonymised quotes from the interview may be used within the write up of the research, which may be published in an academic journal or another publication.	**Yes** **No**	
The researcher has provided contact information for if I need to ask further questions about the research.	**Yes** **No**	
I agree to take part in the research.	**Yes** **No**	
I understand that I will not be paid or have my travel costs reimbursed for taking part in the study.	**Yes** **No**	

Phase 1 of the research	Please write initials in the empty boxes below	
I consent for my GP to be informed that I am taking part in this research.	**Yes** **No**	
I consent to the researcher accessing my GP details from the Obesity Service.	**Yes** **No**	

Future research	Please write initials in the empty boxes below	
I consent to being contacted about possibly taking part in the second phase of the study which would involve a second interview at least 6 months after the surgery.	**Yes** **No**	
I understand that I would be given further information about the second part of the study and that I would have the opportunity to consent to participate or not at the time.	**Yes** **No**	
I understand that whether or not I choose to participate in the second phase of the study will not affect my treatment with the obesity service or whether or not I can participate in the first part of the study.	**Yes** **No**	

Audit and regulation of this research	Please write initials in the empty box below	
I understand that the information gathered during this research may be accessed by the NHS Trust and regulatory authorities who oversee this research.	**Yes** **No**	

Participant's name:

Participant's signature:

Date:

Researcher's name:

Researcher's signature:

Date:

APPENDIX T

Foundations of Initial Deductive Coding Frame

Table T1: *Theory and Research Informing the Deductive Portion of the Coding Frame*

Interview Topic	Question/ Theory/ Research	Code Name	Description and Instructions for Use
Deciding to have weight loss surgery	2, 2a, 2b, 2c, 2d, • *Health belief model, Hochbaum et al,1952* • *stages of change model Prochaska & DiClemente, 1986* • *Pfiel et al, 2013* • *Ogden & Hills, 2008* • *Homer et al, 2015* • *Owers et al, 2017* • *Owen-Smith et al, 2016*	1. Information gathering	**Description:** Gathering information to inform decision to have weight loss surgery. **When to use:** Participant mentions how they learned about weight loss surgery. **When not to use:** Participant does not mention how they learned about weight loss surgery.
		2. Key events	**Description:** Key life events impacting decision to have weight loss surgery. **When to use:** Participant refers to life events which impacted their decision. **When not to use:** Participant does not refer to life events which impacted their decision.
		3. Past events	**Description:** Past life events spoken about in the context of weight and/or decision to have surgery but not necessarily explicitly linked. **When to use:** Participant talks about past events within the context of weight and/or decision to have surgery e.g. "I was bullied at school, I've always been big". **When not to use:** Participant does not refer to past life events within the context of weight and/or decision to have surgery.
		4. Obesity stigma	**Description:** Experience of obesity stigma impacting decision to have weight loss surgery. **When to use:** Participant refers to experience of obesity stigma and it impacting their decision. **When not to use:** Participants does not refer to obesity stigma and its impact on their decision.
		5. WLS stigma	**Description:** Experience of weight loss surgery stigma. **When to use:** Participant talks about weight loss surgery stigma.

			When not to use: Participant does not talk about weight loss surgery stigma.
		6. GPs	**Description:** Access to weight loss surgery as gate kept by GPs. **When to use:** Participant refers to experiences in accessing weight loss surgery via their GP. **When not to use:** Participant does not refer to experiences in accessing weight loss surgery via their GP.
		7. Failure	**Description:** Failed weight loss attempts prior to considering weight loss surgery. **When to use:** Participant mentions failed attempts at weight loss in the lead up to pursing surgery. **When not to use:** Participant does not mention failed attempts at weight loss in the lead up to surgery.
		8. Only option	**Description:** Weight loss surgery referred to as the only option and last resort. **When to use:** Participant refers to surgery as the only viable option for them. **When not to use:** Participant does not refer to surgery as the only viable option for them.
Being assessed for weight loss surgery and pre-surgical workup.	3, 3a, 3b, 3c. 3d. 3e, 3f, • Clinically informed through consultation • Homer et al, 2015 • Pfiel et al, 2014 • Ogden et al, 2011	9. Fear of loss	**Description:** Fear of not being accepted for surgery during the assessment process. **When to use:** Participant talks about fears that they may not be accepted for surgery. **When not to use:** Participant does not talk about fears that they may not be accepted for surgery.
		10. Honesty	**Description:** How honest and open participants felt able to be during assessment. **When to use:** Participant discusses how able they felt to be honest and open. **When not to use:** Participant does not discuss how able they felt to be honest and open.
		11. Helpful	**Description:** MDT staff described as there to help and assist. **When to use:** Participant talks about MDT staff as there to help and assist. **When not to use:** Participant does not talk about MDT staff as there to help and assist.
		12. Unhelpful	**Description:** T3/ assessment described as unhelpful/ negative experience. **When to use:** Participant talks about T3/ assessment as unhelpful/ negative experience.

			When not to use: Participant does not talk T3/ assessment as unhelpful/ negative experience.
		13. Informative	**Description:** Reference to the assessment process as providing information on surgical workup, surgery and life after surgery. **When to use:** Participant refers to assessment process as providing information on any aspect of weight loss surgery. **When not to use:** Participant does not refer to assessment process as providing information on any aspect of weight loss surgery.
		14. Rapport	**Description:** Able to general rapport with MDT staff in absence of obesity stigma. **When to use:** Participant refers to positive relationship with MDT staff. **When not to use:** MDT does not refer to positive relationship with MDT staff.
Relationship to eating	4, 4a, 4b, • Clinically informed through consultation • Ogden & Hills, 2008 • Lloyd et al, 2017 • Ogden et al, 2011 • Wood & Ogden, 2016 • Pfiel et al, 2013	15. Emotional eating	**Description:** Describes a relationship between emotions and eating behaviour. **When to use:** Participant mentions relationship between emotions and eating behaviour. **When not to use:** Participant does not mention relationship between emotions and eating behaviour.
		16. Testing	**Description:** Reference to their relationship with food being difficult and/ or challenging in some way. **When to use:** Participant refers to their relationship with food as difficult and/or challenging. **When not to use:** Participant does not refer to their relationship with food as difficult and/or challenging.
		17. Routines	**Description:** Reference to routines (or their absence) for eating. **When to use:** Participant talks about routine ways of eating. **When not to use:** Participant does not talk about routine ways of eating.
		18. Portions	**Description:** Difficulty with portion sizes of food. **When to use:** Participant talks about difficulty with portion sizes. **When not to use:** Participant does not talk about difficult with portion sizes.
		19. Satiety	**Description:** Reference to a lack of satiety or feeling full. **When to use:** Participant talks about a lack of satiety or feeling full. **When not to use:** Participant does not talk about a lack of satiety or feeling full.
		20. Over-eating	**Description:** Reference to over-eating.

			When to use: Participant talks about over-eating in the absence of references of objective binging. **When not to use:** Participant does not talk about over-eating or talks about over-eating in the context of objective binging- see 'binging' code for these instances.
		21. Binging	**Description:** Reference to objective binging. **When to use:** Participant talks about objective binging. **When not to use:** Participant does not talk about objective binging.
		22. Wrong	**Description:** Reference to eating the "wrong" foods. **When to use:** Participant talks about eating the "wrong" foods e.g. foods typically considered as unhealthy such as processed foods. **When not to use:** Participant does not talk about eating the "wrong" food.
		23. Habits	**Description:** Reference to habitual ways (or their absence) of eating. **When to use:** Participant talks about habitual ways of eating. **When not to use:** Participant does not talk about habitual ways of eating.
		24. Grazing	**Description:** Describes grazing on food throughout the day. **When to use:** Participant mentions grazing on food. **When not to use:** Participant does not mention grazing on food.
Surgery and relationship to eating	5, • Homer et al, 2015 • Ogden et al, 2011 • Pfiel et al, 2014 • Ogden & Hills, 2008 • Owers et al, 2017	25. Prohibition	**Description:** Reference to expectations that the surgery will prohibit old patterns of eating. **When to use:** Participant talks about how they anticipate surgery will prohibit old patterns of eating. **When not to use:** Participant does not talk about anticipating that surgery will prohibit old patterns of eating.
		26. Alternatives	**Description:** Alternative ways of eating following the surgery are considered and discussed. **When to use:** Participant mentions thoughts or plans around alternative ways of eating following surgery. **When not to use:** Participant does not mention thoughts or plans around alternative ways of eating following surgery.
		27. Coping	**Description:** Non-food related ways of coping with emotional challenges are considered for following surgery.

		28. Restriction	**When to use:** Participant discusses non-food related coping strategies for emotional challenges which could be used following surgery. **When not to use:** Participant does not discuss non-food related coping strategies for emotional challenges which could be used following surgery. **Description:** Reference to the expectation that what, when and how participants will be able to eat following surgery will be restricted. **When to use:** Participant refers to expectation that surgery will restrict types and amounts of food that they will be able to consume. **When not to use:** Participant does not refer to an expectation that surgery will restrict types and amounts of food that they will be able to consume.
Hopes, values and surgery	6, 7, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i, 7j, 8, 9, • Self-determination theory, Ryan & Deci, 2000 • ACT, Hayes, 2004 • Homer et al, 2015 • Pfiel et al, 2013 • Clinically informed through consultation	29. Practical hopes	**Description:** Reference to practical changes which they hope for after surgery e.g. "I will be able to walk up the stairs" or "I will be able to sit in any chair". **When to use:** Participant refers to a practical hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a practical hope and/ or the hope is better captured by another hope related code.
		30. Emotional hopes	**Description:** Reference to emotional changes which they hope for after surgery e.g. "I will feel more confident" or "I will be happier". **When to use:** Participant refers to an emotional hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a practical hope and/ or the hope is better captured by another hope related code.
		31. Health hopes	**Description:** Reference to improvement in health conditions which are hoped for following surgery e.g. "My diabetes is going to improve" or "I won't be in so much pain". **When to use:** Participant refers to a health hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a health hope and/ or the hope is better captured by another hope related code.
		32. Aesthetic hopes	**Description:** Reference to improvements in aesthetic appearance which is hoped for following surgery e.g. "I'm going to be lot happier with my size" or "I'm going to find it easier to shop because I'll be smaller".

			When to use: Participant refers to an aesthetic hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to an aesthetic hope and/ or the hope is better captured by another hope related code.
		33. Relational hopes	**Description:** Reference to improvements in their relationships with others and/ or how others relate to/ treat them following surgery e.g "People won't assume the worst of me" or "I'll find it easier to meet someone". **When to use:** Participant refers to a relational hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a relational hope and/ or the hope is better captured by another hope related code.
		34. Values awareness	**Description:** Demonstrates awareness of value system underpinning hopes for life after surgery. Signs of awareness of value system will include descriptions of ways of being rather than examples of doing e.g. "being able to experience new things" rather than "I'll be able to get on a plane"*. **When to use:** Participant talks about value system underpinning hopes for life after surgery. **When not to use:** Participant does not talk about value system underpinning hopes for life after surgery.
Family, friends and surgery	7j, 10, 10a, 10b, 10c, 11, 11a, 11b, 12, 12a, 13, • Clinically informed through consultation • Owers et al, 2017 • Information on this area lacking in systematic literature review	35. Opposing	**Description:** Family or friends who have opposing views to the candidate's decision to have weight loss surgery. **When to use:** Participant talks about family or friends who are in opposition or do not fully agree with the participants decision to have surgery. **When not to use:** Participant does not talk about family or friends who are in opposition or do not fully agree with the participants decision to have surgery.
		36. Encouragement	**Description:** Family or friends who have encouraged or supported the candidate in pursuing the weight loss surgery. **When to use:** Participant mentions family or friends who have encouraged or supported them in the pursuit of weight loss surgery. **When not to use:** Participant does not mention family or friends who have encouraged or supported them in the pursuit of weight loss surgery.

		37. Social eating	**Description:** Reference to eating in social settings and/ or reference to how surgery may impact this. **When to use:** Participant discusses eating in social settings and/ or how surgery may impact this. **When not to use:** Participant does not discuss eating in social settings and/ or how surgery may impact this.
		38. Support	**Description:** Reference to the roles family and friends may have in supporting the candidate post-surgically. **When to use:** Participant refers to the roles family and friends may have in supporting them post-surgically. **When not to use:** Participant does not refer to the roles family and friends may have in supporting them post-surgically.
		39. Co-changing	**Description:** Reference to the idea that family and friends may need to adapt their habits alongside the candidate themselves. **When to use:** Participant makes reference to family and/or friends adapting habits alongside them. **When not to use:** Participant does not make reference to family and/or friends adapting habits alongside them.
Worries for life after surgery	13, 14, 14a, 14b, 14c, • Clinically informed through consultation • Kunda, 1990 • Self-efficacy, Bandura, 1977, Batsis et al, 2009, Schunk & Carbonari, 1984 • Locus of control & learned helplessness, Wallston et al,	40. Re-gain	**Description:** Reference to the fear of not losing weight or regaining weight following surgery. **When to use:** Participant mentions fear of not losing weight or regaining weight following surgery. **When not to use:** Participant does not mention gear of not losing weight or regarding weight following surgery.
		41. Adapting	**Description:** Reference to any concerns about lifestyle changes that the candidates will need to make after surgery. **When to use:** Participant discusses concerns about changes that they will need to implement following surgery. **When not to use:** Participant does not discuss concerns about changes that they will need to implement following surgery.
		42. Recovery	**Description:** Reference to the recovery period following surgery and any associated concerns.

	1976, Maier & Seligman, 1976 • Homer et al, 2015 • Area lacking in systematic literature review	43. Eating out	**When to use:** Participant talks about the recovery period and any concerns that they have about this. **When not to use:** Participant does not talk about the recovery period and any concerns that they have about this. **Description:** Any anticipated challenges with respect to either eating out or eating socially. **When to use:** Participant makes reference to an anticipated challenge with respect to either eating out or eating socially. **When not to use:** Participant does not make reference to an anticipated challenge with respect to either eating our or eating socially.
		44. Excess skin	**Description:** Acknowledgement and/ or concern about the possibility of excess skin following weight loss after surgery. **When to use:** Participant talks about excess skin and any concerns they have about this. **When not to use:** Participant does not talk about excess skin or concerns regarding this following surgery.
Support with concerns about surgery	15, 15a, 15b, 15c, 15d, 15e, • Clinically informed through consultation • Homer et al, 2015 • Pfiel et al, 2014 & 2013	45. Professional help	**Description:** Reference to seeking professional help, support, advice or information with regards to any concerns about the weight loss surgery. **When to use:** Participant discusses the support sought from professionals with regards to concerns about surgery. **When not to use:** Participant does not discuss any support sought from professionals with regards to concerns about surgery.
		46. Other candidates	**Description:** Reference to seeking help, support, advice or information with regards to any concerns about the weight loss surgery from other weight loss surgery candidates. **When to use:** Participant discusses the support sought from other weight loss surgery candidates with regards to concerns about surgery. **When not to use:** Participant does not discuss any support sought from weight loss surgery candidates with regards to concerns about surgery OR participant does talk about support sought from weight loss surgery candidates but this is via an online social media source.

		47. Online	**Description:** Reference to seeking help, support, advice or information with regards to any concerns about the weight loss surgery from online sources. **When to use:** Participant discusses the support sought from online sources with regards to concerns about surgery, this is to include social media sources involving other weight loss surgery candidates. **When not to use:** Participant does not discuss any support sought from online sources with regards to concerns about surgery.
Working alongside surgery	16, 16a, 17, 17a, 17b, 17c, 17d, 17e, 17f • Clinically informed through consultation • Homer et al, 2015 • Ogden et al, 2014 • Pfiel et al, 2014 • Ogden & Hills, 2008	48. Honeymoon period	**Description:** Reference to a period following surgery in which weight loss may be automatic and/ or that this period may come to an end. **When to use:** A period of time following surgery in which weight loss may be automatic and/ or that this period may come to an end. **When not to use:** Participant does not talk about a period of time following surgery in which weight loss may be automatic and/ or that this period may come to an end.
		49. A tool	**Description:** That surgery is a tool that candidates need to use and work with in order to achieve their desired outcomes. **When to use:** Participant talks about the need to work alongside the surgery or acknowledges that the surgery does not "do it all". **When not to use:** Participant does not talk about the need to work alongside the surgery or acknowledge that the surgery does not "do it all".
		50. Responsibility	**Description:** Reference to any responsibility and/or control that the participant believes they have over the outcome of the weight loss surgery. **When to use:** Participant discusses any responsibility and/ or control that they see themselves as having over the outcome of the weight loss surgery. **When not to use:** Participant does not discuss any responsibility and/ or control that they see themselves as having over the outcome of the weight loss surgery.
Preparation for life after surgery	12, 17,17a, 17b, 17c, 17d, 17e, 17f • Theory of planned behaviour, Ajzen, 1985	51. Plans	**Description:** Reference to plans with regards to lifestyle changes and/or ways of coping after surgery. **When to use:** Participant mentions plans around lifestyle changes and/or ways of coping after surgery. **When not to use:** Participant does not mention plans around lifestyle changes and/or ways of coping after surgery.

- Homer et al, 2015
- Lloyd et al, 2017

*Note that here the term ‘values’ is used within an acceptance and commitment framework. This means that values refer to the desired qualities of behaviours, they are not goals but instead underpin goals and moment to moment choices. For a more detailed explanation of values which is accessible, please see online resources provided by Dr Russel Harris that are freely available e.g. https://www.youtube.com/watch?v=T-lRbuy4XtA or access his book The Happiness Trap.

APPENDIX U

Evolution of the Coding Frame

Table U1: *Evolution of the Coding Frame*

Key	
	= Deductive code retained for final coding frame
	= Initial deductive code which was subsequently adapted and therefore removed from the final coding frame
	= Adapted or added deductive code as coding frame developed and based on discussion with independent coder.
	= Inductive code generated from the data itself included in final coding frame

Interview Topic	Question/ Theory/ Research	Code Name	Description and Instructions for Use
Deciding to have weight loss surgery	2, 2a, 2b, 2c, 2d, • *Health belief model, Hochbaum et al,1952* • *stages of change model Prochaska & DiClemente, 1986* • *Pfiel et al, 2013*	Information gathering	**Description:** Gathering information to inform decision to have weight loss surgery. **When to use:** Participant mentions how they learned about weight loss surgery. **When not to use:** Participant does not mention how they learned about weight loss surgery.
		1. Internet	**Description:** Gathering information online to inform decision to have weight loss surgery. **When to use:** Participant mentions internet based learning about weight loss surgery which informed their decision. **When not to use:** Participant does not mention internet based learning about weight loss surgery which informed their decision.

