Spring 2010

The Lived Experience of Obesity and Bariatric Surgery

Chrissy O'Byrne

Carroll College, Helena, MT

Follow this and additional works at: https://scholars.carroll.edu/nursing_theses

Part of the Nursing Commons

Recommended Citation

O'Byrne, Chrissy, "The Lived Experience of Obesity and Bariatric Surgery" (2010). Nursing Undergraduate Theses. 17.
https://scholars.carroll.edu/nursing_theses/17

This Thesis is brought to you for free and open access by the Nursing at Carroll Scholars. It has been accepted for inclusion in Nursing Undergraduate Theses by an authorized administrator of Carroll Scholars. For more information, please contact tkratz@carroll.edu.
The Lived Experience

Running Head: THE LIVED EXPERIENCE

The Lived Experience of Obesity and Bariatric Surgery

Chrissy O’Byrne

Carroll College
SIGNATURE PAGE:

This thesis for honors recognition has been approved for the Department of Nursing.

[Signature]
Director
Date

[Signature]
Reader
Date

[Signature]
Reader
Date
ABSTRACT

Purpose: The purpose of this paper was to explore the lifestyle changes and associated physical and personal challenges associated with bariatric surgery.

Demographics: Participants in this study included four women over the age of 20 who had undergone either a roux-en-y gastric bypass procedure or a laparoscopic banding procedure. Participants were all volunteers who were contacted by this researcher through social networking.

Type of Study: This researcher used the phenomenological research method as a framework for gathering and analyzing data about individuals’ experiences with bariatric surgery and personal lifestyle changes.

Data Collection: Data was collected directly from individuals through closed session personal interviews and was audio recorded.

Findings: Several themes emerged from interviews with participants. These themes included: The Beginning of Obesity as a Problem, Dieting, Losing Weight, and Regaining Weight, Experiencing Social Stigma, Withholding Disclosure, Enhancing Self Esteem, Battling Depression, Enjoying Food in Smaller Quantities, and Recognizing Sustained Weight Loss as a Process.

Nursing Implications: Bariatric surgery is a very good option for individuals who are prepared for and committed to making major lifestyle modifications. It should only be done after all other attempts at sustained weight loss have failed. Nursing teaching regarding diet, exercise, and psychosocial changes that the individual can expect before and after surgery is an important element in the process.
Generalization: The findings of this study cannot be generalized to all bariatric patients, because of the small sample size and the fact that participants were only of one gender. More research regarding this area is needed.
Acknowledgments

I would like to extend my gratitude to Dr. Joni Walton, Dr. Jennifer Elison, Professor Kim Garrison, Joan Stottlemyer, and to my parents for the significant amount of time each of them spent assisting me with the editing, revising, and eventual completion of this paper. Without their valued insight and frequent encouragement this paper would not have been completed.
Dedication

This thesis is dedicated to my parents Brian and Anne O'Byrne to whom this paper would not have been completed without their frequent encouragement, support, and guidance. Thank you for always encouraging me to persevere even when it’s hard, to accomplish all that I can, and to be the best student, sister, daughter, and friend that I can be. Thank you for your patience!
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE PAGE</td>
<td>2</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>3-4</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>5</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>6</td>
</tr>
<tr>
<td><strong>CHAPTER I</strong></td>
<td></td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>10</td>
</tr>
<tr>
<td>The Concern with Obesity</td>
<td></td>
</tr>
<tr>
<td>Defining obesity</td>
<td>10</td>
</tr>
<tr>
<td>Overweight versus obese</td>
<td>11</td>
</tr>
<tr>
<td>Gender differences</td>
<td>11</td>
</tr>
<tr>
<td>Causes</td>
<td>12</td>
</tr>
<tr>
<td>Risk Factors and co-morbidities</td>
<td>12</td>
</tr>
<tr>
<td>Prevalence</td>
<td>13</td>
</tr>
<tr>
<td>Treatments</td>
<td>13</td>
</tr>
<tr>
<td>Impact of obesity on society and the individual</td>
<td>14</td>
</tr>
<tr>
<td>Psychosocial impact</td>
<td>14</td>
</tr>
<tr>
<td>Impact on family and lifestyle</td>
<td>15</td>
</tr>
<tr>
<td>Impact on society</td>
<td>15</td>
</tr>
<tr>
<td>Ethical issues</td>
<td>16</td>
</tr>
<tr>
<td>Summary</td>
<td>16</td>
</tr>
<tr>
<td><strong>CHAPTER II</strong></td>
<td></td>
</tr>
<tr>
<td>REVIEW OF LITERATURE</td>
<td>17</td>
</tr>
<tr>
<td>About Bariatric Surgery</td>
<td></td>
</tr>
<tr>
<td>Types of bariatric procedures</td>
<td>19</td>
</tr>
<tr>
<td>The risks of bariatric surgery</td>
<td>19</td>
</tr>
<tr>
<td>Standards</td>
<td>22</td>
</tr>
<tr>
<td>Medication treatment</td>
<td>23</td>
</tr>
<tr>
<td>Recent research on bariatric surgery</td>
<td>24</td>
</tr>
<tr>
<td>Factors to Address Before Surgery</td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td>27</td>
</tr>
<tr>
<td>Dietary changes</td>
<td>29</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>31</td>
</tr>
<tr>
<td>Psychological considerations</td>
<td>35</td>
</tr>
<tr>
<td>Comfort with the healthcare system</td>
<td>39</td>
</tr>
<tr>
<td>Medical exam</td>
<td>40</td>
</tr>
<tr>
<td>Standard diagnostic workup prior to surgery</td>
<td>41</td>
</tr>
<tr>
<td>Preparation and expectations</td>
<td>42</td>
</tr>
<tr>
<td>The Role of the Nurse</td>
<td>44</td>
</tr>
<tr>
<td>Interventions</td>
<td>44</td>
</tr>
<tr>
<td>Considerations After Surgery</td>
<td></td>
</tr>
<tr>
<td>Intraoperative nursing care</td>
<td>45</td>
</tr>
<tr>
<td>Postoperative nursing care</td>
<td>45</td>
</tr>
</tbody>
</table>
CHAPTER III