• *Ogden & Hills, 2008* • *Homer et al, 2015* • *Owers et al, 2017* • *Owen-Smith et al, 2016*	2. Books	**Description:** Gathering information through books and/or leaflets to inform decision to have weight loss surgery. **When to use:** Participant mentions book/ leaflet based learning about weight loss surgery which informed their decision. **When not to use:** Participant does not mention book/ leaflet based learning about weight loss surgery which informed their decision.
	3. Past Candidates	**Description:** Gathering information from people who have already had weight loss surgery to inform own decision to have weight loss surgery. **When to use:** Participant mentions learning from past candidates about weight loss surgery and that this informed their decision. **When not to use:** Participant does not mention learning from past candidates about weight loss surgery which informed their decision.
	4. Professional Info	**Description:** Gathering information health professionals to inform decision to have weight loss surgery. **When to use:** Participant mentions learning about weight loss surgery from health professionals and this informing their decision. **When not to use:** Participant does not mention learning about weight loss surgery from health professionals which informed their decision.
	5. Key events	**Description:** Key life events impacting decision to have weight loss surgery. **When to use:** Participant explicitly refers to life event which impacted their decision e.g "I'm turning 40 soon and I really want to improve my health before then". **When not to use:** Participant does not explicitly refer to life events which impacted their decision.
	Past events	**Description:** Past life events spoken about in the context of weight and/or decision to have surgery but not necessarily explicitly linked. **When to use:** Participant talks about past events within the context of weight and/or decision to have surgery e.g. "I was bullied at school, I've always been big". **When not to use:** Participant does not refer to past life events within the context of weight and/or decision to have surgery.

6. Triggers	**Description:** Past life events spoken about in the context of decision to have surgery but not necessarily explicitly linked. **When to use:** Participant talks about past events within the context of decision to have surgery e.g. "I was bullied at school, I've always been big". **When not to use:** Participant does not refer to past life events within the context of decision to have surgery.
7. Gain	**Description:** Past life events spoken about in the context of weight gain and appear to be part of the candidates understanding of their weight gain. **When to use:** Participant talks about past events within the context of weight gain e.g. "They left and I felt unloved, I had an operation and have struggled since". **When not to use:** Participant does not refer to past life events within the context of weight gain.
8. Self-love	**Description:** Reference to relationship to self and being dissatisfied with this. **When to use:** Participant discusses relationship to self and how satisfied they feel about it. **When not to use:** Participant does not discuss relationship to self and how satisfied they feel about it.
9. Self-work	**Description:** Reference to candidate working on themselves ahead/ in line with the pursuit of surgery. **When to use:** Participant talks about steps they have taken in working on themselves ahead of/ in line with the pursuit if surgery. **When not to use:** Participant does not talk about steps they have taken in working on themselves ahead of/ in line with the pursuit if surgery.
10. WLS stigma	**Description:** Experience of weight loss surgery stigma. **When to use:** Participant talks about weight loss surgery stigma. **When not to use:** Participant does not talk about weight loss surgery stigma.
11. Suggestion	**Description:** The idea of weight loss surgery as suggested or generated by someone else e.g. a health professional. **When to use:** Participant talks about someone else initially suggesting the idea of weight loss surgery.

	When not to use: Participant does not talk about someone else initially suggesting the idea of weight loss surgery.
12. Mine	**Description:** The idea to pursue weight loss surgery as the candidate's own. **When to use:** Participant talks about their pursuit of weight loss surgery as their own idea. **When not to use:** Participant does not talk about their pursuit of weight loss surgery as their own idea.
13. Chance	**Description:** Chance events as resulting in the pursuit of surgery. **When to use:** Chance events are linked with the participants pursuit of surgery. **When not to use:** Chance events are not linked with the participants pursuit of surgery.
14. Limitations	**Description:** The impact of obesity on the participants life and reference to how this limits them in anyway. **When to use:** Participant refers to limitations they experience as a result of obesity. **When not to use:** Participant does not refer to limitations they experience as a result of obesity.
15. Burden	**Description:** Conceptualisation of self in current position as a burden/ expression of dissatisfaction with feeling reliant on others. **When to use:** Participant talks about of self in current position as a burden/ expression of dissatisfaction with feeling reliant on others. **When not to use:** Participant does not talk about of self in current position as a burden/ expression of dissatisfaction with feeling reliant on others.
16. Private	**Description:** Consideration of privately funded weight loss surgery. **When to use:** Participant talks about considering privately funded surgery. **When not to use:** Participant does not talk about considering privately funded surgery.
17. Shield	**Description:** Reference to ways of coping with or avoiding the judgements of others. **When to use:** Participant makes reference to how they cope with or avoid the judgement of others.

	When not to use: Participant does not make reference to how they cope with or avoid the judgement of others.
18. Initial no	**Description:** Candidates whose initial requests for referral for weight loss surgery assessment was turned down. **When to use:** Participant talks about their initial requests for referral for weight loss surgery assessment was turned down. **When not to use:** Participant does not talk about their initial requests for referral for weight loss surgery assessment was turned down.
19. For them	**Description:** Reference to candidates pursuing surgery due to their family members. **When to use:** Participant talks about pursuing surgery due to their family members. **When not to use:** Participant does not talk about pursuing surgery due to their family members.
20. Barrier	**Description:** Current weight and associated health problems cited as a barrier to making lifestyle changes. **When to use:** Participant cites weight and associated health problems as a barrier to making lifestyle changes. **When not to use:** Participant does not cite weight and associated health problems as a barrier to making lifestyle changes.
21. Obesity stigma	**Description:** Reference to the experience of obesity stigma. **When to use:** Participant refers to experience of obesity stigma. **When not to use:** Participants does not refer to obesity stigma.
22. GPs	**Description:** Access to weight loss surgery as gate kept by GPs. **When to use:** Participant refers to experiences in accessing weight loss surgery via their GP. **When not to use:** Participant does not refer to experiences in accessing weight loss surgery via their GP.
23. Failure	**Description:** Failed weight loss attempts prior to considering weight loss surgery. **When to use:** Participant mentions failed attempts at weight loss in the lead up to pursing surgery.

			When not to use: Participant does not mention failed attempts at weight loss in the lead up to surgery.
		24. Only option	**Description:** Weight loss surgery referred to as the only option and last resort. **When to use:** Participant refers to surgery as the only viable option for them. **When not to use:** Participant does not refer to surgery as the only viable option for them.
Being assessed for weight loss surgery and pre-surgical workup.	3, 3a, 3b, 3c. 3d. 3e, 3f, • Clinically informed through consultation • Homer et al, 2015 • Pfiel et al, 2014 • Ogden et al, 2011	25. Fear of loss	**Description:** Fear off not being accepted for surgery during the assessment process. **When to use:** Participant talks about fears that they may not be accepted for surgery. **When not to use:** Participant does not talk about fears that they may not be accepted for surgery.
		26. Honesty	**Description:** How honest and open participants felt able to be during assessment. **When to use:** Participant discusses how able they felt to be honest and open. **When not to use:** Participant does not discuss how able they felt to be honest and open.
		27. Helpful	**Description:** T3/ assessment described as helpful/ positive experience. **When to use:** Participant talks about T3/ assessment as helpful/ positive experience. **When not to use:** Participant does not talk T3/ assessment as helpful/ positive experience.
		28. Unhelpful	**Description:** T3/ assessment described as unhelpful/ negative experience. **When to use:** Participant talks about T3/ assessment as unhelpful/ negative experience. **When not to use:** Participant does not talk T3/ assessment as unhelpful/ negative experience.
		29. Informative	**Description:** Reference to the assessment process as providing information on surgical workup, surgery and life after surgery. **When to use:** Participant refers to assessment process as providing information on any aspect of weight loss surgery. **When not to use:** Participant does not refer to assessment process as providing information on any aspect of weight loss surgery.

30. Hoops	**Description:** Reference to the amount of stages and/or hoops to be jumped through during pre-surgical pathway. **When to use:** Participant refers to the amount of stages and/or hoops to be jumped through during their pre-surgical pathway. **When not to use:** Participant does not refer to the amount of stages and/or hoops to be jumped through during their pre-surgical pathway.
31. Length	**Description:** Reference to the amount of time it takes to be accepted for surgery. **When to use:** Participant refers to the amount of time it takes from to be accepted for surgery. **When not to use:** Participant does not refer to the amount of time it takes from to be accepted for surgery.
32. Appreciation	**Description:** A view on the value in, or appreciation for the length of the pre-surgical pathways. **When to use:** Participant expresses a view on the value or utility in the length of pre-surgical workup. **When not to use:** Participant does not express a view on the value or utility in the length of pre-surgical workup.
33. Realisation	**Description:** Increasing awareness of the work, effort and length of input required prior to weight loss surgery. **When to use:** Participant talks about a realisation regarding the work, effort and length of input required prior to weight loss surgery. **When not to use:** Participant does not talk about a realisation regarding the work, effort and length of input required prior to weight loss surgery.
34. Blips	**Description:** Struggles and points of weight gain during pre-surgical workup. **When to use:** Participant discusses any struggles or weight gain they experienced during their pre-surgical workup. **When not to use:** Participant does not discuss any struggles or weight gain they experienced during their pre-surgical workup.
35. Normalisation	**Description:** MDT staff as normalising the experience of struggles or weight gain during pre-surgical workup. **When to use:** Participant talks about MDT staff as normalising the experience of struggles or weight gain during pre-surgical workup.

	When not to use: Participant does not talk about MDT staff as normalising the experience of struggles or weight gain during pre-surgical workup.
36. Motivator	**Description:** The requirements of pre-surgical workup as acting as an external motivator and extra form of structure for candidates in adapting their lifestyle and losing weight. **When to use:** Participant refers to pre-surgical workup as providing structure/ acting as an external motivator. **When not to use:** Participant does not refer to pre-surgical workup as providing structure/ acting as an external motivator.
37. Investment	**Description:** The amount of work and investment required from participants as part of their pre-surgical workup and not wanting to see this go to waste e.g. “I’ve worked so hard to get to this point, I’m not going to put it to waste after surgery”. **When to use:** Participant talks about the work they have done to this point and not wanting to waste this. **When not to use:** Participant does not talk about the work they have done to this point and not wanting to waste this.
38. Drastic	**Description:** Realisation or acknowledgement of how the severity of weight loss surgery as a procedure. **When to use:** Participant refers to surgery as drastic or serious. **When not to use:** Participant does not refer to surgery as drastic or serious.
39. Trust	**Description:** Candidates feeling that they have faith in/ trust the MDT/ surgeons. **When to use:** Participant talks about feeling that they have faith in/ trust the MDT/ surgeons. **When not to use:** Participant does not talk about feeling that they have faith in/ trust the MDT/ surgeons.
40. Doubt	**Description:** Candidate expresses doubt or some uncertainty about whether they will have the surgery or not through their own choice. **When to use:** Participant expresses doubt or some uncertainty about whether they will have the surgery or not through their own choice. **When not to use:** Participant does not express doubt or some uncertainty about whether they will have the surgery or not through their own choice.

41. Undoubting	**Description:** Reference to their decision to pursue surgery as unwavering/ experiencing no doubt. **When to use:** Participant talks about their decision to pursue surgery as unwavering/ experiencing no doubt. **When not to use:** Participant does not talk about their decision to pursue surgery as unwavering/ experiencing no doubt.
42. Headspace	**Description:** The pre-surgical pathways as psychologically preparing participants for surgery and all that it requires. **When to use:** Participant refers to the pre-surgical pathway as helping them become psychologically ready for surgery. **When not to use:** Participant does not refer to the pre-surgical pathway as helping them become psychologically ready for surgery.
43. Gaps	**Description:** Gaps identified in service provision during pre-surgical work-up. **When to use:** Participant refers to gaps in their experience of pre-surgical provision. **When not to use:** Participant does not refer to gaps in their experience of pre-surgical provision.
44. Type	**Description:** The experience of candidates in selecting the type of bariatric surgery procedure. **When to use:** Participant refers to the type of weight loss surgery procedure they are having. **When not to use:** Participant does not refer to the type of weight loss surgery procedure they are having.
45. Necessity	**Description:** Experiences of pre-surgical workup leading candidates to question the necessity of weight loss surgery and whether they might achieve their goals without it. **When to use:** Participants talk about questioning the necessity of the weight loss surgery. **When not to use:** Participant does not talk about questioning the necessity of the weight loss surgery.
46. Milk	**Description:** Experience of milk diet during pre-surgical workup.

			When to use: Participant talks about their experience with the milk diet prior to surgery. **When not to use:** Participant does not talk about their experience with the milk diet prior to surgery.
		47. Success	**Description:** The experience of success during pre-surgical workup. **When to use:** Participant talks about moments of success or achievement during pre-surgical workup. **When not to use:** Participant does not talk about moments of success or achievements during pre-surgical workup.
		48. Rushed	**Description:** Reference to appointments with Tier 3/ Tier 4 staff being rushed or not long enough. **When to use:** Participant talks about appointments with Tier 3/ Tier 4 staff being rushed or not long enough. **When not to use:** Participant does not talk about appointments with Tier 3/ Tier 4 staff being rushed or not long enough.
		49. Unclear	**Description:** Reference to the process of pre-surgical workup being unclear or confusing. **When to use:** Participant talks about the process of pre-surgical workup being unclear or confusing. **When not to use:** Participant does not talk about the process of pre-surgical workup being unclear or confusing.
		50. Rapport	**Description:** Able to generate rapport with MDT staff in absence of obesity stigma. **When to use:** Participant refers to positive relationship with MDT staff. **When not to use:** MDT does not refer to positive relationship with MDT staff.
Relationship to eating	4, 4a, 4b, • Clinically informed through consultation • Ogden & Hills, 2008	51. Emotional eating	**Description:** Describes a relationship between emotions and eating behaviour. **When to use:** Participant mentions relationship between emotions and eating behaviour. **When not to use:** Participant does not mention relationship between emotions and eating behaviour.
		52. Testing	**Description:** Reference to their relationship with food being difficult and/ or challenging in some way.

• Lloyd et al, 2017 • Ogden et al, 2011 • Wood & Ogden, 2016 • Pfiel et al, 2013		**When to use:** Participant refers to their relationship with food as difficult and/or challenging. **When not to use:** Participant does not refer to their relationship with food as difficult and/or challenging.
	53. External	**Description:** Describes external triggers to eating e.g. sight/ smell of food. **When to use:** Participant refers to external triggers for eating. **When not to use:** Participant does not refer to external triggers for eating.
	54. Routines	**Description:** Reference to routines (or their absence) for eating. **When to use:** Participant talks about routine ways of eating. **When not to use:** Participant does not talk about routine ways of eating.
	55. Portions	**Description:** Difficulty with portion sizes of food. **When to use:** Participant talks about difficulty with portion sizes. **When not to use:** Participant does not talk about difficult with portion sizes.
	56. Satiety	**Description:** Reference to a lack of satiety or feeling full. **When to use:** Participant talks about a lack of satiety or feeling full. **When not to use:** Participant does not talk about a lack of satiety or feeling full.
	57. Over-eating	**Description:** Reference to over-eating. **When to use:** Participant talks about over-eating in the absence of references of objective binging. **When not to use:** Participant does not talk about over-eating or talks about over-eating in the context of objective binging- see 'binging' code for these instances.
	58. Binging	**Description:** Reference to objective binging. **When to use:** Participant talks about objective binging. **When not to use:** Participant does not talk about objective binging.
	59. Wrong	**Description:** Reference to eating the "wrong" foods. **When to use:** Participant talks about eating the "wrong" foods e.g. foods typically considered as unhealthy such as processed foods. **When not to use:** Participant does not talk about eating the "wrong" food.

60. Insight	**Description:** The development of insight and understanding around relationship to eating from unconscious to conscious. **When to use:** Participant makes reference to becoming aware of their relationship to eating. **When not to use:** Participant does not make reference to becoming aware of their relationship to eating.
61. Disorder	**Description:** The framing of candidates' relationship to food and eating as an eating disorder. **When to use:** Participant explicitly talks about their eating as eating disordered. **When not to use:** Participant does not explicitly talk about their eating as eating disordered.
62. Self-value	**Description:** Relationship to eating as grounded in level of self- value and worth. **When to use:** Participant talks about their level of self- value or worth and how this relates to their relationship to eating. **When not to use:** Participant does not talk about their level of self- value or worth and how this relates to their relationship to eating.
63. Self-harm	**Description:** Use of food as a representation of lack of self-care. **When to use:** Participant makes reference to their use of food as a lack of self-care. **When not to use:** Participant does not make reference to their use of food as a lack of self-care.
64. Enablers love	**Description:** Other people in candidates lives seen as encouraging eating as an act of love. **When to use:** Participant talks about a person/ people in their life encouraging eating as a form of care and love. **When not to use:** Participant does not talk about a person/ people in their life encouraging eating as a form of care and love.
65. Enablers abuse	**Description:** Other people in candidates lives seen as encouraging eating as an act of abuse. **When to use:** Participant talks about a person/ people in their life encouraging eating as a form of abuse.

			When not to use: Participant does not talk about a person/ people in their life encouraging eating as a form of abuse.
		66. Cycles	**Description:** Relationship to eating as a vicious cycle. **When to use:** Participants implies relationship to eating as a vicious cycle. **When not to use:** Participant does not imply relationship to eating as a vicious cycle.
		67. Guilt	**Description:** Experiences of guilt in relation to eating. **When to use:** Participant talks about feeling guilty in relation to eating. **When not to use:** Participant does not talk about feeling guilty in relation to eating.
		68. Control	**Description:** Reference to the amount of control the candidate feels they have over eating. **When to use:** Participant talks about the amount of control they feel they have over eating. **When not to use:** Participant does not talk about the amount of control they feel they have over eating.
		69. Grazing	**Description:** Describes grazing or picking at food. **When to use:** Participant mentions grazing or picking at food. **When not to use:** Participant does not mention grazing or picking food.
Surgery and relationship to eating	5, • Homer et al, 2015 • Ogden et al, 2011 • Pfiel et al, 2014 • Ogden & Hills, 2008 • Owers et al, 2017	70. Prohibition	**Description:** Reference to expectations that the surgery will prohibit old patterns of eating. **When to use:** Participant talks about how they anticipate surgery will prohibit old patterns of eating. **When not to use:** Participant does not talk about anticipating that surgery will prohibit old patterns of eating.
		71. Alternatives	**Description:** Alternative ways of eating following the surgery are considered and discussed. **When to use:** Participant mentions thoughts or plans around alternative ways of eating following surgery. **When not to use:** Participant does not mention thoughts or plans around alternative ways of eating following surgery.

72. Coping	**Description:** Non-food related ways of coping with emotional challenges are considered for following surgery. **When to use:** Participant discusses non-food related coping strategies for emotional challenges which could be used following surgery. **When not to use:** Participant does not discuss non-food related coping strategies for emotional challenges which could be used following surgery.
73. Liquid	**Description:** Anticipating their experience of a liquid diet post-surgically. **When to use:** Participant makes reference to liquid diet post-surgically. **When not to use:** Participant does not make reference to liquid diet post-surgically.
74. Relationship	**Description:** The expectation that the relationship that the participant has with eating will be changed by the surgery. **When to use:** Participant talks about anticipating that how they relate to food will change after surgery. **When not to use:** Participant does not talk about how they relate to food may change after surgery.
75. Sustain	**Description:** Surgery seen as a way to sustain changed eating behaviour in the long-term. **When to use:** Participant conceptualizes surgery as a tool for sustaining long-term weight loss. **When not to use:** Participant does not conceptualise surgery as a tool for sustaining long-term weight loss.
76. Accelerating	**Description:** Surgery seen as a way to accelerate the achievement of outcomes e.g. weight loss. **When to use:** Participant talks about how surgery might speed up the process of them achieving their outcomes. **When not to use:** Participant does not talk about how surgery might speed up the process of them achieving their outcomes.
77. Barrier lift	**Description:** Hope/ expectation that declining weight via surgery will inevitably lead to lifestyle changes. **When to use:** Participant talks about hope/ expectation that declining with via surgery will inevitably lead to lifestyle change.