METHODOLOGY ................................................................. 54
  History of Phenomenology .................................................. 54
  Data Collection .................................................................. 56
  Phenomenology and Obesity ............................................... 57
  Participants ..................................................................... 58
  Setting ......................................................................... 58
  Confidentiality .................................................................. 59
  Analysis of Data Collection ............................................... 59
  Research Reliability .......................................................... 60
  Limitations ........................................................................ 60
  Conclusion ........................................................................ 61

CHAPTER IV

RESULTS ............................................................................... 62
  The Beginning of Obesity as a Problem ................................ 62
  Dieting, Losing Weight, and Regaining Weight ................. 63
  Experiencing Social Stigma ............................................... 64
  Withholding Disclosure ...................................................... 65
  Enhancing Self Esteem ........................................................ 66
    Disliking self .................................................................. 66
    Past struggles .................................................................. 67
    Present feelings ............................................................. 67
    Support systems ............................................................. 68
  Battling Depression ............................................................ 70
  Enjoying Food in Smaller Quantities .................................... 71
    Listening to the band ...................................................... 71
    Dietary changes ............................................................... 73
    Food intolerances ........................................................... 73
    Drinking with meals ........................................................ 75
  Recognizing Sustained Weight Loss as a Process ............... 75
    Accepting defeat ............................................................. 75
    Viewing surgery as a tool ............................................... 76
    Recovering from surgery ................................................ 76
    Giving up pop .................................................................. 77
    Incorporating exercise ..................................................... 78
    Improving health ............................................................ 79
    Encountering a plateau ..................................................... 80
Supporting others................................................................................................................................. 81

CHAPTER V

DISCUSSION......................................................................................................................... 82
Recommendations................................................................................................................... 83
Follow-up .............................................................................................................................. 83
Physical activity ................................................................................................................... 83
Psychological follow-up ......................................................................................................... 84
Areas of Needed Research for the Future .............................................................................. 84
Sexual abuse ......................................................................................................................... 84
Factors of regaining .............................................................................................................. 85

REFERENCES................................................................. 87-92
CHAPTER I

Background

There are currently six million people with morbid obesity living in the United States, and according to the American Society for Metabolic and Bariatric surgery (ASMBS), most individuals who are obese “consider their condition as a greater handicap than deafness, dyslexia or blindness” (ASMBS, 2005, para.13). For those with morbid obesity who are seeking to lose weight, a gastric bypass surgical procedure is often the most successful way to accomplish long term weight loss (ASMBS, 2005). Having such a procedure has the potential to dramatically impact not just their physical health, but their psychological health as well. Unfortunately, nearly 80% of severely obese individuals report feeling judged or disrespected by the healthcare system (ASMBS, 2005). Therefore, it is necessary that healthcare professionals working with such patients understand not just the physiological aspect of the disease, but also the psychological and social implications of morbid obesity as well. This includes being knowledgeable about how bariatric surgery can impact each of these domains. Nurses, as members of the healthcare team and patient advocates, are in a position to teach and provide support to this specific patient population. Consequently, the purpose of this paper is to examine the physical, social, and psychological effects that morbid obesity has on an individual and how bariatric surgery can improve quality of life.

The Concern with Obesity

Defining obesity. Obesity is a health condition characterized by an excessive and unhealthy amount of body fat (Venes, 2009). To determine the presence of obesity, a simple calculation called a body mass index can be done by dividing a person’s height in meters squared into his or her weight in kilograms (Venes, 2009).
The number calculated falls within one of several clinically defined categories. These categories are as follows: underweight (<18.5 kg/m²), healthy (18.5-24.9kg/m²), overweight (25.0-29.9kg/m²), class one obesity (30.0-34.9kg/m²), class two obesity (35.0-39.9kg/m²) class three or morbid obesity (≥40) and super obesity (≥50kg/m²) (ASMBS, 2005). According to these standards all individuals with a body mass index (BMI) greater than or equal to 30 mg/m² are considered to be obese and all individuals with a BMI greater than 40 mg/m² are considered to be morbidly obese. However, individuals are also considered to have morbid obesity if they have a BMI greater than 35 mg/m² with an accompanying co-morbid condition such as diabetes mellitus (Carmody et al., 2005).

Overweight versus obese. It is important to clarify that there is a difference between being considered overweight versus being considered obese. Being overweight refers to weighing more than the recommended standard, but this does not necessarily mean that a person has an excess amount of body fat. For individuals who are overweight "the excess weight may come from muscle, bone, fat, water, or any combination of these" (Ide et al., 2008, p. 31). For instance, individuals can be overweight, not because of excess fat but because of increased muscle mass from lifting weights. In contrast, obesity is attributed to having too much body fat specifically. There are more risks associated with being obese than with being overweight (Ide et al., 2008).

Gender differences. Extra fat is typically distributed differently in men and women. In men excess fat is usually located in the abdominal region, which is called android or central obesity (Ide et al., 2009). For women excess fat is typically located in the thighs and lower body, which is called gynoid obesity (Ide et al., 2008). Despite the
fact that they are more common for one gender, android and gynoid obesity are not necessarily gender specific. Just like women, men can have gynoid obesity and just like men, women can have android obesity.

Causes. In most cases, obesity is not attributed to one single causal factor, but rather is attributed to multiple factors and their interactions with one another. Some people are genetically predisposed to being overweight or obese, while others are predisposed to having a smaller, lightweight frame. Diet and exercise habits, certain types of medications, and hormones are all contributing factors to weight gain and obesity. The prevalence of obesity in the United States has been increasing at a concerning rate over the last several decades, and there is no conclusive information in the literature that explains this phenomenon completely. Researchers at the National Institute of Health reported, “The increase in obesity over the past 30 years has been fueled by a complex interplay of environmental, social, economic, and behavioral factors, acting on a background of genetic susceptibility” (NIH, 2009, para. 3).

Risk Factors and co-morbidities. The health implications of being morbidly obese include many physical risk factors. Having obesity places an individual at an “increased risk of developing diabetes mellitus, hypertension, heart disease, stroke, fatal cancers, and other illnesses” (Venes, 2009). Other illnesses that can develop include but are not limited to obstructive sleep apnea, arthritis, gastroesophageal reflux disease (GERD), infertility and gallbladder disease (Ide et al., 2008). Over time some of these conditions, especially the ones pertaining to the cardiovascular system, can become life threatening. This is emphasized by the findings in a recent research study in which the authors
reported that morbid obesity “has been shown to reduce life expectancy by 5-20 years” (Buzdon, Liao, Reinhardt & Song, 2008, p. 100).

Prevalence. Obesity has been increasing in prevalence for both genders and across all racial and ethnic groups since the early 1990s but “is more common among Hispanics and African Americans” (Crane et al., 2006, p. 824). Additionally, the rates of obesity are higher for middle aged and older men and women than for other age groups.

Treatments. Despite genuine efforts at more conservative methods of weight loss such as dieting and exercise efforts, for some people surgery is the only option that will help them lose weight and keep it off. The exact reason why conservative methods are ineffective is not well understood in the literature, and little is mentioned beyond this fact. The ASMBS reports, however, that “it has been shown that the majority of patients regain all the weight loss over the next five years” with conservative methods (ASMBS, 2005, p. 2). In reviewing a study that evaluated the effectiveness of various non-surgical weight loss methods the ASMBS concluded:

In a nearly four year study, utilizing a two drug regimen of Phentermine and Fenfluramine, behavior modification, diet and exercise, the initial optimistic results have not been sustained, with a one third drop out rate and a final average weight loss of only three pounds in those who were followed for the four years of study. (ASMBS, 2005, p. 2)

One effective weight loss surgery is the Roux-en-Y gastric bypass (RYGB). This is a surgical procedure in which a small gastric pouch is created from the stomach and attached to a portion of the small intestine. Creating a smaller pouch from the stomach causes caloric intake to become highly restricted because there is literally less room for
food, promoting weight loss (ASMBS, 2005) . Positive psychosocial outcomes, such as decreased rates of depression, have been identified for many people who have undergone the procedure (Greenberg, Smith, & Rockart, 2004).

**Impact of obesity on society and the individual.** Morbid obesity impacts an individual’s health and well-being physically, socially, and psychologically. First of all, it increases the individual’s likelihood of developing co-morbidities such as hypertension, obstructive sleep apnea, hyperlipidemia, and type two diabetes mellitus (Ide, Farber & Lautz, 2008). If these diseases are not treated with medications, they can become life-threatening (Ide et al., 2008). As a result, morbid obesity also has a financial impact. Unfortunately, “the cost of care for a morbidly obese adult is 81% greater than for average weight adults,” and the higher the individuals body mass index the more expensive healthcare tends to cost (Brzezinski, 2008, p. 290).

**Psychosocial impact.** Not only does obesity threaten a person’s overall physical health, but it threatens his or her psychological health as well. According to Crane, Kessler, Miglioretti, Saunders, Simon, van Belle, and Von Korff, numerous studies indicate an association between morbid obesity and depression and anxiety disorders (2006). Quality of life for people with morbid obesity is often low because of the many challenges that being overweight pose to them on a daily basis. (Greenberg et al., 2004, p. 6). Additionally, they are more likely to have a history of binge eating episodes and have body image dissatisfaction. (Brody, Burke-Martindale, Grilo, Masheb & Rothschild, 2005). Morbid obesity impacts how the individual is treated by other people, and this includes people he or she encounters in the healthcare setting. Those with morbid obesity are frequently judged by others for the state of their physical appearance and endure
comments from others and sometimes even family members that they are lazy, sinful, gluttonous, or a variety of other hurtful comments (Brzezinski, 2008). Self-esteem can be further impacted by events such as having difficulty finding seats on buses and in restaurants that do not accommodate their large size. As a result, “patients who specifically seek treatment for obesity have a substantially increased risk for lifetime history of major depressive disorder” Greenberg et al., 2004, p. 6).