			When not to use: Participant does not talk about hope/ expectation that declining with via surgery will inevitably lead to lifestyle change.
		78. Panacea	**Description:** Explicit acknowledgement that weight loss surgery is not a panacea for all difficulties. **When to use:** Participant states that surgery will not change all of the current difficulties they face. **When not to use:** Participant does not specify that surgery will not change all of the current difficulties they face.
		79. Excitement	**Description:** Candidates feeling excited about surgery. **When to use:** Participant talks about feeling excited about surgery. **When not to use:** Participant does not talk about feeling excited about surgery.
		80. Full	**Description:** Expectation that surgery will lead to a sense of feeling full. **When to use:** Participant talks about an expectation or hope that surgery will lead to a sense of feeling full. **When not to use:** Participant does not talk about an expectation or hope that surgery will lead to a sense of feeling full.
		81. Restriction	**Description:** Reference to the expectation that what, when and how participants will be able to eat following surgery will be restricted. **When to use:** Participant refers to expectation that surgery will restrict types and amounts of food that they will be able to consume. **When not to use:** Participant does not refer to an expectation that surgery will restrict types and amounts of food that they will be able to consume.
Hopes, values and surgery	6, 7, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i, 7j, 8, 9, • Self-determination	Practical Hopes	**Description:** Reference to practical changes which they hope for after surgery e.g. "I will be able to walk up the stairs" or "I will be able to sit in any chair". **When to use:** Participant refers to a practical hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a practical hope and/ or the hope is better captured by another hope related code.

theory, Ryan & Deci, 2000 • ACT, Hayes, 2004 • Homer et al, 2015 • Pfiel et al, 2013 • Clinically informed through consultation	82. Mobility	**Description:** Reference to improved mobility anticipated following surgery. **When to use:** Participant talks about anticipating improved mobility following surgery. **When not to use:** Participant does not talk about anticipating improved mobility following surgery.
	83. DL	**Description:** Reference to improved quality or frequency of activities of daily living following surgery. **When to use:** Participant talks about how activities of daily living will improve after surgery. **When not to use:** Participant does not talk about how activities of daily living will improve following surgery.
	84. Travel	**Description:** Reference to how travelling will be easier following surgery e.g. on planes or buses. **When to use:** Participant talks about how travelling will be easier following surgery. **When not to use:** Participant does not talk about how travelling will be easier following surgery.
	85. Play	**Description:** Reference to a hope that candidates will be able to engage in more leisure activities following surgery. **When to use:** Participant talks about being able to do more leisure activities following surgery. **When not to use:** Participant does not talk about being able to do more leisure based activities following surgery.
	86. Work	**Description:** Hoping to be able to increase or return to work, either paid or unpaid (e.g. house work). **When to use:** Participant talks about hoping to increase or return to work. **When not to use:** Participant does not talk about hoping to increase or return to work.
	87. Wonderful	**Description:** Reference to an expectation that life will be wonderful or much improved after surgery. **When to use:** Participant refers to expectation that life will be wonderful or much improved after surgery.

	When not to use: Participant does not refer to expectation that life will be wonderful or much improved after surgery.
Emotional hopes	**Description:** Reference to emotional changes which they hope for after surgery e.g. “I will feel more confident” or “I will be happier”. **When to use:** Participant refers to an emotional hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a practical hope and/ or the hope is better captured by another hope related code.
88. Happy	**Description:** Reference to the hope that they will feel happier after surgery. **When to use:** Participant refers to hope that they will feel happier after surgery. **When not to use:** Participant does not refer to hope that they will feel happier after surgery.
89. Confident	**Description:** Reference to the hope that they will feel more confident after surgery. **When to use:** Participant refers to hope that they will feel more confident after surgery. **When not to use:** Participant does not refer to hope that they will feel more confident after surgery.
90. Fullness	**Description:** Anticipating, hoping or expecting life to be more full and vibrant following surgery. **When to use:** Participant makes reference to hope that life will be fuller/ more vibrant following surgery. **When not to use:** Participant does not make reference to hope that life will be fuller/ more vibrant following surgery.
Health hopes	**Description:** Reference to improvement in health conditions which are hoped for following surgery e.g. “My diabetes is going to improve” or “I won’t be in so much pain”. **When to use:** Participant refers to a health hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a health hope and/ or the hope is better captured by another hope related code.

91. Improve health	**Description:** Reference to improvement in health conditions which are hoped for following surgery e.g. "My diabetes is going to improve" or "I won't be in so much pain". **When to use:** Participant refers to a health hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a health hope and/ or the hope is better captured by another hope related code.
92. Prevent health	**Description:** Reference to a hope that having surgery will prevent future health problems. **When to use:** Participants talks about how surgery may help prevent future health problems. **When not to use:** Participant does not talk about how surgery may help prevent future health problems.
93. Extend life	**Description:** Reference to how surgery may help the candidate to extend their life expectancy. **When to use:** Participant talks about a hope that surgery will help them to live longer. **When not to use:** Participant does not talk about a hope that surgery will help them to live longer.
94. Medication	**Description:** Hopes of reducing medications or becoming medication free after surgery. **When to use:** Participant refers to a hope/ belief that they will reduce or stop taking medication following surgery. **When not to use:** Participant does not refer to a hope/ belief that they will reduce or stop taking medication following surgery.
95. Mental health	**Description:** Expectation/ hope that mental health will improve following weight loss surgery. **When to use:** Participant talks about an expectation/ hope that mental health will improve following weight loss surgery. **When not to use:** Participant does not talk about an expectation/ hope that mental health will improve following weight loss surgery.

96. Proud	**Description:** Anticipation of feeling proud of what they have achieved post-surgically **When to use:** Participant imagines feeling proud of themselves after surgery. **When not to use:** Participant does not report imagining feeling proud of themselves after surgery.
97. Self-like	**Description:** Expectation that how much the candidate likes themselves will improve with surgery. **When to use:** Participant talks about expecting their level of self-like to increase following surgery. **When not to use:** Participant does not talk about expecting their level of self-like to increase following surgery.
Relational hopes	**Description:** Reference to improvements in their relationships with others and/ or how others relate to/ treat them following surgery e.g "People won't assume the worst of me" or "I'll find it easier to meet someone". **When to use:** Participant refers to a relational hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a relational hope and/ or the hope is better captured by another hope related code.
98. Contribution	**Description:** A hope that following surgery that they will make an improved contribution towards others in their lives. **When to use:** Participant makes reference to the expectation that they will contribute in a new or additional ways to the lives of those around them. **When not to use:** Participant does not make reference to the expectation that they will contribute in a new or additional ways to the lives of those around them.
99. Independence	**Description:** A hope that surgery will result in improved independence and autonomy in life. **When to use:** Participant talks about hoping for improved autonomy and independence following surgery/ being less dependent on others. **When not to use:** Participant does not talk about hoping for improved autonomy and independence following surgery/ being less dependent on others.
100. Connection	**Description:** The hope that following surgery, their relationships and a sense of connection within these will be improved.

	When to use: Participant discusses how their existing relationships will improve following surgery. **When not to use:** Participant does not discuss how their existing relationships will improve following surgery.
101. Fertility	**Description:** A hope that fertility will improve/ that they will be able to have children. **When to use:** Participant talks about improvements in fertility and/ or hoping to have children following surgery. **When not to use:** Participant does not talk about improvements in fertility and/ or hoping to have children following surgery.
102. Children	**Description:** A hope of being able to do more activities with their children as well as being there as they grow. **When to use:** Reference made to how what they do with their children and how long they will be there to witness them grow is made. **When not to use:** Reference made to how what they do with their children and how long they will be there to witness them grow is not made.
103. Current relationships	**Description:** Expectation that their relationship with their current partner may improve. **When to use:** Participant talks about the possibility of an improved relationship with their partner following surgery. **When not to use:** Participant does not talk about the possibility that their relationship with their partner will improve following surgery.
104. Bye stigma	**Description:** Reference to hopes for reduced experience of obesity stigma following surgery. **When to use:** Participant refers to a hope for reduced experience of obesity stigma. **When not to use:** Participant does not refer to a hope for reduced obesity stigma.
105. New Relationships	**Description:** Hopes for new relationships, either platonic or romantic. **When to use:** Participant refers hoping for new relationships after surgery. **When not to use:** Participant does not refer to hoping for new relationships after surgery.

106. Normality	**Description:** Reference to becoming "normal". **When to use:** Participant talks about surgery as an avenue to becoming "normal" or being able to do "normal" things. **When not to use:** Participant does not talk about surgery as an avenue to becoming "normal" or being able to do "normal" things.
107. Unchanging	**Description:** Beliefs about aspects of life that the surgery won't or can't change as a result of weight loss surgery. **When to use:** Participant makes reference to things which they believe will remain unchanged following weight loss surgery. **When not to use:** Participant does not make reference to things which they believe will remain unchanged following weight loss surgery.
108. Gloom	**Description:** Expectation that without surgery life would be unhappy or undesired in some way. **When to use:** Reference made to the prospect of life without surgery as unhappy, undesired or depressing. **When not to use:** Reference not made to the prospect of life without surgery as unhappy, undesired or depressing.
109. Plod on	**Description:** The idea that life would go on as it is/ nothing would change/ get better or worse if surgery did not go ahead. **When to use:** Participant talks about the idea that life would go on as it is/ nothing would change if surgery did not go ahead. **When not to use:** Participant does not talk about the idea that life would go on as it is/ nothing would change if surgery did not go ahead.
Aesthetics	**Description:** Reference to improvements in aesthetic appearance which is hoped for following surgery e.g. "I'm going to be lot happier with my size" or "I'm going to find it easier to shop because I'll be smaller". **When to use:** Participant refers to an aesthetic hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to an aesthetic hope and/ or the hope is better captured by another hope related code.

		110. Shopping	**Description:** Reference to anticipating that shopping for clothes will be easier and more enjoyable following surgery. **When to use:** Participant talks about hoping that shopping will be easier or more enjoyable following surgery. **When not to use:** Participant does not talk about hoping that shopping will be easier or more enjoyable following surgery.
		111. Thinner	**Description:** Reference made to losing weight and looking thinner following surgery and looking forward to this. **When to use:** Participant talks about hoping to look thinner following surgery. **When not to use:** Participant does not talk about hoping to look thinner following surgery.
		112. Body image	**Description:** Reference made to an anticipation that body image will improve following surgery. **When to use:** Participant talks about how their body image will improve following surgery. **When not to use:** Participant does not talk about how their body image may improve following surgery.
		Value Awareness	**Description:** Demonstrates awareness of value system underpinning hopes for life after surgery. Signs of awareness of value system will include descriptions of ways of being rather than examples of doing e.g. "being able to experience new things" rather than "I'll be able to get on a plane". **When to use:** Participant talks about value system underpinning hopes for life after surgery. **When not to use:** Participant does not talk about value system underpinning hopes for life after surgery.
Family, friends and surgery	7j, 10, 10a, 10b, 10c, 11, 11a, 11b, 12, 12a, 13, • Clinically informed	113. Opposing	**Description:** Family or friends who have opposing views to the candidate's decision to have weight loss surgery. **When to use:** Participant talks about family or friends who are in opposition or do not fully agree with the participants decision to have surgery. **When not to use:** Participant does not talk about family or friends who are in opposition or do not fully agree with the participants decision to have surgery.

through consultation • Owers et al, 2017 • Information on this area lacking in systematic literature review	114. Encouragement	**Description:** Family or friends who have encouraged or supported the candidate in pursuing the weight loss surgery. **When to use:** Participant mentions family or friends who have encouraged or supported them in the pursuit of weight loss surgery. **When not to use:** Participant does not mention family or friends who have encouraged or supported them in the pursuit of weight loss surgery.
	115. Sharing	**Description:** The sharing of their weight loss surgery with family and friends. **When to use:** Participant mentions telling family or friends about the surgery. **When not to use:** Participant does not mention telling family or friends about the surgery.
	116. Secret	**Description:** Keeping the weight loss surgery a secret from family or friends. **When to use:** Participant talks about withholding that they are having the surgery from family or friends. **When not to use:** Participant does not talk about withholding the surgery from family or friends.
	117. Social eating	**Description:** Reference to eating in socially and/ or reference to how surgery may impact this. **When to use:** Participant discusses eating in socially and/ or how surgery may impact this. **When not to use:** Participant does not discuss eating in socially and/ or how surgery may impact this.
	118. Bad influence	**Description:** Family/ friends referred to as influencing bad lifestyle habits. **When to use:** Participant refers to family/ friends as being a bad influence on their lifestyle habits. **When not to use:** Participant does not refer to family/ friends as being a bad influence on their lifestyle habits.
	119. Sense making	**Description:** Descriptions of how family/ friends make sense of and learn about the weight loss surgery. **When to use:** Participant talks about how family/ friends learned about the surgery. **When not to use:** Participant does not talk about how family/ friends learned about the surgery.

120. Family worries	**Description:** Descriptions of concerns which family/ friends have about the weight loss surgery. **When to use:** Participant refers to concerns which family/ friends have about the surgery. **When not to use:** Participant does not refer to concerns which family/ friends have about the surgery.
121. Unspoken	**Description:** Wonderings about family/ friend's position and relationship to surgery which candidates have not explore explicitly with their family/ friends. **When to use:** Participant talks about their ideas about family/ friend's position/ relationship to surgery having not spoken to them explicitly about this. **When not to use:** Participant does not talk about their ideas about family/ friend's position/ relationship to surgery having not spoken to them explicitly about this.
Support	**Description:** Reference to the roles family and friends may have in supporting the candidate post-surgically. **When to use:** Participant refers to the roles family and friends may have in supporting them post-surgically. **When not to use:** Participant does not refer to the roles family and friends may have in supporting them post-surgically.
122. Emotional	**Description:** Reference to the emotional support that family or friends may provide in relation to surgery and lifestyle changes. **When to use:** Participant talks about how family and friends have/ will provide emotional support in relation to surgery and lifestyle changes. **When not to use:** Participant does not talk about how family and friends have/ will provide emotional support in relation to surgery and lifestyle changes.
123. Reminders	**Description:** Reference to prompts and reminders that family or friends may provide in relation to surgery and lifestyle changes. **When to use:** Participant talks about prompts and reminders that family or friends may provide in relation to surgery and lifestyle changes. **When not to use:** Participant does not talk about prompts and reminders that family or friends may provide in relation to surgery and lifestyle changes.

124. Recovery support	**Description:** Reference to the support that family or friends might provide during the recovery period following surgery. **When to use:** Participant talks about the support family or friends might provide during the recovery period. **When not to use:** Participant does not talk about the support family or friends might provide during the recovery period.
125. Diet change	**Description:** Reference to the support that family or friends might provide with regards to dietary changes. **When to use:** Participant talks about the support that family or friends might provide with regards to dietary changes. **When not to use:** Participant does not talk about the support that family or friends might provide with regards to dietary changes.
126. Childcare	**Description:** Reference to the support that family or friends might provide with childcare during and following surgery. **When to use:** Participant talks about the support that family or friends might provide with childcare during and following surgery. **When not to use:** Participant does not talk about the support that family or friends might provide with childcare during and following surgery.
127. Commiserating	**Description:** Reference to the support that family and friends might provide if following surgery, candidates do not achieve what they hoped. **When to use:** Participants talk about the support that family and friends might provide if following surgery, candidates do not achieve what they hoped. **When not to use:** Participant does not talk about the support that family and friends might provide if following surgery, candidates do not achieve what they hoped.
128. Unspecified support	**Description:** Reference to the idea that family/ friends will provide support but the nature of the support is not specified. **When to use:** Participant talks about the idea that family/ friends will provide support but the nature of the support is not specified. **When not to use:** Participant does not talk about the idea that family/ friends will provide support but the nature of the support is not specified OR the participant

	talks about the idea that family/ friends will provide support but the nature of the support is specified.
Co-changing	**Description:** Reference to the idea that family and friends may need to adapt their habits alongside the candidate themselves. **When to use:** Participant makes reference to family and/or friends adapting habits alongside them. **When not to use:** Participant does not make reference to family and/or friends adapting habits alongside them.
129. Food shopping	**Description:** Reference to family/friends changing the way they shop for food alongside the candidate themselves. **When to use:** Participant talks about how family/friends may change the way they shop for food alongside themselves. **When not to use:** Participant does not talk about how family/friends may change the way they shop for food alongside themselves.
130. Diet	**Description:** Reference to family/friends changing the content of what they eat alongside the candidate themselves. **When to use:** Participant talks about their family/friends changing the content of what they eat alongside themselves. **When not to use:** Participant does not talk about their family/friends changing the content of what they eat alongside themselves.
131. Moving	**Description:** Reference to family/ friends exercising more alongside the candidate themselves. **When to use:** Participant talks about their family/ friends exercising more alongside themselves. **When not to use:** Participant does not talk about their family/ friends exercising more alongside themselves.
132. Habits	**Description:** Reference to family/ friends developing improved habits and routines with regards to lifestyle alongside the candidate themselves. **When to use:** Participant talks about family/ friends developing improved habits and routines with regards to lifestyle alongside themselves.

			When not to use: Participant does not talk about family/ friends developing improved habits and routines with regards to lifestyle alongside the themselves.
Worries for life after surgery	13, 14, 14a, 14b, 14c, • Clinically informed through consultation • Kunda, 1990 • Self-efficacy, Bandura, 1977, Batsis et al, 2009, Schunk & Carbonari, 1984 • Locus of control & learned helplessness, Wallston et al, 1976, Maier & Seligman, 1976 • Homer et al, 2015 • Area lacking in systematic literature review	133. Re-gain	**Description:** Reference to the fear of not losing weight or regaining weight following surgery. **When to use:** Participant mentions fear of not losing weight or regaining weight following surgery. **When not to use:** Participant does not mention gear of not losing weight or regarding weight following surgery.
		134. Adapting	**Description:** Reference to any concerns about lifestyle changes that the candidates will need to make after surgery. **When to use:** Participant discusses concerns about changes that they will need to implement following surgery. **When not to use:** Participant does not discuss concerns about changes that they will need to implement following surgery.
		135. Recovery	**Description:** Reference to the recovery period following surgery and any associated concerns. **When to use:** Participant talks about the recovery period and any concerns that they have about this. **When not to use:** Participant does not talk about the recovery period and any concerns that they have about this.
		136. Eating out	**Description:** Any anticipated challenges with respect to either eating out. **When to use:** Participant makes reference to an anticipated challenge with respect to either eating out. **When not to use:** Participant does not make reference to an anticipated challenge with respect to either eating out.
		137. Dumping	**Description:** Concern about dumping syndrome after surgery. **When to use:** Participant makes reference to concerns about dumping syndrome after surgery. **When not to use:** Participant does not make reference to concerns about dumping syndrome after surgery.