Impact on family and lifestyle. Having morbid obesity places certain limitations upon the individual. Excess weight can limit people’s mobility and ability to climb steps or walk long distances. Their size may limit them to places that they can go and the activities they can perform. Brzezinski stated that “caring for a family member dealing with morbid obesity puts a strain on all family members or significant others involved” (2008, p. 295). Family members may have to take on roles to help care for the individual with morbid obesity, such as preparing meals, helping the individual to the bathroom, and with personal hygiene (Brzezinski, 2008).

Impact on society. The prevalence of morbid obesity impacts both society and the economy. For instance, “each year, over 300,000 adults in the U.S will die from obesity related causes” (Doty, Fletcher & Menifield 2008, p. 83). The economy is impacted because of the large amount of money that is expended on treating obesity and obesity related problems. Ide, Elliot, Farber, and Lautz reported that “the total annual cost of overweight and obesity is estimated to be $117 billion with direct costs of $61 billion and indirect costs of $56 billion” (2008, p.30). Direct costs include expenses for prevention, diagnosing disorders or diseases, hospitalizing patients, and the medical expenses of treating the problem. Indirect costs are the value of wages that the individual loses in
income because he or she is unable to work due to a medical condition or loses because of premature death (Ide et al., 2008, p. 30).

*Ethical issues.* It is impossible to talk about the issue of morbid obesity in the United States without addressing several important ethical issues that arise from it. One issue of concern for individuals with morbid obesity is discrimination. According to Greenberg et al., “obese women are less likely to marry, have less education, and have lower household incomes than non-obese women” (2004, p. 6). Another issue to consider is employee insurance coverage for gastric bypass surgery. Working for certain companies or corporations sometimes includes health insurance coverage, but policies do not always include coverage for weight loss surgeries, even though it may essential for the health of the individual.

*Summary*

Morbid obesity is a major health concern in the United States. The number of people who are overweight and obese has steadily increased over the last 20 years (Doty et al., 2008). Because of this trend, there is now a significant portion of the population who is at risk for certain cardiovascular disorders and other health complications that can interfere with quality of life. For most people with morbid obesity, bariatric surgery is the best way to maintain weight loss and improve health (American, 2005).
CHAPTER II
Review of Literature

To find information about obesity and the many physical risk factors that are associated with it, one does not have to search very hard or for very long. From articles published in newspapers, magazines and journals to websites posted on the internet, there is an extensive amount of research readily available about the physical health risks of obesity. The fact that over 60% of the population is overweight or obese indicates a need for healthcare professionals to be knowledgeable about what these health risks are, how to recognize them, and how to teach patients they encounter about them (Brechner et al., 2005).

While it is very important that health care professionals treat the physical problem that is presented to them, it is equally important to remember that they are not just treating a problem, but an entire person. In addition to the physical dimension, individuals also have social, psychological, and spiritual dimensions that require consideration. Individuals with obesity are at risk for psychosocial problems such as depression and may even face judgment and ridicule from others for the state of their physical appearance (Courouclas et al., 2007). Therefore it is essential that more than just the physical health of the individual be assessed.

Clearly, to recognize the physical problems is important, but to have insight into who that person is and what his or her life experience has been is just as important in treating all dimensions of the individual. When nurses only treat the physical problem that they are presented with, they are neglecting to see the whole person and that person’s life experiences and choices that have brought him or her to this specific point in their
lives. Only looking at the physical problem can lead the nurse to making faulty assumptions that undermine the integrity of the patient.

Morbid obesity is a health problem that encompasses every area of a person’s life.

From the physical limitations that large size and conditions like arthritis impose, to the social stigma they face in public and in their professional and personal relationships, individuals with morbid obesity face many difficult challenges on a daily basis. It is easy for people who are not overweight or obese to make assumptions about the obese population. A common assumption is that obese individuals are lazy people who do not take care of themselves the way they should and that if they just ate less and exercised more they would not be overweight. However, for individuals with morbid obesity, the solution is not as simple as just exercising more and eating less. It is not that they are lazy and have not tried to improve their health, but rather it is often the case that they have tried repeatedly for a long period of time to lose weight but have not been successful with it. This is a reflection not on their worth or motivation as people, but on a physical problem that needs medical treatment.

Although it is often considered to be a last resort, bariatric surgery is a treatment option for people with morbid obesity who have not had success with trying to lose weight through behavior modification, diet, exercise, or weight loss programs alone. It is in fact a major surgery associated with many risks, but this surgery also has the ability to improve the person’s long term health and mortality. In many cases the risks of the surgery are outweighed by the benefits it provides in the long run and is considered the best treatment option for individuals with morbid obesity (Ide et al., 2008). This chapter
will explore what the current literature offers in terms of the impact of obesity on a person's life experiences and bariatric surgery as an intervention.

About Bariatric Surgery

*Types of bariatric procedures.* There are several different kinds of bariatric surgeries, but the two most commonly performed procedures are the roux-en-y gastric bypass and laparoscopic adjustable gastric banding. Other bariatric surgeries include vertical banded gastroplasty, biliopancreatic diversion, and biliopancreatic diversion with duodenal switch.

In a roux-en-y gastric bypass (RYGB), a portion of the stomach is stapled off and created into a small pouch. The patient’s stomach size is decreased so that it cannot hold as much food as it could before. The pouch that is created can only hold about an ounce of food (Dakin & Kendrick, 2006). In addition to decreasing the size of the stomach, the portion of the small intestine that is connected to the stomach, called the duodenum, is bypassed. This is the part of the intestine where nutrients from ingested food are absorbed. The duodenum is bypassed by cutting the middle portion of the intestine, the jejunum, away from where it connects to the duodenum and attaching it to the new stomach pouch so that food goes directly into the jejunum instead of the duodenum. The part of the duodenum that once connected to the beginning of the jejunum is then reattached to a portion of the jejunum at a site called a stoma (Venes, 2009). Therefore this is both a restrictive and a mal-absorptive procedure because the amount of food that can be ingested is limited by the smaller size of the stomach and the amount of absorbed food is limited by bypassing the duodenum. RYGB is the most commonly performed bariatric
surgery and “the number of these operations has dramatically increased from about 16,000 in the early 1990s to > 100,000 in 2003…” (Carmody et al., 2005, p. 512).

A laparoscopic adjustable gastric band (LAGB) is another type of bariatric surgery in which a silicone band, which can be inflated, is surgically placed around the stomach. This band is connected to a reservoir which is located just underneath the skin in the abdomen. Normal saline can be placed into or removed from the reservoir with a needle (Dakin & Kendrick, 2006). The addition of saline into the reservoir causes the band to be more restrictive on the stomach pouch so that it can hold less food. Removal of saline from the reservoir causes the band to loosen so that the stomach pouch can hold more food (Dakin & Kendrick, 2006). The silicon band wraps around the upper portion of the stomach and is placed during the laparoscopic procedure. It is purely a restrictive procedure, and unlike RYGB it does not alter the body’s ability to absorb food. In the months following surgery, the band is gradually inflated more and more which leads to an increase in restriction and weight loss. Interestingly, although RYGB is a more complex procedure, it is associated with greater rates of long term weight loss than LAGB (Dakin & Kendrick, 2006).

A biliopancreatic diversion and a duodenal switch are both restrictive procedures in which stomach size is reduced, with the major difference between the two procedures being the amount of absorption that occurs. A duodenal switch (DS) is considered to be a variation of the BPD procedure (Dakin & Kendrick, 2006). In a BPD with duodenal switch (BPD-DS) less of the stomach is removed than in a BPD alone. Unlike in BPD, when a duodenal switch is performed, the stomach is cut vertically and the remaining stomach remains connected to the duodenum. Part of the lower intestine, the ileum, is
brought up and connected to the duodenum at the area where pancreatic and liver enzymes enter the duodenum (Dakin & Kendrick, 2006). This means that most of the intestine is bypassed, but some absorption of food still occurs because of the availability of pancreatic and liver enzymes which help with digestion and absorption. Vertical banded gastroplasty is essentially an older and less effective form of the LAGB and is rarely used anymore since RYGB and LAGB became the procedures of choice for many physicians (Dakin & Kendrick, 2006).

**The risks of bariatric surgery.** Each type of bariatric surgery has its own risks and benefits specific to the surgery as well as the risks that are involved with having any surgery. For any surgery there is a risk of developing a condition called deep vein thrombosis or DVT. A DVT occurs when a blood clot forms and is trapped in one of the veins of the legs. They usually form as a result of immobility and stasis of blood after surgery, which predisposes the individual to clot formation. Symptoms of DVT include tenderness, warmth, and redness in the calves (Venes, 2009). If it is not noticed and treated, the clot can dislodge and travel to the lungs which is called a pulmonary embolism or to the brain and cause a stroke. Other risks of almost any abdominal surgery include respiratory depression from anesthesia and infection (Venes, 2009).

Specific risks and complications of RYGB surgery include the risk of gastric pouch leaking, damage to nearby abdominal organs, abdominal hernias, bowel obstruction, wound infections, and death (Ide et al., 2008). Other complications that can occur are changes in bowel habits with constipation or frequent diarrhea, difficulty swallowing due to stomach restriction, and vitamin and protein deficiencies (ASBS, 2008). The major risk or complication following a LAGB is having the band slip out of
place, band erosion, patient intolerance to the band, and difficulty accessing the port or reservoir that is used to add or remove fluid (Ide et al., 2008). The major risks of BPD and BPD-DS include malnutrition, anemia, hernia formation, bowel obstruction, bone disease due to insufficient calcium absorption, and death (Ide et al., 2007).

*Standards.* Although bariatric surgery is an option for those seeking weight loss, it is not recommended for everyone. Specific guidelines created by the American Association of Clinical Endocrinologists, The Obesity Society, and the American Society for Metabolic & Bariatric Surgery provide evidence based recommendations for the eligibility, preoperative and postoperative care, and management of complications following surgery. Eligibility is determined by body mass index and is recommended for individuals who have a BMI of 40 or greater and who are not considered to be at “excessive risk” (NGC, 2008). It is also recommended for those who have a BMI of 35 or higher with co-morbid conditions that further jeopardize health such as diabetes mellitus and coronary artery disease (NGC, 2008).

Bariatric surgeries require a multidisciplinary approach in which every aspect of the individual is taken into consideration. Potential patients need to be knowledgeable about not only the risks and benefits of the procedure, but the cognitive-behavioral changes they will need to make in their lives before and after the procedure as well. It is believed that the most successful patients are those who have their surgery done through a Bariatric Surgery Center of Excellence Program (BSCOE) in which intense preoperative teaching and physical, social, and psychological evaluation occur during the six months prior to surgery (CMM, 2006). In fact, Medicare and Medicaid and some other insurance agencies will only cover the procedure if it is done through such a
program or at a level one, American College of Surgeons (ACS) approved Bariatric Surgery Center (CMM, 2006).