138. Hair loss	**Description:** Concern about hair loss following surgery. **When to use:** Participant talks about concerns about hair loss after surgery. **When not to use:** Participant does not talk about concerns about hair loss after surgery.
139. Supplements	**Description:** Concern about required supplement following surgery. **When to use:** Participant expresses concerns about supplements required following surgery. **When not to use:** Participant does not express concerns about supplements required following surgery.
140. Identity	**Description:** Concern about self-perceived changes in identity following surgery. **When to use:** Participant expresses concern that their identity/ personality may change after surgery. **When not to use:** Participant does not express concern that their identity/ personality may change after surgery.
141. Personality	**Description:** Concern about others perceiving their personality and identity differently following surgery. **When to use:** Participant expresses concern about others perceiving their personality and identity differently following surgery. **When not to use:** Participant does not express concern about others perceiving their personality and identity differently following surgery.
142. Affiliations	**Description:** Concern that existing relationships will change or breakdown. **When to use:** Participant talks about concerns that existing relationships may change or end. **When not to use:** Participant does not talk about concerns that existing relationships may change or end.
143. Sickness	**Description:** Concern about nausea or vomiting following surgery. **When to use:** Participant expresses concern about nausea or vomiting following surgery. **When not to use:** Participant does not express concern about nausea or vomiting following surgery.
144. Baby steps	**Description:** Reference to the plan to take life after surgery one day/step at a time.

			When to use: Participant talks about the plan to take life after surgery one day/step at a time. **When not to use:** Participant does not talk about the plan to take life after surgery one day/step at a time.
		145. Pros & cons	**Description:** The weighing up of pros and cons of concerns and hoped for outcomes of surgery. **When to use:** Participant talks about weighing up of pros and cons of concerns and hoped for outcomes of surgery. **When not to use:** Participant does not talk about weighing up of pros and cons of concerns and hoped for outcomes of surgery.
		146. Odds	**Description:** Candidates weighing up the odds that the surgery might not go as hoped. **When to use:** Participant talks about the likelihood of surgery not going as hoped/ going right. **When not to use:** Participant does not talk about the likelihood of surgery not going as hoped/ going right.
		147. Excess skin	**Description:** Acknowledgement and/ or concern about the possibility of excess skin following weight loss after surgery. **When to use:** Participant talks about excess skin and any concerns they have about this. **When not to use:** Participant does not talk about excess skin or concerns regarding this following surgery.
Support with concerns about surgery	15, 15a, 15b, 15c, 15d, 15e, • Clinically informed through consultation • Homer et al, 2015	148. Professional help	**Description:** Reference to seeking professional help, support, advice or information with regards to any concerns about the weight loss surgery. **When to use:** Participant discusses the support sought from professionals with regards to concerns about surgery. **When not to use:** Participant does not discuss any support sought from professionals with regards to concerns about surgery.
		149. Other candidates	**Description:** Reference to seeking help, support, advice or information with regards to any concerns about the weight loss surgery from other weight loss surgery candidates.

- Pfiel et al, 2014 & 2013

When to use: Participant discusses the support sought from other weight loss surgery candidates with regards to concerns about surgery.
When not to use: Participant does not discuss any support sought from weight loss surgery candidates with regards to concerns about surgery OR participant does talk about support sought from weight loss surgery candidates but this is via an online social media source.

150. Family — **Description:** Reference to talking about concerns with family members or friends.
When to use: Participant makes reference to talking with family or friends about worries for surgery.
When not to use: Participant does not make reference to talking with family or friends about worries for surgery.

151. Vicarious — **Description:** Reference to learning through the experiences and mistakes of past candidates.
When to use: Participant makes reference to learning through the experiences/ mistakes of past candidates.
When not to use: Participant does not make reference to learning through the experiences/ mistakes of past candidates.

152. None — **Description:** The choice to not seek addition support explicitly acknowledged.
When to use: Participant talks about deciding not to seek support.
When not to use: Participant does not talk about deciding not to seek support.

153. Get on — **Description:** The idea that candidates will deal with challenges/ concerns following surgery by just "getting on with it".
When to use: Participant makes reference to the idea that they will deal with challenges/ concerns by just "getting on with it".
When not to use: Participant does not make reference to the idea that they will deal with challenges/ concerns by just "getting on with it".

154. Bad enough — **Description:** Concerns needing to be "bad enough" before candidates will seek help/ advice.
When to use: Participant talks about the idea that concerns need to be "bad enough" before they will seek help/advice.
When not to use: Participant does not talk about the idea that concerns need to be "bad enough" before they will seek help/advice.

		155. Bliss	**Description:** Reference to not thinking about concerns as a way of coping. **When to use:** Participant expresses tendency to no think about concerns as a way of coping. **When not to use:** Participant does not express tendency to no think about concerns as a way of coping.
		156. Online	**Description:** Reference to seeking help, support, advice or information with regards to any concerns about the weight loss surgery from online sources. **When to use:** Participant discusses the support sought from online sources with regards to concerns about surgery, this is to include social media sources involving other weight loss surgery candidates. **When not to use:** Participant does not discuss any support sought from online sources with regards to concerns about surgery.
Working alongside surgery	16, 16a, 17, 17a, 17b, 17c, 17d, 17e, 17f • Clinically informed through consultation • Homer et al, 2015 • Ogden et al, 2014 • Pfiel et al, 2014 • Ogden & Hills, 2008	157. Honeymoon period	**Description:** Reference to a period following surgery in which weight loss may be automatic and/ or that this period may come to an end. **When to use:** A period of time following surgery in which weight loss may be automatic and/ or that this period may come to an end. **When not to use:** Participant does not talk about a period of time following surgery in which weight loss may be automatic and/ or that this period may come to an end.
		158. A tool	**Description:** That surgery is a tool that candidates need to use and work with in order to achieve their desired outcomes. **When to use:** Participant talks about the need to work alongside the surgery or acknowledges that the surgery does not "do it all". **When not to use:** Participant does not talk about the need to work alongside the surgery or acknowledge that the surgery does not "do it all".
		159. Beforehand	**Description:** Reference to pre-operative lifestyle changes that candidates make. **When to use:** Participant talks about pre-operative lifestyle changes that they have or are going to make. **When not to use:** Participant does not talk pre-operative lifestyle changes that they have or are going to make.
		160. Good enough	**Description:** Reference to outcomes following surgery not needing to be perfect/ that there is a level that would be "good enough".

			When to use: Participant talks about to outcomes following surgery not needing to be perfect/ that there is a level that would be "good enough". **When not to use:** Participant does not talk about to outcomes following surgery not needing to be perfect/ that there is a level that would be "good enough".
		161. Responsibility	**Description:** Reference to any responsibility and/or control that the participant believes they have over the outcome of the weight loss surgery. **When to use:** Participant discusses any responsibility and/ or control that they see themselves as having over the outcome of the weight loss surgery. **When not to use:** Participant does not discuss any responsibility and/ or control that they see themselves as having over the outcome of the weight loss surgery.
Preparation for life after surgery	12, 17,17a, 17b, 17c, 17d, 17e, 17f • Theory of planned behaviour, Ajzen, 1985 • Homer et al, 2015 • Lloyd et al, 2017	162. Exercise	**Description:** Reference to plans to exercise after surgery. **When to use:** Participant mentions plans to exercise **When not to use:** Participant does not mention plans to exercise after surgery.
		163. Structure	**Description:** Reference to plans to implement eating routines after surgery. **When to use:** Participant mentions plans to implement eating routines after surgery. **When not to use:** Participant does not mention plans to implement eating routines after surgery.
		164. Size	**Description:** Reference to plans to change portion sizes after surgery. **When to use:** Participant mentions plans to change portion sizes after surgery. **When not to use:** Participant does not mention plans change portion sizes following surgery.
		165. Dietary	**Description:** Reference to plans to change the types of foods consumed post-surgically. **When to use:** Participant mentions plans to change the type of food consumed after surgery. **When not to use:** Participant does not mention plans change the types of food consumed following surgery.
		166. Experiential	**Description:** Reference to the idea that the participant anticipates they will learn as they go along. **When to use:** Participant suggests that they will learn as they go along.

	When not to use: Participant does not mention that they will learn as they go along.
167. Not yet	**Description:** Little thought or plans for required lifestyle changes after surgery. **When to use:** Participant suggests little thought or plans for the required lifestyle changes after surgery. **When not to use:** No evidence/ suggestion that the participant has given little thought or planning to the required lifestyle changes after surgery.
168. Focus	**Description:** Expressions of focus and determination with respect to the end goal. **When to use:** Participant talks about their focus or determination with regards to their goals for surgery. **When not to use:** Participant does not talk about their focus or determination with regards to their goals for surgery.
169. Fate	**Description:** Reference to the role of fate in life after surgery. **When to use:** Participant talks about things going wrong or not as expected after surgery as in the hands of fate. **When not to use:** Participant does not talk about things going wrong or not as expected after surgery as in the hands of fate.
170. Setbacks	**Description:** Expectation that there will be setbacks after surgery. **When to use:** Participant demonstrates an expectation that they will have to overcome setbacks after surgery. **When not to use:** Participant does not demonstrate an expectation that they will have to overcome setbacks after surgery.
171. Life-long	**Description:** Expectation that the lifestyle changes required will be life-long. **When to use:** Participant talks about the lifestyle changes that are required alongside surgery as being life-long. **When not to use:** Participant does not talk about the lifestyle changes that are required alongside surgery as being life-long.
172. Settle	**Description:** Expectation that following a period of recovery they will settle into a routine/ way of eating/ normality. **When to use:** Participant talks about anticipating that following an initial period of recovery they will settle into a routine or way of eating that is seen as normality.

	When not to use: Participant does not talk about anticipating that following an initial period of recovery they will settle into a routine or way of eating that is seen as normality.
173. Prepared	**Description:** Reference to how prepared the candidate feels for surgery and life after. **When to us:** Participant makes reference to how prepared they feel for surgery and life after. **When not to use:** Participant does not make reference to how prepared they feel for surgery and life after.
174. Plan B	**Description:** A plan B for if things do not go as hoped. **When to use:** Participant talks about their plans for if the surgery does not achieve what they want it to. **When not to use:** Participant does not talk about their plans for if the surgery does not achieve what they want it to.

APPENDIX V

Final Inductive and Deductive Coding Frame

Table V1: *Final Inductive and Deductive Coding Frame*

173 Codes in Total
82 Deductive Codes
91 Inductive Codes

Code Name	Description and Instructions for Use
1. Internet	**Description:** Gathering information online to inform decision to have weight loss surgery. **When to use:** Participant mentions internet based learning about weight loss surgery which informed their decision. **When not to use:** Participant does not mention internet based learning about weight loss surgery which informed their decision.
2. Books	**Description:** Gathering information through books and/or leaflets to inform decision to have weight loss surgery. **When to use:** Participant mentions book/ leaflet based learning about weight loss surgery which informed their decision. **When not to use:** Participant does not mention book/ leaflet based learning about weight loss surgery which informed their decision.
3. Past Candidates	**Description:** Gathering information from people who have already had weight loss surgery to inform own decision to have weight loss surgery. **When to use:** Participant mentions learning from past candidates about weight loss surgery and that this informed their decision. **When not to use:** Participant does not mention learning from past candidates about weight loss surgery which informed their decision.
4. Professional Info	**Description:** Gathering information health professionals to inform decision to have weight loss surgery. **When to use:** Participant mentions learning about weight loss surgery from health professionals and this informing their decision. **When not to use:** Participant does not mention learning about weight loss surgery from health professionals which informed their decision.

5. Key events	**Description:** Key life events impacting decision to have weight loss surgery. **When to use:** Participant explicitly refers to life event which impacted their decision e.g "I'm turning 40 soon and I really want to improve my health before then". **When not to use:** Participant does not explicitly refer to life events which impacted their decision.
6. Triggers	**Description:** Past life events spoken about in the context of decision to have surgery but not necessarily explicitly linked. **When to use:** Participant talks about past events within the context of decision to have surgery e.g. "I was bullied at school, I've always been big". **When not to use:** Participant does not refer to past life events within the context of decision to have surgery.
7. Gain	**Description:** Past life events spoken about in the context of weight gain and appear to be part of the candidates understanding of their weight gain. **When to use:** Participant talks about past events within the context of weight gain e.g. "They left and I felt unloved, I had an operation and have struggled since". **When not to use:** Participant does not refer to past life events within the context of weight gain.
8. Self-love	**Description:** Reference to relationship to self and being dissatisfied with this. **When to use:** Participant discusses relationship to self and how satisfied they feel about it. **When not to use:** Participant does not discuss relationship to self and how satisfied they feel about it.
9. Self-work	**Description:** Reference to candidate working on themselves ahead/ in line with the pursuit of surgery. **When to use:** Participant talks about steps they have taken in working on themselves ahead of/ in line with the pursuit if surgery. **When not to use:** Participant does not talk about steps they have taken in working on themselves ahead of/ in line with the pursuit if surgery.
10. WLS stigma	**Description:** Experience of weight loss surgery stigma. **When to use:** Participant talks about weight loss surgery stigma. **When not to use:** Participant does not talk about weight loss surgery stigma.
11. Suggestion	**Description:** The idea of weight loss surgery as suggested or generated by someone else e.g. a health professional. **When to use:** Participant talks about someone else initially suggesting the idea of weight loss surgery. **When not to use:** Participant does not talk about someone else initially suggesting the idea of weight loss surgery.
12. Mine	**Description:** The idea to pursue weight loss surgery as the candidate's own. **When to use:** Participant talks about their pursuit of weight loss surgery as their own idea. **When not to use:** Participant does not talk about their pursuit of weight loss surgery as their own idea.

13. Chance	**Description:** Chance events as resulting in the pursuit of surgery. **When to use:** Chance events are linked with the participants pursuit of surgery. **When not to use:** Chance events are not linked with the participants pursuit of surgery.
14. Limitations	**Description:** The impact of obesity on the participants life and reference to how this limits them in anyway. **When to use:** Participant refers to limitations they experience as a result of obesity. **When not to use:** Participant does not refer to limitations they experience as a result of obesity.
15. Burden	**Description:** Conceptualisation of self in current position as a burden/ expression of dissatisfaction with feeling reliant on others. **When to use:** Participant talks about of self in current position as a burden/ expression of dissatisfaction with feeling reliant on others. **When not to use:** Participant does not talk about of self in current position as a burden/ expression of dissatisfaction with feeling reliant on others.
16. Private	**Description:** Consideration of privately funded weight loss surgery. **When to use:** Participant talks about considering privately funded surgery. **When not to use:** Participant does not talk about considering privately funded surgery.
17. Shield	**Description:** Reference to ways of coping with or avoiding the judgements of others. **When to use:** Participant makes reference to how they cope with or avoid the judgement of others. **When not to use:** Participant does not make reference to how they cope with or avoid the judgement of others.
18. Initial no	**Description:** Candidates whose initial requests for referral for weight loss surgery assessment was turned down. **When to use:** Participant talks about their initial requests for referral for weight loss surgery assessment was turned down. **When not to use:** Participant does not talk about their initial requests for referral for weight loss surgery assessment was turned down.
19. For them	**Description:** Reference to candidates pursuing surgery due to their family members. **When to use:** Participant talks about pursuing surgery due to their family members. **When not to use:** Participant does not talk about pursuing surgery due to their family members.
20. Barrier	**Description:** Current weight and associated health problems cited as a barrier to making lifestyle changes. **When to use:** Participant cites weight and associated health problems as a barrier to making lifestyle changes. **When not to use:** Participant does not cite weight and associated health problems as a barrier to making lifestyle changes.
21. Obesity stigma	**Description:** Reference to the experience of obesity stigma. **When to use:** Participant refers to experience of obesity stigma.

	When not to use: Participants does not refer to obesity stigma.
22. GPs	**Description:** Access to weight loss surgery as gate kept by GPs. **When to use:** Participant refers to experiences in accessing weight loss surgery via their GP. **When not to use:** Participant does not refer to experiences in accessing weight loss surgery via their GP.
23. Failure	**Description:** Failed weight loss attempts prior to considering weight loss surgery. **When to use:** Participant mentions failed attempts at weight loss in the lead up to pursing surgery. **When not to use:** Participant does not mention failed attempts at weight loss in the lead up to surgery.
24. Only option	**Description:** Weight loss surgery referred to as the only option and last resort. **When to use:** Participant refers to surgery as the only viable option for them. **When not to use:** Participant does not refer to surgery as the only viable option for them.
25. Fear of loss	**Description:** Fear of not being accepted for surgery during the assessment process. **When to use:** Participant talks about fears that they may not be accepted for surgery. **When not to use:** Participant does not talk about fears that they may not be accepted for surgery.
26. Honesty	**Description:** How honest and open participants felt able to be during assessment. **When to use:** Participant discusses how able they felt to be honest and open. **When not to use:** Participant does not discuss how able they felt to be honest and open.
27. Helpful	**Description:** T3/ assessment described as helpful/ positive experience. **When to use:** Participant talks about T3/ assessment as helpful/ positive experience. **When not to use:** Participant does not talk T3/ assessment as helpful/ positive experience.
28. Unhelpful	**Description:** T3/ assessment described as unhelpful/ negative experience. **When to use:** Participant talks about T3/ assessment as unhelpful/ negative experience. **When not to use:** Participant does not talk T3/ assessment as unhelpful/ negative experience.
29. Informative	**Description:** Reference to the assessment process as providing information on surgical workup, surgery and life after surgery. **When to use:** Participant refers to assessment process as providing information on any aspect of weight loss surgery. **When not to use:** Participant does not refer to assessment process as providing information on any aspect of weight loss surgery.
30. Hoops	**Description:** Reference to the amount of stages and/or hoops to be jumped through during pre-surgical pathway. **When to use:** Participant refers to the amount of stages and/or hoops to be jumped through during their pre-surgical pathway.

	When not to use: Participant does not refer to the amount of stages and/or hoops to be jumped through during their pre-surgical pathway.
31. Length	**Description:** Reference to the amount of time it takes to be accepted for surgery. **When to use:** Participant refers to the amount of time it takes from to be accepted for surgery. **When not to use:** Participant does not refer to the amount of time it takes from to be accepted for surgery.
32. Appreciation	**Description:** A view on the value in, or appreciation for the length of the pre-surgical pathways. **When to use:** Participant expresses a view on the value or utility in the length of pre-surgical workup. **When not to use:** Participant does not express a view on the value or utility in the length of pre-surgical workup.
33. Realisation	**Description:** Increasing awareness of the work, effort and length of input required prior to weight loss surgery. **When to use:** Participant talks about a realisation regarding the work, effort and length of input required prior to weight loss surgery. **When not to use:** Participant does not talk about a realisation regarding the work, effort and length of input required prior to weight loss surgery.
34. Blips	**Description:** Struggles and points of weight gain during pre-surgical workup. **When to use:** Participant discusses any struggles or weight gain they experienced during their pre-surgical workup. **When not to use:** Participant does not discuss any struggles or weight gain they experienced during their pre-surgical workup.
35. Normalisation	**Description:** MDT staff as normalising the experience of struggles or weight gain during pre-surgical workup. **When to use:** Participant talks about MDT staff as normalising the experience of struggles or weight gain during pre-surgical workup. **When not to use:** Participant does not talk about MDT staff as normalising the experience of struggles or weight gain during pre-surgical workup.
36. Motivator	**Description:** The requirements of pre-surgical workup as acting as an external motivator and extra form of structure for candidates in adapting their lifestyle and losing weight. **When to use:** Participant refers to pre-surgical workup as providing structure/ acting as an external motivator. **When not to use:** Participant does not refer to pre-surgical workup as providing structure/ acting as an external motivator.
37. Investment	**Description:** The amount of work and investment required from participants as part of their pre-surgical workup and not wanting to see this go to waste e.g. “I’ve worked so hard to get to this point, I’m not going to put it to waste after surgery”. **When to use:** Participant talks about the work they have done to this point and not wanting to waste this.

	When not to use: Participant does not talk about the work they have done to this point and not wanting to waste this.
38. Drastic	**Description:** Realisation or acknowledgement of how the severity of weight loss surgery as a procedure. **When to use:** Participant refers to surgery as drastic or serious. **When not to use:** Participant does not refer to surgery as drastic or serious.
39. Trust	**Description:** Candidates feeling that they have faith in/ trust the MDT/ surgeons. **When to use:** Participant talks about feeling that they have faith in/ trust the MDT/ surgeons. **When not to use:** Participant does not talk about feeling that they have faith in/ trust the MDT/ surgeons.
40. Doubt	**Description:** Candidate expresses doubt or some uncertainty about whether they will have the surgery or not through their own choice. **When to use:** Participant expresses doubt or some uncertainty about whether they will have the surgery or not through their own choice. **When not to use:** Participant does not express doubt or some uncertainty about whether they will have the surgery or not through their own choice.
41. Undoubting	**Description:** Reference to their decision to pursue surgery as unwavering/ experiencing no doubt. **When to use:** Participant talks about their decision to pursue surgery as unwavering/ experiencing no doubt. **When not to use:** Participant does not talk about their decision to pursue surgery as unwavering/ experiencing no doubt.
42. Headspace	**Description:** The pre-surgical pathways as psychologically preparing participants for surgery and all that it requires. **When to use:** Participant refers to the pre-surgical pathway as helping them become psychologically ready for surgery. **When not to use:** Participant does not refer to the pre-surgical pathway as helping them become psychologically ready for surgery.
43. Gaps	**Description:** Gaps identified in service provision during pre-surgical work-up. **When to use:** Participant refers to gaps in their experience of pre-surgical provision. **When not to use:** Participant does not refer to gaps in their experience of pre-surgical provision.
44. Type	**Description:** The experience of candidates in selecting the type of bariatric surgery procedure. **When to use:** Participant refers to the type of weight loss surgery procedure they are having. **When not to use:** Participant does not refer to the type of weight loss surgery procedure they are having.
45. Necessity	**Description:** Experiences of pre-surgical workup leading candidates to question the necessity of weight loss surgery and whether they might achieve their goals without it. **When to use:** Participants talk about questioning the necessity of the weight loss surgery.

	When not to use: Participant does not talk about questioning the necessity of the weight loss surgery.
46. Milk	**Description:** Experience of milk diet during pre-surgical workup. **When to use:** Participant talks about their experience with the milk diet prior to surgery. **When not to use:** Participant does not talk about their experience with the milk diet prior to surgery.
47. Success	**Description:** The experience of success during pre-surgical workup. **When to use:** Participant talks about moments of success or achievement during pre-surgical workup. **When not to use:** Participant does not talk about moments of success or achievements during pre-surgical workup.
48. Rushed	**Description:** Reference to appointments with Tier 3/ Tier 4 staff being rushed or not long enough. **When to use:** Participant talks about appointments with Tier 3/ Tier 4 staff being rushed or not long enough. **When not to use:** Participant does not talk about appointments with Tier 3/ Tier 4 staff being rushed or not long enough.
49. Unclear	**Description:** Reference to the process of pre-surgical workup being unclear or confusing. **When to use:** Participant talks about the process of pre-surgical workup being unclear or confusing. **When not to use:** Participant does not talk about the process of pre-surgical workup being unclear or confusing.
50. Rapport	**Description:** Able to generate rapport with MDT staff in absence of obesity stigma. **When to use:** Participant refers to positive relationship with MDT staff. **When not to use:** MDT does not refer to positive relationship with MDT staff.
51. Emotional eating	**Description:** Describes a relationship between emotions and eating behaviour. **When to use:** Participant mentions relationship between emotions and eating behaviour. **When not to use:** Participant does not mention relationship between emotions and eating behaviour.
52. Testing	**Description:** Reference to their relationship with food being difficult and/ or challenging in some way. **When to use:** Participant refers to their relationship with food as difficult and/or challenging. **When not to use:** Participant does not refer to their relationship with food as difficult and/or challenging.
53. External	**Description:** Describes external triggers to eating e.g. sight/ smell of food. **When to use:** Participant refers to external triggers for eating. **When not to use:** Participant does not refer to external triggers for eating.
54. Routines	**Description:** Reference to routines (or their absence) for eating. **When to use:** Participant talks about routine ways of eating. **When not to use:** Participant does not talk about routine ways of eating.
55. Portions	**Description:** Difficulty with portion sizes of food. **When to use:** Participant talks about difficulty with portion sizes.

	When not to use: Participant does not talk about difficult with portion sizes.
56. Satiety	**Description:** Reference to a lack of satiety or feeling full. **When to use:** Participant talks about a lack of satiety or feeling full. **When not to use:** Participant does not talk about a lack of satiety or feeling full.
57. Over-eating	**Description:** Reference to over-eating. **When to use:** Participant talks about over-eating in the absence of references of objective binging. **When not to use:** Participant does not talk about over-eating or talks about over-eating in the context of objective binging- see 'binging' code for these instances.
58. Binging	**Description:** Reference to objective binging. **When to use:** Participant talks about objective binging. **When not to use:** Participant does not talk about objective binging.
59. Wrong	**Description:** Reference to eating the "wrong" foods. **When to use:** Participant talks about eating the "wrong" foods e.g. foods typically considered as unhealthy such as processed foods. **When not to use:** Participant does not talk about eating the "wrong" food.
60. Insight	**Description:** The development of insight and understanding around relationship to eating from unconscious to conscious. **When to use:** Participant makes reference to becoming aware of their relationship to eating. **When not to use:** Participant does not make reference to becoming aware of their relationship to eating.
61. Disorder	**Description:** The framing of candidates' relationship to food and eating as an eating disorder. **When to use:** Participant explicitly talks about their eating as eating disordered. **When not to use:** Participant does not explicitly talk about their eating as eating disordered.
62. Self-value	**Description:** Relationship to eating as grounded in level of self- value and worth. **When to use:** Participant talks about their level of self- value or worth and how this relates to their relationship to eating. **When not to use:** Participant does not talk about their level of self- value or worth and how this relates to their relationship to eating.
63. Self-harm	**Description:** Use of food as a representation of lack of self-care. **When to use:** Participant makes reference to their use of food as a lack of self-care. **When not to use:** Participant does not make reference to their use of food as a lack of self-care.
64. Enablers love	**Description:** Other people in candidates lives seen as encouraging eating as an act of love.

	When to use: Participant talks about a person/ people in their life encouraging eating as a form of care and love. **When not to use:** Participant does not talk about a person/ people in their life encouraging eating as a form of care and love.
65. Enablers abuse	**Description:** Other people in candidates lives seen as encouraging eating as an act of abuse. **When to use:** Participant talks about a person/ people in their life encouraging eating as a form of abuse. **When not to use:** Participant does not talk about a person/ people in their life encouraging eating as a form of abuse.
66. Cycles	**Description:** Relationship to eating as a vicious cycle. **When to use:** Participants implies relationship to eating as a vicious cycle. **When not to use:** Participant does not imply relationship to eating as a vicious cycle.
67. Guilt	**Description:** Experiences of guilt in relation to eating. **When to use:** Participant talks about feeling guilty in relation to eating. **When not to use:** Participant does not talk about feeling guilty in relation to eating.
68. Control	**Description:** Reference to the amount of control the candidate feels they have over eating. **When to use:** Participant talks about the amount of control they feel they have over eating. **When not to use:** Participant does not talk about the amount of control they feel they have over eating.
69. Grazing	**Description:** Describes grazing or picking at food. **When to use:** Participant mentions grazing or picking at food. **When not to use:** Participant does not mention grazing or picking food.
70. Prohibition	**Description:** Reference to expectations that the surgery will prohibit old patterns of eating. **When to use:** Participant talks about how they anticipate surgery will prohibit old patterns of eating. **When not to use:** Participant does not talk about anticipating that surgery will prohibit old patterns of eating.
71. Alternatives	**Description:** Alternative ways of eating following the surgery are considered and discussed. **When to use:** Participant mentions thoughts or plans around alternative ways of eating following surgery. **When not to use:** Participant does not mention thoughts or plans around alternative ways of eating following surgery.
72. Coping	**Description:** Non-food related ways of coping with emotional challenges are considered for following surgery. **When to use:** Participant discusses non-food related coping strategies for emotional challenges which could be used following surgery.

	When not to use: Participant does not discuss non-food related coping strategies for emotional challenges which could be used following surgery.
73. Liquid	**Description:** Anticipating their experience of a liquid diet post-surgically. **When to use:** Participant makes reference to liquid diet post-surgically. **When not to use:** Participant does not make reference to liquid diet post-surgically.
74. Relationship	**Description:** The expectation that the relationship that the participant has with eating will be changed by the surgery. **When to use:** Participant talks about anticipating that how they relate to food will change after surgery. **When not to use:** Participant does not talk about how they relate to food may change after surgery.
75. Sustain	**Description:** Surgery seen as a way to sustain changed eating behaviour in the long-term. **When to use:** Participant conceptualizes surgery as a tool for sustaining long-term weight loss. **When not to use:** Participant does not conceptualise surgery as a tool for sustaining long-term weight loss.
76. Accelerating	**Description:** Surgery seen as a way to accelerate the achievement of outcomes e.g. weight loss. **When to use:** Participant talks about how surgery might speed up the process of them achieving their outcomes. **When not to use:** Participant does not talk about how surgery might speed up the process of them achieving their outcomes.
77. Barrier lift	**Description:** Hope/ expectation that declining weight via surgery will inevitably lead to lifestyle changes. **When to use:** Participant talks about hope/ expectation that declining with via surgery will inevitably lead to lifestyle change. **When not to use:** Participant does not talk about hope/ expectation that declining with via surgery will inevitably lead to lifestyle change.
78. Panacea	**Description:** Explicit acknowledgement that weight loss surgery is not a panacea for all difficulties. **When to use:** Participant states that surgery will not change all of the current difficulties they face. **When not to use:** Participant does not specify that surgery will not change all of the current difficulties they face.
79. Excitement	**Description:** Candidates feeling excited about surgery. **When to use:** Participant talks about feeling excited about surgery. **When not to use:** Participant does not talk about feeling excited about surgery.
80. Full	**Description:** Expectation that surgery will lead to a sense of feeling full. **When to use:** Participant talks about an expectation or hope that surgery will lead to a sense of feeling full. **When not to use:** Participant does not talk about an expectation or hope that surgery will lead to a sense of feeling full.

81. Restriction	**Description:** Reference to the expectation that what, when and how participants will be able to eat following surgery will be restricted. **When to use:** Participant refers to expectation that surgery will restrict types and amounts of food that they will be able to consume. **When not to use:** Participant does not refer to an expectation that surgery will restrict types and amounts of food that they will be able to consume.
82. Mobility	**Description:** Reference to improved mobility anticipated following surgery. **When to use:** Participant talks about anticipating improved mobility following surgery. **When not to use:** Participant does not talk about anticipating improved mobility following surgery.
83. DL	**Description:** Reference to improved quality or frequency of activities of daily living following surgery. **When to use:** Participant talks about how activities of daily living will improve after surgery. **When not to use:** Participant does not talk about how activities of daily living will improve following surgery.
84. Travel	**Description:** Reference to how travelling will be easier following surgery e.g. on planes or buses. **When to use:** Participant talks about how travelling will be easier following surgery. **When not to use:** Participant does not talk about how travelling will be easier following surgery.
85. Play	**Description:** Reference to a hope that candidates will be able to engage in more leisure activities following surgery. **When to use:** Participant talks about being able to do more leisure activities following surgery. **When not to use:** Participant does not talk about being able to do more leisure based activities following surgery.
86. Work	**Description:** Hoping to be able to increase or return to work, either paid or unpaid (e.g. house work). **When to use:** Participant talks about hoping to increase or return to work. **When not to use:** Participant does not talk about hoping to increase or return to work.
87. Wonderful	**Description:** Reference to an expectation that life will be wonderful or much improved after surgery. **When to use:** Participant refers to expectation that life will be wonderful or much improved after surgery. **When not to use:** Participant does not refer to expectation that life will be wonderful or much improved after surgery.
88. Happy	**Description:** Reference to the hope that they will feel happier after surgery. **When to use:** Participant refers to hope that they will feel happier after surgery. **When not to use:** Participant does not refer to hope that they will feel happier after surgery.

89. Confident	**Description:** Reference to the hope that they will feel more confident after surgery. **When to use:** Participant refers to hope that they will feel more confident after surgery. **When not to use:** Participant does not refer to hope that they will feel more confident after surgery.
90. Fullness	**Description:** Anticipating, hoping or expecting life to be more full and vibrant following surgery. **When to use:** Participant makes reference to hope that life will be fuller/ more vibrant following surgery. **When not to use:** Participant does not make reference to hope that life will be fuller/ more vibrant following surgery.
91. Improve health	**Description:** Reference to improvement in health conditions which are hoped for following surgery e.g. "My diabetes is going to improve" or "I won't be in so much pain". **When to use:** Participant refers to a health hope which is not best captured by another hope related code. **When not to use:** Participant does not refer to a health hope and/ or the hope is better captured by another hope related code.
92. Prevent health	**Description:** Reference to a hope that having surgery will prevent future health problems. **When to use:** Participants talks about how surgery may help prevent future health problems. **When not to use:** Participant does not talk about how surgery may help prevent future health problems.
93. Extend life	**Description:** Reference to how surgery may help the candidate to extend their life expectancy. **When to use:** Participant talks about a hope that surgery will help them to live longer. **When not to use:** Participant does not talk about a hope that surgery will help them to live longer.
94. Mental health	**Description:** Expectation/ hope that mental health will improve following weight loss surgery. **When to use:** Participant talks about an expectation/ hope that mental health will improve following weight loss surgery. **When not to use:** Participant does not talk about an expectation/ hope that mental health will improve following weight loss surgery.
95. Proud	**Description:** Anticipation of feeling proud of what they have achieved post-surgically **When to use:** Participant imagines feeling proud of themselves after surgery. **When not to use:** Participant does not report imagining feeling proud of themselves after surgery.

96. Self-like	**Description:** Expectation that how much the candidate likes themselves will improve with surgery. **When to use:** Participant talks about expecting their level of self-like to increase following surgery. **When not to use:** Participant does not talk about expecting their level of self-like to increase following surgery.
97. Contribution	**Description:** A hope that following surgery that they will make an improved contribution towards others in their lives. **When to use:** Participant makes reference to the expectation that they will contribute in a new or additional ways to the lives of those around them. **When not to use:** Participant does not make reference to the expectation that they will contribute in a new or additional ways to the lives of those around them.
98. Independence	**Description:** A hope that surgery will result in improved independence and autonomy in life. **When to use:** Participant talks about hoping for improved autonomy and independence following surgery/ being less dependent on others. **When not to use:** Participant does not talk about hoping for improved autonomy and independence following surgery/ being less dependent on others.
99. Connection	**Description:** The hope that following surgery, their relationships and a sense of connection within these will be improved. **When to use:** Participant discusses how their existing relationships will improve following surgery. **When not to use:** Participant does not discuss how their existing relationships will improve following surgery.
100. Fertility	**Description:** A hope that fertility will improve/ that they will be able to have children. **When to use:** Participant talks about improvements in fertility and/ or hoping to have children following surgery. **When not to use:** Participant does not talk about improvements in fertility and/ or hoping to have children following surgery.
101. Children	**Description:** A hope of being able to do more activities with their children as well as being there as they grow. **When to use:** Reference made to how what they do with their children and how long they will be there to witness them grow is made. **When not to use:** Reference made to how what they do with their children and how long they will be there to witness them grow is not made.

102. Current relationships	**Description:** Expectation that their relationship with their current partner may improve. **When to use:** Participant talks about the possibility of an improved relationship with their partner following surgery. **When not to use:** Participant does not talk about the possibility that their relationship with their partner will improve following surgery.
103. Bye stigma	**Description:** Reference to hopes for reduced experience of obesity stigma following surgery. **When to use:** Participant refers to a hope for reduced experience of obesity stigma. **When not to use:** Participant does not refer to a hope for reduced obesity stigma.
104. New Relationships	**Description:** Hopes for new relationships, either platonic or romantic. **When to use:** Participant refers hoping for new relationships after surgery. **When not to use:** Participant does not refer to hoping for new relationships after surgery.
105. Normality	**Description:** Reference to becoming "normal". **When to use:** Participant talks about surgery as an avenue to becoming "normal" or being able to do "normal" things. **When not to use:** Participant does not talk about surgery as an avenue to becoming "normal" or being able to do "normal" things.
106. Unchanging	**Description:** Beliefs about aspects of life that the surgery won't or can't change as a result of weight loss surgery. **When to use:** Participant makes reference to things which they believe will remain unchanged following weight loss surgery. **When not to use:** Participant does not make reference to things which they believe will remain unchanged following weight loss surgery.
107. Gloom	**Description:** Expectation that without surgery life would be unhappy or undesired in some way. **When to use:** Reference made to the prospect of life without surgery as unhappy, undesired or depressing. **When not to use:** Reference not made to the prospect of life without surgery as unhappy, undesired or depressing.
108. Plod on	**Description:** The idea that life would go on as it is/ nothing would change/ get better or worse if surgery did not go ahead. **When to use:** Participant talks about the idea that life would go on as it is/ nothing would change if surgery did not go ahead.

	When not to use: Participant does not talk about the idea that life would go on as it is/ nothing would change if surgery did not go ahead.
109. Shopping	**Description:** Reference to anticipating that shopping for clothes will be easier and more enjoyable following surgery. **When to use:** Participant talks about hoping that shopping will be easier or more enjoyable following surgery. **When not to use:** Participant does not talk about hoping that shopping will be easier or more enjoyable following surgery.
110. Thinner	**Description:** Reference made to losing weight and looking thinner following surgery and looking forward to this. **When to use:** Participant talks about hoping to look thinner following surgery. **When not to use:** Participant does not talk about hoping to look thinner following surgery.
111. Body image	**Description:** Reference made to an anticipation that body image will improve following surgery. **When to use:** Participant talks about how their body image will improve following surgery. **When not to use:** Participant does not talk about how their body image may improve following surgery.
112. Opposing	**Description:** Family or friends who have opposing views to the candidate's decision to have weight loss surgery. **When to use:** Participant talks about family or friends who are in opposition or do not fully agree with the participants decision to have surgery. **When not to use:** Participant does not talk about family or friends who are in opposition or do not fully agree with the participants decision to have surgery.
113. Encouragement	**Description:** Family or friends who have encouraged or supported the candidate in pursuing the weight loss surgery. **When to use:** Participant mentions family or friends who have encouraged or supported them in the pursuit of weight loss surgery. **When not to use:** Participant does not mention family or friends who have encouraged or supported them in the pursuit of weight loss surgery.
114. Sharing	**Description:** The sharing of their weight loss surgery with family and friends. **When to use:** Participant mentions telling family or friends about the surgery. **When not to use:** Participant does not mention telling family or friends about the surgery.
115. Secret	**Description:** Keeping the weight loss surgery a secret from family or friends. **When to use:** Participant talks about withholding that they are having the surgery from family or friends. **When not to use:** Participant does not talk about withholding the surgery from family or friends.
116. Social eating	**Description:** Reference to eating in socially and/ or reference to how surgery may impact this. **When to use:** Participant discusses eating in socially and/ or how surgery may impact this. **When not to use:** Participant does not discuss eating in socially and/ or how surgery may impact this.