In such programs, patients meet with nutritionists and dieticians on several occasions before the surgery to learn about nutrition and healthy eating behaviors and diet modifications. Patients also have sessions with psychologists to determine their level of mental health and their psychosocial needs. Additionally, patients take classes in which they learn about what bariatric procedures entail and attend support groups in which they discuss their thoughts and concerns. Nurses are often in charge of making sure that patients are directed toward the right areas and are getting through the program the way it is designed. In fact due to the increasing numbers of bariatric procedures and the need for substantial patient teaching and care involved, bariatric nursing emerged as a nursing specialty. A National Association of Bariatric Nurses (NABN) was established in 2004 “out of a recognized need for the nursing profession to dedicate resources, knowledge, and research towards improving the life and nursing care of people suffering from obesity” (NABN, 2007, para.1). Patients also work in conjunction with other members of the program including physicians, psychiatrists, and dietitians. These programs work on the assumption that having bariatric surgery is not a solution in itself to morbid obesity. Rather it is part of a multidisciplinary process that requires time and effort from both the patient and every person working in conjunction with the patient before, during, and after surgery.

Medication treatment. Medications are typically very successful in treating a variety of medical problems, but one problem that they are not successful at treating is morbid obesity. Although there are several weight-loss medications on the market that
are FDA approved, such as Orlistat and Sibutramine, most of these medications can only be used short term for three months or fewer and only contribute to temporary weight loss (Kirby, 2003). For those who have morbid obesity and who have a BMI >40, such medications are typically ineffective in helping the individual lose and keep off weight permanently. Bariatric surgery, specifically RYGB is considered to be the treatment of choice for this population of individuals (Ide et al, 2008).

Recent research on bariatric surgery. The number of bariatric procedures performed per year in the United States has increased from approximately 13,000 in 1998 to 103,000 in 2003 (Baker et al., 2008). The increase in the number of procedures performed is a result of several factors. In addition to a growing awareness in the general population that obesity has many health risks and affects long-term mortality, insurance companies are now recognizing bariatric surgery as a legitimate treatment when previously they had not (Baker et al., 2008).

In a review article of a study conducted by The Centers for Medicare and Medicaid Services (CMS) some important information regarding gaps in the literature was revealed. The committee reviewed 184 articles collected from two separate Medline database searches. The first search was a review of articles using the terms “bariatric” or “obesity” AND “surgery” AND “elderly” or “older” (Brechner, 2005, p. 433). The second search reviewed articles written after April 2003 using the terms “bariatric” or “obesity” AND “surgery” (Brechner et al. 2005, p. 433). Of these 184 articles, 22 were considered acceptable by the standards set by the committee. Such standards were that the studies had to be of “sufficient design and quality to provide an unbroken chain of evidence supporting the premise of the paper” to receive a fair or good quality rating.
The Lived Experience 25

(Brechner et al., 2005, p. 433). The four analysts also included and reviewed five TAs in their research. They sought to determine the degree to which data was available on sustained weight loss, short term mortality, longevity, co-morbidities, and complications for the general population as well as for those over the age of 65. They also sought data comparing outcomes for individuals who had at least one co-morbidity compared to those who did not.

The two most important findings that the CMS analysts found when reviewing the recent research on bariatric procedures were two significant gaps in the literature. The first gap the analysts encountered was that very few articles they reviewed even mentioned the specific effects, risks, or outcomes of bariatric procedures for patients over 65. This is unfortunate because data regarding how this older population of patients respond to bariatric treatment in comparison to younger populations would be helpful in determining more specific and optimal preoperative and postoperative care and teaching. Secondly, very few studies compared the outcomes of individuals who had at least one co-morbidity prior to surgery compared to those who did not. This is a significant gap because data on the number of co-morbidities preoperatively in comparison to postoperative success would be helpful in determining the degree to which co-morbidities impact postoperative healing and weight loss (Brechner, 2005).

In terms of information regarding sustained weight loss, only four of the 22 articles addressed this with data, and only one article provided data about sustained weight loss for individuals over the age of 65. However, four of the five TAs did provide data on sustained weight loss, but none provided data for the 65- and-over population. Of these articles that did address sustained weight loss, the approaches taken by the
researchers and the data the research yielded varied (Brechner, 2005). Some studies focused on RYGB in comparison to VBG with data supporting results that RYGB yields greater sustained weight loss over time. Other studies that were reviewed focused more on VGB or BPD procedures. What all the studies had in common was that no matter what procedure was performed, patients initially lost weight, but the amount of weight loss and the amount of weight regained changed depended on the surgery. Overall, better results were found with mal-absorptive procedures or combination procedures than for purely restrictive procedures like LAGB (Brechner et al., 2005).

Data on short term mortality expected after surgery was more prevalent in the evaluated research, and of the 22 articles, 6 provided data on this topic and 3 of the TAs did. None of these studies addressed the over 65 population specifically. The basic finding of these studies was that patients are at a low risk of dying postoperatively especially if the surgeon is experienced at performing the procedure (Brechner, 2005). In terms of addressing longevity, only 2 of the articles provided data on longevity, one which had data for those over age 65. None of the TA’s reviewed addressed longevity. After reviewing the articles, the analysts “found an indication longevity was decreased in persons with high BMI and increased in persons undergoing bariatric surgery who survived to 1 year postsurgery” (Brechner et al., 2005, p. 440).

All in all, the analysts reviewing the literature for CMS found that current research studies addressed some of the factors, but typically not all of the factors CMS was seeking in the literature. The analysts called for more high quality studies given that many of the articles that were initially selected for review were not considered to be of
sufficient quality by CMS standards. Despite the vast amount of research available, not all of it is helpful or even done well enough to glean valid data.

Factors to Address Before Surgery

Physical activity. Bariatric surgeries like RYGB can be life changing if the person who undergoes the procedures commits and adheres to very specific lifestyle changes. One such lifestyle change is a commitment to regular physical activity. The American Society for Metabolic and Bariatric Surgery (ASMBS) suggests that individuals about to undergo obesity surgery begin to incorporate mild exercise into their daily routine before surgery to reduce the risk of complications. The ASMBS suggests that before surgery, if they are not already physically active, that patients perform mild exercise 3-4 times per week for at least 20 minutes. This can help accelerate the process of wound healing and decrease recovery time in addition to decreasing the risks of postoperative complications (ASMBS, 2008).

The number of individuals in the U.S. population with morbid obesity “increased fourfold between 1986 and 2000” (Bond et al., 2006, p. 422). Recognizing the fact that bariatric surgery is most often the best solution for individuals with morbid obesity seeking long term weight loss, Bond et al. sought to answer several important questions in their research study. How does a patient’s quality of life, current level of physical activity, and readiness to participate in moderate physical activity after surgery change as the patient gets closer to the scheduled surgery day? The researchers sought to answer this question by measuring the changes in participants responses to survey questions at a consult visit and then at a history and physical visit prior to surgery 1-3 months later (Bond et al., 2006). The researchers used a questionnaire called the International Physical
Activity Questionnaire to measure and assess improvements or regression in quality of life, current level of physical activity, and physical activity readiness for the preoperative participants. Furthermore, participants were divided into two separate groups: those considered to be sufficiently physically active and those considered to be insufficiently physically active and comparisons were made between the two groups.

Bond et al. concluded that for many patients preparing for gastric bypass surgery, the time before surgery is a time marked by change as well as the time following the procedure. For instance, “with respect to mental QOL, participants scores on the SF-36v2 mental health domain increased significantly from the first to second presurgical visit to a level nearly equivalent with the US population norm” (Bond et al., 2006, p. 430). Not only were positive changes in mental health noted, but an increase in the number of participants prepared to incorporate moderate exercise activity in their life was increased as well. Certain individuals even improved their levels of activity between the first and second visits prior to surgery. Despite improvements noted in some people there were still a number of people from both groups who regressed or remained the same in terms of their quality of life, current level of physical activity, and readiness for moderate physical activity after surgery (Bond et al., 2006).

This research study indicates that individuals have the capacity and potential to make changes in their physical activity and consequently their overall quality of life before surgery. Such improvements may even positively impact the patient’s success with regular, moderate exercise and weight loss afterwards. These findings point out an important implication for nursing practice. With the right education and emotional and psychosocial support, it is possible that individuals preparing for bariatric surgery can
create positive improvements in their life before surgery. Incorporating healthy lifestyle behaviors prior to surgery has the potential to positively impact their success with weight loss and health maintenance after surgery.

While the findings of this study were interesting and worth being further evaluated by more research, they did have certain limitations that must be addressed. One such limitation is the sample involved in the study. The participants consisted of primarily middle aged Caucasian women from the southeast United States. While there were some participants who were African American and some men involved in the study, there were not a sufficient number to make the sample completely representative (Bond et al., 2006). The findings therefore may only apply to a more specific subgroup of individuals with morbid obesity, middle aged women, than for those with morbid obesity in general.

*Dietary changes.* The protocol for preoperative diet and weight loss depends primarily on the physician’s preferences and the specific bariatric surgical program the patient is going through. In some programs surgical candidates are required to lose a certain amount of weight before they will be considered for surgery. While not all surgeons require this, “the rationale for this is to reduce the adverse effects of comorbid conditions, improve the ability of the patient to undergo the surgical procedure, and help ensure patient compliance” (Ide et al., 2008, p. 42). Alternatively, some physicians ask candidates to maintain an all liquid diet two weeks before the surgery, because “a preoperative liquid diet has been shown to decrease liver volume in bariatric surgical patients, which can facilitate exposure of the stomach during the procedure” (Ide et al., 2008, p. 42).
In a quantitative research study conducted by Baker et al., 2008, the researchers sought to test how variables regarding eating behaviors before surgery impacted postoperative eating behaviors and overall weight loss for individuals who underwent bariatric surgery. This article has important implications for the portion of individuals who have bariatric surgery and do not see the success that they want and the physician intended. Among some of the suspected reasons for this are psychosocial factors that were not considered before surgery, and poor postoperative adherence to the specific diet. The major implication in this article is that preoperative dietary teaching may impact a person’s eating behaviors and adherence to a new diet following surgery so that optimal success can be accomplished. The main goal the researchers sought to achieve was to identify a relationship between the amount of weight loss achieved at nearly 2 years following surgery to psychosocial and behavioral variables, dietary intake, and adherence to the postoperative diet.