117. Bad influence	**Description:** Family/ friends referred to as influencing bad lifestyle habits. **When to use:** Participant refers to family/ friends as being a bad influence on their lifestyle habits. **When not to use:** Participant does not refer to family/ friends as being a bad influence on their lifestyle habits.
118. Sense making	**Description:** Descriptions of how family/ friends make sense of and learn about the weight loss surgery. **When to use:** Participant talks about how family/ friends learned about the surgery. **When not to use:** Participant does not talk about how family/ friends learned about the surgery.
119. Family worries	**Description:** Descriptions of concerns which family/ friends have about the weight loss surgery. **When to use:** Participant refers to concerns which family/ friends have about the surgery. **When not to use:** Participant does not refer to concerns which family/ friends have about the surgery.
120. Unspoken	**Description:** Wonderings about family/ friend's position and relationship to surgery which candidates have not explore explicitly with their family/ friends. **When to use:** Participant talks about their ideas about family/ friend's position/ relationship to surgery having not spoken to them explicitly about this. **When not to use:** Participant does not talk about their ideas about family/ friend's position/ relationship to surgery having not spoken to them explicitly about this.
121. Emotional	**Description:** Reference to the emotional support that family or friends may provide in relation to surgery and lifestyle changes. **When to use:** Participant talks about how family and friends have/ will provide emotional support in relation to surgery and lifestyle changes. **When not to use:** Participant does not talk about how family and friends have/ will provide emotional support in relation to surgery and lifestyle changes.
122. Reminders	**Description:** Reference to prompts and reminders that family or friends may provide in relation to surgery and lifestyle changes. **When to use:** Participant talks about prompts and reminders that family or friends may provide in relation to surgery and lifestyle changes. **When not to use:** Participant does not talk about prompts and reminders that family or friends may provide in relation to surgery and lifestyle changes.

123. Recovery support	**Description:** Reference to the support that family or friends might provide during the recovery period following surgery. **When to use:** Participant talks about the support family or friends might provide during the recovery period. **When not to use:** Participant does not talk about the support family or friends might provide during the recovery period.
124. Diet change	**Description:** Reference to the support that family or friends might provide with regards to dietary changes. **When to use:** Participant talks about the support that family or friends might provide with regards to dietary changes. **When not to use:** Participant does not talk about the support that family or friends might provide with regards to dietary changes.
125. Childcare	**Description:** Reference to the support that family or friends might provide with childcare during and following surgery. **When to use:** Participant talks about the support that family or friends might provide with childcare during and following surgery. **When not to use:** Participant does not talk about the support that family or friends might provide with childcare during and following surgery.
126. Commiserating	**Description:** Reference to the support that family and friends might provide if following surgery, candidates do not achieve what they hoped. **When to use:** Participants talk about the support that family and friends might provide if following surgery, candidates do not achieve what they hoped. **When not to use:** Participant does not talk about the support that family and friends might provide if following surgery, candidates do not achieve what they hoped.
127. Unspecified support	**Description:** Reference to the idea that family/ friends will provide support but the nature of the support is not specified. **When to use:** Participant talks about the idea that family/ friends will provide support but the nature of the support is not specified. **When not to use:** Participant does not talk about the idea that family/ friends will provide support but the nature of the support is not specified OR the participant talks about the idea that family/ friends will provide support but the nature of the support is specified.

128. Food shopping	**Description:** Reference to family/friends changing the way they shop for food alongside the candidate themselves. **When to use:** Participant talks about how family/friends may change the way they shop for food alongside themselves. **When not to use:** Participant does not talk about how family/friends may change the way they shop for food alongside themselves.
129. Diet	**Description:** Reference to family/friends changing the content of what they eat alongside the candidate themselves. **When to use:** Participant talks about their family/friends changing the content of what they eat alongside themselves. **When not to use:** Participant does not talk about their family/friends changing the content of what they eat alongside themselves.
130. Moving	**Description:** Reference to family/ friends exercising more alongside the candidate themselves. **When to use:** Participant talks about their family/ friends exercising more alongside themselves. **When not to use:** Participant does not talk about their family/ friends exercising more alongside themselves.
131. Habits	**Description:** Reference to family/ friends developing improved habits and routines with regards to lifestyle alongside the candidate themselves. **When to use:** Participant talks about family/ friends developing improved habits and routines with regards to lifestyle alongside themselves. **When not to use:** Participant does not talk about family/ friends developing improved habits and routines with regards to lifestyle alongside the themselves.
132. Re-gain	**Description:** Reference to the fear of not losing weight or regaining weight following surgery. **When to use:** Participant mentions fear of not losing weight or regaining weight following surgery. **When not to use:** Participant does not mention gear of not losing weight or regarding weight following surgery.
133. Adapting	**Description:** Reference to any concerns about lifestyle changes that the candidates will need to make after surgery. **When to use:** Participant discusses concerns about changes that they will need to implement following surgery. **When not to use:** Participant does not discuss concerns about changes that they will need to implement following surgery.
134. Recovery	**Description:** Reference to the recovery period following surgery and any associated concerns. **When to use:** Participant talks about the recovery period and any concerns that they have about this. **When not to use:** Participant does not talk about the recovery period and any concerns that they have about this.
135. Eating out	**Description:** Any anticipated challenges with respect to either eating out. **When to use:** Participant makes reference to an anticipated challenge with respect to either eating out. **When not to use:** Participant does not make reference to an anticipated challenge with respect to either eating out.

136. Dumping	**Description:** Concern about dumping syndrome after surgery. **When to use:** Participant makes reference to concerns about dumping syndrome after surgery. **When not to use:** Participant does not make reference to concerns about dumping syndrome after surgery.
137. Hair loss	**Description:** Concern about hair loss following surgery. **When to use:** Participant talks about concerns about hair loss after surgery. **When not to use:** Participant does not talk about concerns about hair loss after surgery.
138. Supplements	**Description:** Concern about required supplement following surgery. **When to use:** Participant expresses concerns about supplements required following surgery. **When not to use:** Participant does not express concerns about supplements required following surgery.
139. Identity	**Description:** Concern about self-perceived changes in identity following surgery. **When to use:** Participant expresses concern that their identity/ personality may change after surgery. **When not to use:** Participant does not express concern that their identity/ personality may change after surgery.
140. Personality	**Description:** Concern about others perceiving their personality and identity differently following surgery. **When to use:** Participant expresses concern about others perceiving their personality and identity differently following surgery. **When not to use:** Participant does not express concern about others perceiving their personality and identity differently following surgery.
141. Affiliations	**Description:** Concern that existing relationships will change or breakdown. **When to use:** Participant talks about concerns that existing relationships may change or end. **When not to use:** Participant does not talk about concerns that existing relationships may change or end.
142. Sickness	**Description:** Concern about nausea or vomiting following surgery. **When to use:** Participant expresses concern about nausea or vomiting following surgery. **When not to use:** Participant does not express concern about nausea or vomiting following surgery.
143. Baby steps	**Description:** Reference to the plan to take life after surgery one day/step at a time. **When to use:** Participant talks about the plan to take life after surgery one day/step at a time. **When not to use:** Participant does not talk about the plan to take life after surgery one day/step at a time.
144. Pros & cons	**Description:** The weighing up of pros and cons of concerns and hoped for outcomes of surgery. **When to use:** Participant talks about weighing up of pros and cons of concerns and hoped for outcomes of surgery. **When not to use:** Participant does not talk about weighing up of pros and cons of concerns and hoped for outcomes of surgery.
145. Odds	**Description:** Candidates weighing up the odds that the surgery might not go as hoped. **When to use:** Participant talks about the likelihood of surgery not going as hoped/ going right.

	When not to use: Participant does not talk about the likelihood of surgery not going as hoped/ going right.
146. Excess skin	**Description:** Acknowledgement and/ or concern about the possibility of excess skin following weight loss after surgery. **When to use:** Participant talks about excess skin and any concerns they have about this. **When not to use:** Participant does not talk about excess skin or concerns regarding this following surgery.
147. Professional help	**Description:** Reference to seeking professional help, support, advice or information with regards to any concerns about the weight loss surgery. **When to use:** Participant discusses the support sought from professionals with regards to concerns about surgery. **When not to use:** Participant does not discuss any support sought from professionals with regards to concerns about surgery.
148. Other candidates	**Description:** Reference to seeking help, support, advice or information with regards to any concerns about the weight loss surgery from other weight loss surgery candidates. **When to use:** Participant discusses the support sought from other weight loss surgery candidates with regards to concerns about surgery. **When not to use:** Participant does not discuss any support sought from weight loss surgery candidates with regards to concerns about surgery OR participant does talk about support sought from weight loss surgery candidates but this is via an online social media source.
149. Family	**Description:** Reference to talking about concerns with family members or friends. **When to use:** Participant makes reference to talking with family or friends about worries for surgery. **When not to use:** Participant does not make reference to talking with family or friends about worries for surgery.
150. Vicarious	**Description:** Reference to learning through the experiences and mistakes of past candidates. **When to use:** Participant makes reference to learning through the experiences/ mistakes of past candidates. **When not to use:** Participant does not make reference to learning through the experiences/ mistakes of past candidates.
151. None	**Description:** The choice to not seek addition support explicitly acknowledged. **When to use:** Participant talks about deciding not to seek support. **When not to use:** Participant does not talk about deciding not to seek support.
152. Get on	**Description:** The idea that candidates will deal with challenges/ concerns following surgery by just "getting on with it". **When to use:** Participant makes reference to the idea that they will deal with challenges/ concerns by just "getting on with it".

	When not to use: Participant does not make reference to the idea that they will deal with challenges/ concerns by just "getting on with it".
153. Bad enough	**Description:** Concerns needing to be "bad enough" before candidates will seek help/ advice. **When to use:** Participant talks about the idea that concerns need to be "bad enough" before they will seek help/advice. **When not to use:** Participant does not talk about the idea that concerns need to be "bad enough" before they will seek help/advice.
154. Bliss	**Description:** Reference to not thinking about concerns as a way of coping. **When to use:** Participant expresses tendency to no think about concerns as a way of coping. **When not to use:** Participant does not express tendency to no think about concerns as a way of coping.
155. Online	**Description:** Reference to seeking help, support, advice or information with regards to any concerns about the weight loss surgery from online sources. **When to use:** Participant discusses the support sought from online sources with regards to concerns about surgery, this is to include social media sources involving other weight loss surgery candidates. **When not to use:** Participant does not discuss any support sought from online sources with regards to concerns about surgery.
156. Honeymoon period	**Description:** Reference to a period following surgery in which weight loss may be automatic and/ or that this period may come to an end. **When to use:** A period of time following surgery in which weight loss may be automatic and/ or that this period may come to an end. **When not to use:** Participant does not talk about a period of time following surgery in which weight loss may be automatic and/ or that this period may come to an end.
157. A tool	**Description:** That surgery is a tool that candidates need to use and work with in order to achieve their desired outcomes. **When to use:** Participant talks about the need to work alongside the surgery or acknowledges that the surgery does not "do it all". **When not to use:** Participant does not talk about the need to work alongside the surgery or acknowledge that the surgery does not "do it all".

158. Beforehand	**Description:** Reference to pre-operative lifestyle changes that candidates make. **When to use:** Participant talks about pre-operative lifestyle changes that they have or are going to make. **When not to use:** Participant does not talk pre-operative lifestyle changes that they have or are going to make.
159. Good enough	**Description:** Reference to outcomes following surgery not needing to be perfect/ that there is a level that would be "good enough". **When to use:** Participant talks about to outcomes following surgery not needing to be perfect/ that there is a level that would be "good enough". **When not to use:** Participant does not talk about to outcomes following surgery not needing to be perfect/ that there is a level that would be "good enough".
160. Responsibility	**Description:** Reference to any responsibility and/or control that the participant believes they have over the outcome of the weight loss surgery. **When to use:** Participant discusses any responsibility and/ or control that they see themselves as having over the outcome of the weight loss surgery. **When not to use:** Participant does not discuss any responsibility and/ or control that they see themselves as having over the outcome of the weight loss surgery.
161. Exercise	**Description:** Reference to plans to exercise after surgery. **When to use:** Participant mentions plans to exercise **When not to use:** Participant does not mention plans to exercise after surgery.
162. Structure	**Description:** Reference to plans to implement eating routines after surgery. **When to use:** Participant mentions plans to implement eating routines after surgery. **When not to use:** Participant does not mention plans to implement eating routines after surgery.
163. Size	**Description:** Reference to plans to change portion sizes after surgery. **When to use:** Participant mentions plans to change portion sizes after surgery. **When not to use:** Participant does not mention plans change portion sizes following surgery.
164. Dietary	**Description:** Reference to plans to change the types of foods consumed post-surgically. **When to use:** Participant mentions plans to change the type of food consumed after surgery. **When not to use:** Participant does not mention plans change the types of food consumed following surgery.
165. Experiential	**Description:** Reference to the idea that the participant anticipates they will learn as they go along. **When to use:** Participant suggests that they will learn as they go along. **When not to use:** Participant does not mention that they will learn as they go along.

166. Not yet	**Description:** Little thought or plans for required lifestyle changes after surgery. **When to use:** Participant suggests little thought or plans for the required lifestyle changes after surgery. **When not to use:** No evidence/ suggestion that the participant has given little thought or planning to the required lifestyle changes after surgery.
167. Focus	**Description:** Expressions of focus and determination with respect to the end goal. **When to use:** Participant talks about their focus or determination with regards to their goals for surgery. **When not to use:** Participant does not talk about their focus or determination with regards to their goals for surgery.
168. Fate	**Description:** Reference to the role of fate in life after surgery. **When to use:** Participant talks about things going wrong or not as expected after surgery as in the hands of fate. **When not to use:** Participant does not talk about things going wrong or not as expected after surgery as in the hands of fate.
169. Setbacks	**Description:** Expectation that there will be setbacks after surgery. **When to use:** Participant demonstrates an expectation that they will have to overcome setbacks after surgery. **When not to use:** Participant does not demonstrate an expectation that they will have to overcome setbacks after surgery.
170. Life-long	**Description:** Expectation that the lifestyle changes required will be life-long. **When to use:** Participant talks about the lifestyle changes that are required alongside surgery as being life-long. **When not to use:** Participant does not talk about the lifestyle changes that are required alongside surgery as being life-long.
171. Settle	**Description:** Expectation that following a period of recovery they will settle into a routine/ way of eating/ normality. **When to use:** Participant talks about anticipating that following an initial period of recovery they will settle into a routine or way of eating that is seen as normality. **When not to use:** Participant does not talk about anticipating that following an initial period of recovery they will settle into a routine or way of eating that is seen as normality.
172. Prepared	**Description:** Reference to how prepared the candidate feels for surgery and life after. **When to us:** Participant makes reference to how prepared they feel for surgery and life after. **When not to use:** Participant does not make reference to how prepared they feel for surgery and life after.
173. Plan B	**Description:** A plan B for if things do not go as hoped. **When to use:** Participant talks about their plans for if the surgery does not achieve what they want it to. **When not to use:** Participant does not talk about their plans for if the surgery does not achieve what they want it to.

APPENDIX W

Portion of a Coded Transcript

	Thank you for taking part, my first question is what made you decide to take part?
• Gaps • Realisation	Erm, I think it's because there isn't anything that other people have done to sort of, how you feel what the experience is like of what you go through. I mean you have the pictures on the board in the waiting room of before and after, but there's nothing really before the before bit of the surgery, so I think it's kinda nice that you get the opportunity to talk about how you dealt with everything, what you did to go through, so that some people can actually look at it and think 'right is this actually what I want to put myself through' cus it's mentally hard as well as physically but nothing kinda of really prepares you for what you're going through.
	Is it what you expected?
• Length • Realisation	Erm to be honest I read a lot about weight loss surgery prior so I knew that there was work that had to go in to it but no, I mean when I look back at it now I never expected that it would have taken this long to get to where I am now before surgery, I honestly thought it would have been a year and then yeah, you get surgery, little did I realise how much work actual has to go into it.
	Lots of work. When do you first remember considering weight loss surgery?
	10 years ago.
	So a long time ago. What was going on for you at the time, was it your idea, was it someone else's idea, what made you think of this as an option?
• Mine • Triggers • GP • Initial No • Failure	It was my idea, I wanted it because I've always struggled with my weight, ever since I was a kid, and I went to my GP where I used to live in (PLACE NAME) and they said 'no' I couldn't have it because I didn't fit the criteria and you had to fit certain NHS criterias. So they put me on a tablet called orlistat and I just kinda had that and it was horrible (laughs)

Yeah it's not nice

- GP
- Chance

(laughs) it was horrible, it was only when I moved to (PLACE NAME) 4 years ago and my GP now sort of said to me 'have you ever considered it' and then I explained to her and she said 'well I'm going to refer you for it' so if it wasn't for her really I wouldn't be here now.

You wouldn't have re-visited the idea?

Yeah

And were there any life events or anything happening that influenced your decision to pursue weight loss surgery?

- Key Events
- Self-Love
- Bye Stigma
- Obesity Stigma

Yeah, I mean my sister's heavily pregnant now, she's got 2 other children, she's getting married next year as well and to be honest, I don't want to be the fat sister with my sister at her wedding and my sister's very very skinny (laughs). So the family that she's marrying into, they kinda of have fat phobia if you understand what I mean by that?

Yeah

- Obesity Stigma
- Self-Love
- Thinner
- Body Image
- Confident

Erm if we have family get togethers, they sort of just stare at me and watch what I eat as well, like ooo, so really it was kinda of, I don't want to embarrass my sister in that way at her wedding ever. And to be honest, I don't want to embarrass myself, I'd rather sort of be able to fit comfortable into a nice dress (laughs), I don't do dresses as it is so.

It's a big deal?

Yeah

And what made you think now, now's the right time?

- Self-work
- Enabler Abuse

Erm I think more I'm at a stable environment to do it, at the time I had not long broke up with my boyfriend before and it was just an unhealthy relationship so I had to go through some counselling because I suffer with

- Gain
- Key Events
- Triggers
- Self-work

depression and he basically fed me. He was a feeder and he thrived of my insecurities and so he made me very very insecure of how I was. And it was only when sorta, I went to see my counselor that she was like 'look you don't need someone like that in your life- you can do this' and so I basically went through a couple of years of just sort of self loving myself again really. And then I thought no, I'm there mentally now, I know that I can do this and at the end of it I know that what I see in the mirror is how I want to look.

Okay, and for you, did you feel like there were any other options available to you?

- Only Option

Erm, what to lose weight? There wasn't really, they wouldn't give me weight loss surgery 10 years ago and it was 'this is orlistat, this is what you can be on, take this'

Okay, so what's your experience been of being assessed for weight loss surgery and all the process that's involved with getting to this point?

- Excited
- Motivator
- Blips
- Success
- Appreciation
- Helpful
- Headspace
- Milk

Erm its quite, I mean at the beginning you're all excited because you don't quite know what to expect. And then obviously you start off with the dieticians and you talk about your portion controls and your nutritional values. That stuff kind of seems easy and you think- yeah I can do this! And then as it goes on, cus you have to get weighed all the time, if you put weight on then they're like 'why have you put weight on, are you following what you're supposed to?' erm and then you kind of get to that point where you get this niggly- I'm not going to do this, I'm not going to achieve it, but when you get past the dieticians and you're coming up to meet the surgeons you know that there's more, you've got to be 100% I know I can do this. Erm cus yeah, like now doing the milk (diet) I'm around food all day long but that little niggly voice has kind of gone.

Do you know what helped? How did you achieve that?

- Motivator
- Investment
- Fear of Loss

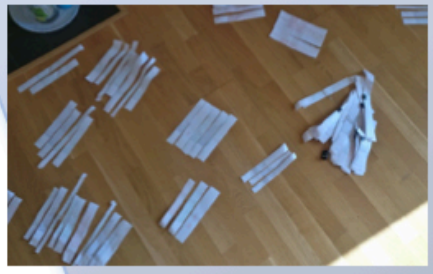
I don't know to be honest, I think it's just more me, I know that if I go Tuesday morning and I get on the scales because nurse (NAME) said, so get weighed Tuesday morning before they book you in and I think it's that, if I get on them scales and they can say that I

	haven't stuck to the milk because I wouldn't off lost weight, my liver wouldn't have shrunk, they're not going to do the surgery. I'm not no better off because then I'm going to have to start all over again after Christmas and I might as well just do it and get there and I'm done! **Did you feel able to be open and honest with your pre-surgical assessments?**
• Honesty • Failure • Normalisation • Blips • Rapport	Yeah, I mean they ask you have you stuck to it and if you tell them the truth because I mean, everyone who goes to that clinic obviously has some kind of problem with food, their weight, you know, you're human, everyone cheats. I mean I've done every diet I can possibly think of, and yeah, I start of good and then I think oh yeah, I'll just slip of the beaten track a bit and I'll pick it back up the next day. We've all been there we've all done it, they don't make you feel guilty for doing it because they said at the end of the day it's a big change that you have to physically train yourself to stay on the straight and narrow and not go of the path a bit.

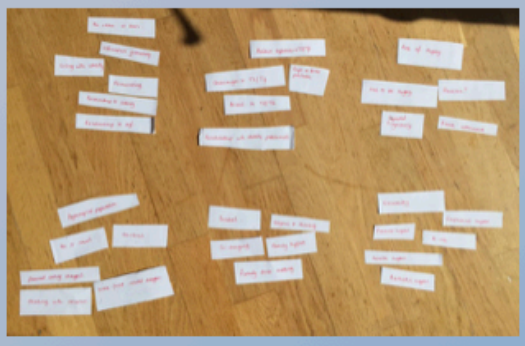
APPENDIX X

Analytical Process from Codes to Themes

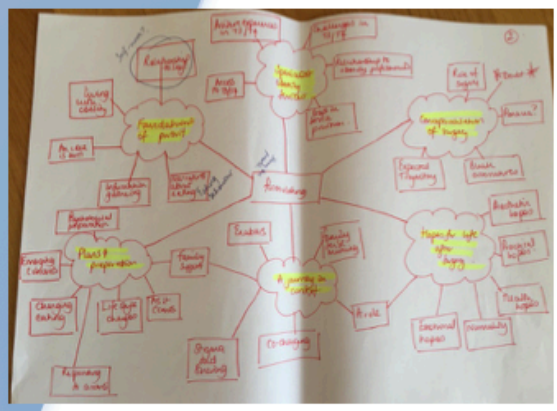
Once all data had been coded, the analysis moved away from NVivo software, to paper form to allow for the mapping of codes, sub-themes and superordinate themes.
A label for each code was printed off. Code labels were grouped together into initial themes according to patterns. Inductive and deductive codes were mixed together.



As the initial themes emerged, different themes were grouped together according to similarities and patterns, forming superordinate themes.



Superordinate themes and sub-themes within these, were organised visually using thematic maps. Below are two early thematic maps, prior to the final thematic map which is presented in chapter 4.



The coded data and overall transcripts were revisited and quotes within each sub-theme and superordinate theme were checked to ensure they corresponded with the patterns and stories told by the thematic map. The thematic map was subsequently refined.

APPENDIX Y

Final Themes, Codes and Example Quotes

Table Y1: *Final Themes, Codes and Example Quotes*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
Foundations of Pursuit	Living with Obesity	• Burden	*"The burden that I'm putting on my wife at the moment is unacceptable. I want to try and at least reduce that burden, even if I can't eliminate it."* Sam
		• Limitations	*"My weight is going to slow me down, it doesn't stop me but it makes it harder."* Carrie
		• Shield	*"I'll want to do more with them and go to more places and stuff because at the moment I don't, I shy away from doing anything."* Stacey
		• Obesity Stigma	*"I want to be with and just lead a normal life, which when you do carry excess weight, you can't because people are always judging you."* Gill
	An Idea is Born	• Mine	*"I've asked my doctor for quite a few years."* Jamie
		• Chance	*"It was only when I moved to (place name) 4 years ago and my GP now sort of said to me 'have you ever considered it' and then I explained to her and she said 'well I'm going to refer you for it' so if it wasn't for her really I wouldn't be here now."* Joanna
		• Suggestion	*"They (GP) approached me, yeah I think there were a lot of things that were going on at the time and then they approached me."* Amy
		• Encouragement	*"My wife is very positive about it and very keen for me to have the surgery."* Sam

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Opposing	*"My best friends, one of them thinks I should just diet."* Gill
		• For Them	*"I've got my son and I sort of sit and think, actually, I'm doing this for him."* Amy
		• Key Events	*"Although it was my (significant birthday) this year."* Jamie
		• Triggers	*"Because I was just getting so fat and I wasn't getting anywhere. The last time I lost a lot of weight I was, well it was 30 years ago, before I had my youngest daughter. I'd got down to 8 ½ stone and I kept it off as well until I fell pregnant and that was it."*
	Descriptions of Eating Behaviour	• Emotional Eating	*"Boredom is one of the worst things. If I'm bored I'll go and see what I can eat."* Sharon
		• Satiety	*"I've got the problem of never really being full up."* Gill
		• External	*"Sweet stuff, if it's there I'll eat it and if it's not it doesn't bother me."* Sharon
		• Binging	*"I've always been a comfort eater and a binge eater."* Gill
		• Wrong	*"I like food! That's the bottom line, I'm not under any illusions as to why I'm the size and shape that I am. I not only like food, all the food I like is the wrong sort of food."* Sam
		• Portions	*"I always ate far too much."* Sharon
		• Routines	*"It's not what I eat, it's the times of day that I eat. I used to eat at 10 or 11 at night to sit down and have dinner, which is not a good thing really."* Paul
		• Grazing	*"Like picking at the children's snack cupboard and going in there and trying to pick at things."* Stacey
		• Over-Eating	*"If the mood took me I could unconsciously eat a pack of biscuits without knowing it."* Sam

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
	Information Gathering	• Type	*"I note the band and sleeve are apparently favoured more than the bypass in France and Scandinavia."* Sam
		• Private	*"I mean there's always going down the private route but that is a lot of money and there's a lot of things to consider with that."* Paul
		• Internet	*"I'm part of a bariatric support group and you read a lot of things on there, it's the UK support group on Facebook."* Paul
		• Books	*"We've bought a couple of books both about the surgery and life after."* Sam
		• Past Candidates	*"I funny enough know one lady that had surgery, I don't know what she had, and she said that she lost a lot and then she put some back on but she is happy with what she's carrying, so I think for me it's just not going in there with a high expectation to perform, I'm just going to take each day as it comes."* Amy
		• Professional Info	*"I wrote to my liver consultant and asked her if she could give me a call because I wanted to know what might be expected if did or didn't have the surgery in terms of what that would do to my liver."* Sam
	Sense Making	• Self-Work	*"As far as the depression goes, I've kept it off for donkeys years, I've managed to control it with the help of Prozac, I do occasionally go back to the help of counselling if I need it but I haven't had that for quite some time."* Gill
		• Self-Love	*"I don't like me in general at the moment and with me it can make me feel a bit of recluse, I will shut myself off. I think this will help me to feel better about myself."* Carrie
		• Self-Value	*"I felt unloved- he doesn't want me so no one will want me. And sadly as my mum said, when I got old enough and started doing a paper round and earning my own money and went out with friends, she had*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			no control of what I was eating. And yeah, just kind of went from there." Joanna
		• Self-Harm	*"I thought why am I bothering, no one else bothers so why should I bother and then probably around this time last year and I hit 19 stone."* Sharon
		• Cycles	*"Eating the chocolate in the moment is okay but it doesn't make any difference, you're still going to be in the same position 5 minutes later. I've perhaps become more self aware in that regard. Certainly as a kid and a teenager and on it to my 20s and 30s, it was a coping mechanism, it was something to make myself feel better for a period of time even if that period of time was relatively short."* Sam
		• Testing	*"I think I've always known I've had a bad relationship with food."* Sophie
		• Control	*"I'm one of these people that may think I really fancy a chocolate biscuit. If it's in the cupboard I can say oh I don't really want it, if it's not in the cupboard I want it and I have to go and buy it."* Carrie
		• Disorder	*"Everyone who goes to that clinic obviously has some kind of problem with food, their weight."* Joanna
		• Insight	*"You've always done it, so when you look back you think- oh gosh it all stems from my childhood."* Amy
		• Guilt	*"And after you've eaten how do you feel?"* Interviewer, "*Guilty."* Rachel
		• Gain	*"My youngest is 7 and I put on a lot of weight with that pregnancy and I've got older children as well and I've just never been able to lose it and I've always just put that little bit more on."* Jamie

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
Specialist Obesity Services	Positive Experiences in Tier 3 and Tier 4	• Normalisation	*"I'll just slip of the beaten track a bit and I'll pick it back up the next day. We've all been there we've all done it, they don't make you feel guilty for doing it because they said at the end of the day it's a big change."* Joanna
		• Helpful	*"I learnt a lot, it's very informative. It was all pretty helpful in different ways with dietary plans and everything else which I hadn't actually explored before."* Paul
		• Informative	*"But you know they give you some good information."* Carrie
	Relationship to Obesity Professionals	• Trust	*"They are always there at the end of the phone if you need to ring them. If you've got any questions they're always there if you need them."* Paul
		• Honesty	*"Yeah there was no point not to be, it wasn't going to be in my best interest and if you lie about something, especially if you've lied about what you've eaten or how you've done something, your weight is going to tell them anyway so what's the point."* Carrie
		• Rapport	*"Yeah I haven't felt judged er which is what I was a bit worried about. Which I suppose I shouldn't have really have worried because the job they're in they're seeing fat people every day but yeah you get so used to being judged all the time that it's it's nice not to feel that. And because none of them are particularly like I haven't sort of had anyone who's been like a size 6 to 8 or anything coming in. They've all been coming in like what, 10, 12, 14 and that helps because you're sort of looking and they know what it's like not to be Cindy Crawford if you like."* Sophie

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
	Challenges in Tier 3 and Tier 4	• Length	*"When I very first started going through the system I must have been in my later 30s early 40s so that would be around 20 years ago, that's when I first considered it and I was first put forward for it."* Gill
		• Hoops	*"There were a series of appointments that at times didn't feel as though they were going anywhere."* Sam
		• Unhelpful	*"This time around I felt they had got me a slightly the wrong order, I saw the anesthetist a year before I saw the surgeon and I would have thought that I would have seen the anesthetist a couple of weeks before or a couple of weeks after or whatever, and I get the impression that they perhaps mixed up the routine of it all."* Gill
		• Unclear	*"Quick, it wasn't quick to get to it but you felt like you were in and out in 5 minutes and it was like is that it? What's actually happening now? Is that me yeah I'm now going forward or am I still sort of you may go forward or what?"* Carrie
		• Rushed	*"I think they were good don't get me wrong but I think there should be a bit more time, it's very rushed."* Rachel
		• Milk	*"And I literally just looked at milk and I was like I hate you, I don't want to take you."* Joanna
	Access to Tier 3 and 4	• GP	*"I was really lucky I've got a GP who is really supportive, a lot of people don't."* Carrie
		• Initial No	*"I asked my then GP in about 2008-9 and I was told that it's not possible and so it went on the back burner until about 2015 and then I got the referral here from my new GP who said yes it is potentially possible."* Sam
		• Fear of Loss	*"I just thought, is it ever going to happen, is surgery ever going to happen, I couldn't see it at the end of the tunnel, I just thought it would*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			be one thing after another, I just didn't ever see surgery so now it's actually happening it's quite a shock." Stacey
	Gaps in Service Provision	• Gaps	*"2nd thing that the team could start incorporating at the early stages along with reminding about excess skin is once you get to your goal weight, then what? How do you go to maintain rather than weight loss, this is something that I can't remember ever being covered, how do you ensure you do go to maintain rather than ruining all the work done?"* Carrie
Conceptualization of Surgery	Panacea?	• Fullness	*"Just another step of coming out at the other end and you can go back to feeling when you were younger. Because I was younger and I was like running around and I was like- yay- you know I can, the world's my oyster."* Amy
		• Panacea	*"And just being physically well, hopefully, I'm not gonna say that it's going to cure everything but I think it will help."* Amy
		• Wonderful	*"A hell of a lot better, yeah, I'll be living my life to how I should be, more energy and hopefully trying to have a baby, you know having a family and just having a better relationship with food as well."* Joanna
		• Unchanging	*"Why I hope that a successful outcome of surgery will improve things I know it's not going to wave a magic wand, all the health issues I've got will still be there."* Sam
		• Good Enough	*"I funny enough know one lady that had surgery, I don't know what she had, and she said that she lost a lot and then she put some back on but she is happy with what she's carrying, so I think for me it's just not going in there with a high expectation to perform, I'm just going to take each day as it comes, I think for me if you go in and think yep, it's the be all and end all and then it doesn't work out the way you're*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			imagining it, you'll be frustrated, so I'm just going to go in and think you know what, let's just take each day as it comes." Amy
	Has to be Surgery	• Only Option	*"I'd explored a lot of diets and seen a lot of dieticians and everything else and nothing was working. I just felt that this was my last resort really to try and lose a bit of weight."* Paul
		• Barrier	*"Obviously I'm trying to lose weight, I've got under active thyroid as well, I've got mobility issues that aren't helping the situation."* Carrie
		• Plod on	*"(life would be) Exactly the same as it is now, I don't think there would be any improvement."* Stacey
		• Gloom	*"I suspect that if I don't have the surgery, in two years my life will not be hugely different from what it is now but I suspect it will be a bit worse with many regards and I will probably feel both physically and emotionally unwell."* Sam
		• Failure	*"I tried everything. Slimming World, Weight Watchers, all the fad diets, I tried everything."* Stacey
	Or Does It?	• Pros and Cons	*"I honestly don't know how bad it's going to be. I'm hoping that because I've lost a fair amount and because I'm not as large as some people going under this that once I'm able to start exercising again, I will hopefully be able to manage some of that, I know it's not going to 100%, I'm under no illusions, there will be something that's not particularly pleasant, I'm just hoping that I will be able to address it and work with it and minimize as best I can. It's going to be there, it's not going to be great but I'd rather be better health wise and have some excess skin than be in the position that I'm in currently."* Carrie
		• Odds	*"People getting problems with pains in their stomach, things like that. So there are some physical issues that I am a little bit worried about*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			but for me that's just a small price to pay and that's probably only 1 in 10 or something that has problems." Paul
		• Doubt	*"I don't know, maybe other people do go in to this thinking yep, 100% behind this, there's not going to be any issues. I think even on the morning when they're wheeling me into theatre or whatever I think I'll say I've still got some doubts and concerns"* Sam
		• Undoubting	*"I've got no doubts about the surgery."* Paul
		• Drastic	*"It was the time that I needed to do something drastic and I say drastic because I've been on diets, I go to the gym, it wasn't doing what it need to do."* Carrie
		• Necessity	*"No not doubts about actually having it but it has made me think that if I can do it on my own I'm better off."* Sharon
	Role of Surgery	• A tool	*"A lot of it is going to be down to me and not just, yeah there's the physical part there of not being able to eat as much, at least in the short term, so that will almost inevitably have a positive impact but yeah it's down to me."* Sam
		• Responsibility	*"I think everything will be down to me. They just taking my stomach back to kind of like a baby sort of thing and I have to look after it."* Rachel
		• Accelerating	*"I would still be in a better place, not as far on as I hope I will be with the surgery but I've still got to keep going."* Carrie
		• Sustain	*"So that was when I initially discussed it with my GP and my GP at the time thought it would be a good idea because as I say, I could lose it, or in the past I could but I haven't been able to keep it off."* Gill

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Relationship	*"I'm an emotional eater, so if I'm sad I'll eat and if I'm bored I'll eat, if there's nothing to do I'll eat. So I think that that's all going to change."* Stacey
		• Full	*"I'm really really really hoping that it does work in that it makes me feel full up, I mean they assure me it will."* Gill
	Expected Trajectory	• Beforehand	*"And I think I'm trying to now more and more listen to my body if I'm eating a meal because so often it's like well this is my plate of dinner I have to eat it all. Or I'll eat it all because I'm not really enjoying it and it's like trying to go even if you're enjoying it actually I'm happily full now, leave it and trying to get my head round that is is like trying to do it all beforehand so it's less to deal with afterwards."* Sophie
		• Honeymoon Period	*"The surgery will control you for the first 3 months because your body has got to get used to it, your body is healing, your body is telling you that actually you need to go slow. So the surgery for at least the first few months, it's critical that you listen to the surgery and you listen to your body, otherwise you're just going to break it. You're going to feel like hell. I'm under no illusions. After that, when your body has started to heal, it's then down to you to make sure that you don't ruin that surgery and that you use the surgery to get to where you want to be."* Carrie
		• Settle	*"I think I understand the concept of what will be the new normal."* Sam
		• Life-Long	*"I think just the whole lifestyle change is going to be different. The way that I live now is going to be totally changed."* Stacey
		• Set Backs	*"I don't think I'm under any illusions what so ever that I will go home after the operation and everything will be sweetness and light, I know*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			it's going to be bloody hard. And it will be tough and it will be unpleasant and it will not be comfortable and because of my situation over the last couple of years I have, I do everything in my power to make life as comfortable as possible within the constraints that I face and so coming out of the comfort zone is certainly going to be difficult." Sam
		• Realisation	*"And it isn't just literally oh here's your date for surgery and off you go, everything is done and dusted and you're sorted because there is a whole load of run up and that run up is hard and then they give you the sheet that says right this is what is going to happen for the next 3 months and you think Jesus, you forget that it is a complete lifestyle change."* Carrie
Hopes for Life After Surgery	Aesthetic Hopes	• Thinner	*"Good hopefully. I'm nice and thin, I'll be looking good."* Paul
		• Body Image	*"And to be honest, I don't want to embarrass myself, I'd rather sort of be able to fit comfortable into a nice dress (laughs), I don't do dresses as it is so."* Joanna
		• Shopping	*"Definitely, I won't mind going out shopping, whereas now I dread it. I'm quite looking forward to going in to normal shops."* Stacey
	Emotional Hopes	• Confident	*"I'll be more confident in myself."* Stacey
		• Proud	*"I'll be feeling pretty good about myself as well as I will know that I've achieved something amazing you know."* Joanna
		• Happy	*"To be honest a lot of my emotion is down to the way I feel, my weight and everything so I'm hoping that as I start to lose the weight I'm going to be a lot happier."* Rachel

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Self-Like	*"I think the most important thing for me is how I see me and I think this surgery will help me with that, I need to like me again and at the minute I don't like me with this weight."* Carrie
		• Mental Health	*"I would hope that some of the depression and anxiety problems that I've got will lessen. I'm not sure that they will go away but between the weight loss and the CBT and that side of things, hopefully being more independent and active will improve my mental health."* Sam
	Practical Hopes	• Work	*"I would hope to do bit more work, to be out of the house a bit more. I quite like being self employed and working from home so I'm not that keen to get back in to full time employment but there are certain things that I could do that I can't do right now. When I first came out of my job in I did some trading for businesses which I just couldn't do now so that's something that I could potentially look to take up again."* Sam
		• Travel	*"One thing for me once I've gone through which will change my lifestyle is I hopefully won't always be checking for weight limits for activities and whether I'll get wedged in a chair, knowing plane seats & belts won't be a concern."* Carrie
		• Play	*"I can start doing things that I used to do, I used to love going up into town, friends and I, just having an evening sitting, people watching whatever, I love going up there and doing all sorts of things."* Gill
		• Mobility	*"I'll be able to do more things with them. The way it is at the moment, they go out in the school holidays and that and I can't go out on day trips with them because I can't walk far. I do have a wheelchair at home but it's not always convenient to take it."* Paul
		• ADL	*"Hopefully I would be able to get out and about more and just do more generally. I hope that I'll be more mobile and therefore more able to*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			do stuff around the house to help my wife. Our dogs getting on a bit so whether he'll be around or not in a couple of years I don't know but hopefully it would mean that I could take him for a walk and be able to get out and about and see people and go to gigs and things like that." Sam
	Health Hopes	• Improve Health	*"And just being physically well, hopefully, I'm not gonna say that it's going to cure everything but I think it will help."* Amy
		• Extend	*"I'll probably be feeling happy and also thankful that I got the surgery done and out the way at the time I did. Obviously the longer it's left the more risks to my health and stuff. People like my GP have told me that if I don't lose weight I will die."* Paul
		• Prevent Health	*"We've got a history of later onset type 2 diabetes in the family, so you suddenly look at that and you think actually, it's going to be early onset diabetes for me if I carry on, erm and because my weight is all around the middle, that's the worst place so I sort of think, well actually, I could live longer now because I've made this change now."* Amy
	Normality	• Bye Stigma	*"To never let myself get sort of bullied by anyone about my weight ever again."* Joanna
		• Normality	*"Just how you feel I think, just how you feel in yourself. When you try to explain to someone who's not big, you're always the biggest person that walks in the room and it is something that people look at, whether they say they don't or not, I don't believe that, I think you know, you stand out, so just maybe blending in and being normal."* Jamie
	Relational Hopes	• Connection	*"It would be nice to have more friends, sometimes I do get very lonely but yeah, I would have more confidence to go out and meet people."* Sharon

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Fertility	*"One of the reasons that I'm doing this is because I don't have any fertility, for me to have children I would have to go through IVF, erm which obviously I wouldn't qualify at my size as I am and I've sat and thought long and hard about it and yeah having kids is one thing I would love to have."* Joanna
		• Children	*"Obviously my children. I like to be able to do more. Well one's at university so he doesn't want go swimming with mum or anything any more and my daughter is off doing her own thing but I've got a 7 year old and I'd just like to do, well I do do things but obviously I get tired really quickly and things like that so I think it will improve that."* Jamie
		• Current Relationships • New Relationships	*"A better relationship with my husband."* Rachel
			"Maybe there will be somebody else in my life if I can lose some weight. I don't want to get married again but just to have a companionship." Sharon
		• Independence	*"I suppose to prove that I can still do it, that I want to do it, that's more important than anything, because I suppose after everything that's gone wrong, I could just sort of sit down and say no- let somebody else look after me but I'm not ready for that, and I want to make sure that I can get out there and do things, see my family, be with people that I want to be with and just lead a normal life."* Gill
		• Contribution	*"My wife is just an astonishing woman. I hope that that relationship is every bit as strong as it is now and hopefully stronger in so far that it won't be a one-way street which is what it's become."* Sam
A Journey in Context	Enablers	• Enablers Abuse	*"I had not long broke up with my boyfriend before and it was just an unhealthy relationship so I had to go through some counselling*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			because I suffer with depression and he basically fed me. He was a feeder and he thrived of my insecurities and so he made me very very insecure of how I was." Joanna
		• Enablers Love	*"Her background is very much that the woman provides for the family and one way that she demonstrates love for her family is providing food that they like and plenty of it and so I wonder, I think part of her more reticent approach is perhaps grounded in that in that she may not be able to demonstrate love in that way. I've not had that conversation with her but I think that might be part of it."* Sam
		• Bad Influence	*"The only way I think it will impact with my mum is, I think I said this to you before that I see her inadvertently as a slight enabler because she's always like do you want a biscuit with that or do you want this?"* Carrie
	Stigma and Sharing	• WLS stigma	*"Like a lot of people think that when you go for surgery it's an easy way out but it's actually not, it's really hard."* Rachel
		• Sharing	*"Yes, my parents are very important in my life and I've spoken to them and my mum's not happy but she'll support me, my immediate family, my brother, he doesn't say a lot but he basically said that if that's what you want to do then great, go for it, my nieces and my nephew, my youngest niece she has a weight problem and she's like yeah go for it, my eldest niece doesn't say a lot but as far as she's concerned if it makes me happy, yes, my best friends, one of them thinks I should just diet (laughs) but once again, if I'm happy with it then go ahead, my other friend, she's like yeah go for it."* Gill
		• Secrets	*"I haven't said anything to my son, erm, I dunno, I just find it a bit challenging, cus he's 22, so his life has just begun and he's whizzing*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			around here there and everywhere, and he's working but its, yeah, I'll probably tell him before I go in, I haven't really discussed it with him." Amy
	Family Sense Making	• Family Worries	*"I think my little girl is a bit nervous because her mum's not going to be there for a few days."* Stacey
		• Sense Making	*"My mum, she's petrified and she doesn't want me to have it done, she's frightened I'm not going to wake up from the anesthetic and she's just really worried. She's know somebody about 30 years ago, obviously it's come on a lot since then, but they were trying to eat a mars bar or something and she tells me that they died from it and so she's really worried that I'm going to carry on eating like that and I've explained to her that obviously I can't, it really doesn't work like that."* Jamie
		• Unspoken	*"I'm not sure how my husband's going to be afterwards. I think that he's probably secure in how I am now at the moment he's been really supportive and really good with it but I don't know how it will change."* Jamie
	Family Support	• Child-care	*"They've got to be there to look after my children because I won't be able to pick up or lift or do any of that."* Stacey
		• Reminders	*"I think my friend who knows about it will actually keep me going as in he will make sure I'm alright, he's the one who always reminds me to eat and things like that."* Carrie
			"I think I'll need support from family and stuff like that." Jamie

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Unspecified Support • Diet Change	*"He just tells me off and if I don't listen whatever it is that I'm eating that I shouldn't be, he will come and take it away and throw it in the bin or give it to the dog."* Paul
			"I think my friend who knows about it will actually keep me going as in he will make sure I'm alright." Carrie
		• Emotional • Recovery Support	*"My wife is very positive about it and very keen for me to have the surgery and is very supportive of it and I know that she will do everything that she can to make it as smooth as possible."* Sam
		• Commiserating	*"They would support me not to become depressed, encourage me to try something different, they would just be there really to stop me from going under."* Rachel
	Co-changing	• Diet	*"I think so because I'm going to be eating a lot better and he wants to eat better than he does and I'm just gonna get on and get planning and sort of do more of a meal structure for us really."* Amy
		• Moving	*"I've got one friend I know that will be pushing me to get back to the swimming pool and the gym."* Gill
		• Habits	*"Pretty much the same as it is now because we've got into the habits now and we are just going to keep carrying on with that."* Paul
		• Food Shopping	*"Yeah, and he's noticed that what we used to eat was, and as he said he's not exactly fantastic with what he eats now, erm but I can't say anything because if that's what you want to eat that's fine but when I have surgery it's not going to be like that, the food shopping is going to be different and there's going to be colours in our shopping."* Joanna
Plans and Preparation	Psychological Preparation	• Appreciation	*"I think what has helped me prepare for this, it is a long process and although when you start of you think oh my god this is so far away, you need it. You have to see that you can maintain this because we're*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			talking 2 years later, ok where do you think you're going to be? Well I've already done this for 3 years to a certain degree, I've had to maintain and keep going so it's prepared me to be able to yeah alright I've been able to do this without the surgery but hopefully putting the surgery in will give me that additional burst to say this is why you've put yourself through this, this is why you've kept yourself on this path, now keep it going, don't ruin it. So I needed that time to get myself in the right head space, to be able to prep myself, to be able to work because the team do give you leaflet sheets and stuff like that and they do call you in regularly, I have been able to start working on it earlier rather than just waiting until the end and that for me, I was prepping all the way, it isn't just oh yeah just go to here and it's all good, you've got to make it a complete journey so yeah I've kicked it of for the last 3 years. Yeah you have blips, you're going to, there's no 2 ways about it, I think that time has given me a good preparation not only physically but mentally to be able to continue it and say yeah I can do this. If I don't question it, if I'm not scared about it then yeah take me off the list now because I think that is wrong, it has to challenge you." Carrie
		• Success	*"Well being on the milk diet it's really strange because I haven't done any of those things because I don't know, I just think because I'm so determined and I want the surgery so much, I'm determined not to. Because all over Christmas it was like all these lovely foods every where and the smells and stuff, chocolates and cakes (candidate was on milk diet over Christmas period) and I was so determined. It's in yourself, you have to be determined yourself not to do anything or eat anything for it to actually work."* Stacey

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Headspace	*"Yeah, my focus has wavered but it hasn't gone, I think that's probably the best way to put it. It is a shame it didn't happen because I had got myself in to such a frame of mind, I'd got the milk in, I'd got the Oxo cubes in."* Gill
		• Excitement	*"I'll be feeling pretty good about myself as well as I will know that I've achieved something amazing you know. So yeah, I'm looking forward to the future, I'm not one of those people who is like 'ooo I don't know', I'm really excited for the future because I know at the end of this I'm going to look in the mirror and be like, I did it!"* Joanna
		• Motivator	*"I think going through this whole process, in fact I was talking to my friend yesterday, it does change your way of thinking, I haven't had a melt down yet from the milk diet which is a miracle in itself but yeah it does change and when you go to all these different appointments and they tell you the difference between your head hunger and physical hunger, you can tell the difference and it does make you think differently. You know, I've had this opportunity and I've really just got to go for it and do exactly what's asked from me which I have. And you do, you do feel a bit different and your mindset does change, well mine has anyway."* Jamie
		• Investment	*"Not overeating otherwise I'm going to go through all of this and then few years down the line, put all the weight back on."* Rachel

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Focus	*"But regardless I still need to stay on this path, it's going to be dam struggle and it'll be a long time getting there and they'll be a lot of ups and downs with it. Hopefully I would still be in a better place, not as far on as I hope I will be with the surgery but I've still got to keep going, I've still got to get myself back some how. Whatever route, I have to get myself there, not just for physical health but for my mental health, I have to get me there."* Carrie
		• Blips	*"And then as it goes on, cus you have to get weighed all the time, if you put weight on then they're like 'why have you put weight on, are you following what you're supposed to?' erm and then you kind of get to that point where you get this niggly- I'm not going to do this, I'm not going to achieve it, but when you get past the dieticians and you're coming up to meet the surgeons."* Joanna
		• Prepared	*"At the moment I feel very confident. Whether I will nearer the time I don't know. I just think that I can do it, I can cope with having little portions and the liquid to start with."* Sharon
	Changing Eating	• Alternatives	*"When you get yourself in the mind set of having the operation, you know that your eating habits are going to change, you know that your lifestyle is going to change and you know that you've got to adapt in a major way."* Gill
		• Social Eating	*"Funny enough, because of Christmas, we would have all been together as a family as usual having a Christmas dinner, but I wouldn't have been having the meal, but I would still be sitting and the table with everybody and I was still going to be cooking it and I was still going to be dishing it up."* Gill

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Eating Out	*"But no, it's again going with the healthier option, you can go out and eat but it's the alternatives, you can look at the menu and go right, I can have that, I can have that, I can have that and still be sociable, or you say, I'm having the kids portion and that's the way I see it, I sort of think it's just switching things around."* Amy
		• Size	*"I'll have to eat to keep me alive but that it will obviously just be smaller portions."* Gill
		• Dietary	*"I think it will be how to train myself, if someone says to me here's a bowl of lettuce or here is a bowl of chocolate cake, I've got to be able to say no to that and yes to the other, I think it's more going to be, I need help more with better decisions."* Joanna
		• Structure	*"One of the biggest problems for is that I can't eat when I get up, I have to wait a certain amount of time so at the minute it's making sure that I'm up in plenty of time to get myself to a position where I'm able to eat and I'm sure that I do not start work before I've had something to eat or I grab something to eat to take it with me to eat at my desk whilst I start booting up and let it go down sort of thing or that I do go and have lunch."* Carrie
	Lifestyle Changes	• Barrier-lift	*"It will change a bit because obviously I will lose weight and I need to exercise in order to heal properly so it will change, I'll still have the problems with my legs that I've got but nobody really knows what is the matter with my legs, the doctors are baffled by it but ever since I came out of that coma, I lose all the feeling in my right leg and I can't walk very far, I don't know why, so I'll always have that problem. But I'm thinking as I lose the weight and I can walk a bit more every day I'll*

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
			probably come to a point where I can get passed that, well I'm hoping anyway." Paul
		• Exercise	*"I like swimming but I won't swim anymore, whereas once the weight comes off- back to the gym swimming, doing all the things that I've always done, perhaps more moderately now that I'm a bit older."* Gill
		• Coping	*"Distraction, like I'll go on my phone or I'll go and make a cup of tea just to take your mind of it or I'll start doing something at work that I probably should have been doing anyway before I started thinking about food."* Jamie
	As it Comes	• Baby Steps	*"Yeah, cus it's such an adjustment, obviously you're not just going in to have a tooth removed, it's a big change and yeah I think it's just going to be that I have to wake up and take each day as it comes, so I don't get overwhelmed and I don't sit there and think have I made the right choice. I think it is one of those, unless you have physically been through it I don't think you can know what to expect, it's just going to be every day you wake up, just take it."* Joanna
		• Fate	*"If it doesn't work or I don't start losing weight, I haven't really thought over much apart from what will be will be, there's nothing I can do to change that, I've got to learn to live with it and move on."* Gill
		• Not Yet	*"No, no, no I mean I think I'm 50 50, I'm mentally prepared for Tuesday (operation date) and I think that's as far as I've got, I think I've just got to take it as it comes."* Joanna
		• Experiential	*"I suppose with the food, the nurses explained that it's like trial and error, you do try again a bit later so I guess that's something that I'm just going to have to learn to live with really."* Jamie

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
	Emerging Concerns	• Re-gain	*"The thing is with surgery it's a life long thing that after surgery that's what I need to do. I don't want to go backwards after surgery and become fat again. It has changed the whole way that I think about and my life and everything else."* Paul
		• Adapting	*"Then they give you the sheet that says right this is what is going to happen for the next 3 months and you think Jesus, you forget that it is a complete lifestyle change."* Carrie
		• Recovery	*"I think the initial hurdle is getting well because with any surgery, you feel rubbish."* Amy
		• Identify	*"I hope not, I hope not. I have actually thought about that myself because everyone is like oh you're a big person, a big outgoing bubbly personality, people lose that. I don't think I'll lose my personality cus that's who I am but yeah, I've also thought that as well."* Joanna
		• Personaility	*"I think she'll view me completely differently, I think she see me as no longer the person that is her friend, which I don't know why she sees it that way but it's weird because she knew me when I was a lot smaller, when we first met I was an awful lot smaller than what I am now. So I don't know why she feels like that. Mind you, I'll have to remind her of that because then she'll probably say oh yeah and it won't be an issue any more."* Gill
		• Affiliations	*"I question the friend who said you're not going to be the same person, but then I don't think it will impact it no, I think she might go through a period of, cus she has depressive issues and I think it might affect her but I think it will affect her a lot more than me."* Gill
		• Supplements	*"I really don't fancy injecting myself all the time."* Sharon

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Hair Loss	*"I mean one of the things was losing hair which I haven't got to worry about that anymore because I lost my hair anyway. So that was one of my big worries because after weight loss one of the side effects is losing hair."* Rachel
		• Dumping	*"I think that some of the other potential after effects, you hear terms like dumping syndrome and other bits and pieces, it's mentioned, it's covered very briefly but because there is so much information coming in, I think it needs to be address again and remind people."* Carrie
		• Excess Skin	*"I'm just worried about the excess skin and how it will look, yeah, cus you're always body conscious when you're over weight but to be conscious again when you've got a load of excess skin isn't brilliant either, I'm trying not to think about so it doesn't get in my head because in a way it's a minor thing, it's major but minor, I'm trying not to think about it."* Amy
		• Liquid	*"Well I won't be able to eat as much in terms of portion size and I know I've got to state basically on a liquid diet to start with so even then it's still going to be hard because I have done the milk diet once before, it was for my daughter's wedding, I wanted to lose some quick, I managed it, I did manage it but it was hard. Particularly because I don't like milk and you've got to have it for surgery."* Sharon
		• Sickness	*"I hate feeling sick, so that's sort of worrying me as well."* Joanna
	Responding to Concerns	• Other Candidates	*"I think there is a weight loss group that they run here so I might ask them about that, I think it's just good to be around people who have been there."* Amy

Superordinate Theme	Sub-Theme	Codes *Inductive* *Deductive*	Quotes
		• Online	*"But we go on the internet together, we research all this stuff, we watch videos of surgeries so we kind of know what is involved, what could go wrong and how we can deal with it if it does."* Paul
		• Family	*"I have spoken to people about living on my own if anything happens, if anything goes wrong, if I don't heal properly or whatever, I have spoken to people about that, my friends have all said that you know we're only a phone call away and you silly cow, all you have to do is call an ambulance, I though oh yeah, that's true, so yes, I have discussed things with friends."* Amy
		• Professional Help	*"The only sort of conversations that I've had are with the team. That's probably the only people that I've spoken to about it."* Carrie
		• Bliss	*"That's a really difficult question, do you know I haven't really thought about anything being hard because when you get yourself in the mind set of having the operation, you know that your eating habits are going to change, you know that your lifestyle is going to change and you know that you've got to adapt in a major way, you don't really think about that."* Gill
		• None	*"Apart from that I've not really spoken to anybody about concerns. I don't want to give anyone negative thoughts for them to say well we don't think you're ready for it."* Paul
		• Vicarious	*"Also his niece has just had this done privately so when he realised that we were having the same surgery, you know it's then comparing and discussing, how's she going, what's she been through, how am I going etc."* Carrie

Superordinate Theme	**Sub-Theme**	**Codes** *Inductive* *Deductive*	**Quotes**
		• Bad Enough	*"If I was really worried about something and say I was having panic attacks and it was really effecting me but because at the moment it's not really effecting me that's why I haven't spoken to anybody."* Stacey
		• Get On	*"You just have to get on with it don't you, there's no option to it, you've got to do it and that's it."* Sharon
		• Plan B	*"But I think my friends especially would be like right come on, we'll go and do something else. One of my friends makes me go swimming with her every week, even if I don't want to go, so they are really good friends so I'm lucky."* Jamie