The researchers of this study followed participants for nearly two years after their gastric bypass procedure and administered a psychosocial/behavioral evaluation one month prior to surgery along with a battery of surveys to measure self-esteem, depression, eating behaviors, diet, and other variables (Baker et al., 2008). This same battery of surveys was sent to participants at 20, 40, 66, and 92 weeks post-surgery to measure weight loss and dietary adherence, and psychosocial health. Participants included 36 men and 164 women in an urban hospital. All participants underwent a roux-en-y gastric bypass procedure either laproscopically or openly between 2001 and 2004 and received dietary counseling prior to the procedure. Participants were divided into two
groups before the procedure: those who were considered to strictly adhere to a healthy diet and those who were considered to have poor adherence to a healthy diet.

Although on average participants in Baker and colleagues study lost 25% of their initial weight by 20 weeks after surgery and nearly 40% by 92 weeks, some participants were more successful than others. There were differences in the amount of weight lost and kept off at 2 years after surgery between participants who strictly adhered to their diet and those who did not. Over time those who were initially considered to be high in dietary adherence reported less adherence as time from the surgery increased. The authors of this study reported that “adherence to the dramatically reduced portion sizes is believed to be a significant challenge for many patients” (Baker et al., 2008, p. 645). They reported that “of the potential predictor variables of interest investigated, gender, baseline cognitive restraint, and self reported dietary adherence at postoperative week 20, when participants had returned to eating regular food, were significant predictors of the percentage of weight lost over time (Baker et al., 2008, p. 644). This study indicates that adherence to the postoperative diet is related to the amount of weight lost, meaning that better dietary compliance results in greater weight loss for most individuals.

**Co-morbidities.** Co-morbid conditions are health conditions that a person has in addition to an already existing health problem. They can be life threatening and compound the threat that the primary condition poses to overall health. For a person with morbid obesity, which is life threatening in itself, there are several common co-morbidities that can develop if his or her excess weight goes untreated. These co-morbid conditions can be particularly damaging to the cardiovascular and musculoskeletal systems.
Hypertension, or high blood pressure, is one co-morbidity that can develop as a result of obesity. A normal blood pressure is considered to be <120/80. A person with hypertension has a blood pressure consistently greater than 140/90 (Venes, 2009). High blood pressure is dangerous to a person’s health because it places increased work on the heart and damages blood vessels. In addition to hypertension, atherosclerosis can develop, which occurs when fatty deposits form on blood vessel walls causing them to narrow, and this can lead to a blockage or heart attack.

Another serious co-morbidity that people with obesity can develop is type 2 diabetes. This is a disorder of the pancreas in which insufficient amounts of insulin is secreted, which leads to high blood sugar. Constant high blood sugar levels can be damaging to nerves and cause other complications. Sometimes it can be controlled with diet and exercise, but often for people who are obese they will need to go on medication to prevent hyperglycemia (Venes, 2009).

Arthritis can result from excess weight that is placed on the joints. Arthritis can develop in any joint, but for people with morbid obesity, it commonly develops in the knees and impairs their ability to walk and therefore the places they can go. Additionally, individuals with obesity can also experience difficulty breathing when walking or during periods of exertion. They can also develop a condition called obstructive sleep apnea, in which they experience periods when they stop breathing for short periods of time while they sleep.

Even if a person is morbidly obese and does not have a co-morbidity, he or she is at an increased risk for developing one because of the stress that excess weight places upon almost every area and organ of the body. Fortunately, “most co-morbidities
significantly improve or resolve with resolution of the obesity (Ide et al., 2008, p. 32). This statement is supported by research by Kushner & Noble that indicates greater levels of improvement and resolution in co-morbid conditions such as hypertension, diabetes mellitus, sleep apnea, hyperlipidemia, and nonalcoholic fatty liver disease for those who have had bariatric surgery in comparison to those who have not. In their research Kushner & Noble analyzed the results of several research studies that focused on how bariatric surgery benefited individuals who had bariatric surgery compared to control groups who had not.

From reviewing these studies, Kushner and Noble (2006) identified an inverse relationship between bariatric surgery and the presence of comorbid conditions. They found that despite this encouraging information, more research about long term outcomes is needed to establish more concrete conclusions. In general, from the four studies evaluated, only two of which were recent, individuals who have had bariatric surgery lost a greater percentage of weight at two and ten years after surgery than individuals who did not have surgery.

One problem encountered was the lack of available research studies on the topic of long term outcomes of bariatric surgery, and the fact that the studies that are available have different definitions about what constitutes improvement. The lack of a standard makes comparing and evaluating different studies a challenge. The results from these few studies include different types of bariatric surgeries, some of which are not performed anymore, and come up with varying results. Secondly, the fact that the authors of this article only reviewed four articles is another drawback, because it draws results from a small pool of information, some of which is not current within the last 10 years.
Overall, although this article does offer some insight into how bariatric surgery improves physical health, it lacks any conclusive information. The main message it sends is that more research in this specific area is needed, and that the research that is available should not be considered comprehensive. The most important implication for nursing in this study is the call for more nursing research. More research about what the long term outcomes are for individuals who have had bariatric surgery is necessary in improving current understanding about the lived experience after bariatric surgery. This information could improve the current approach and preparation for bariatric surgery, and ultimately impact weight loss success and maintenance after surgery.

In a study by Carmody et al., 2005, the researchers sought to answer whether or not having major co-morbidities in comparison to having minor co-morbidities was a predictor of complications after open or laparoscopic gastric bypass surgery and less weight loss. It is well known that those with major co-morbidities such as diabetes mellitus, hypertension, obstructive sleep apnea, venous stasis, obesity hypoventilation and pseudotumor cerebri are at greater perioperative risk than those who do not have major co-morbidities before undergoing bariatric surgery. What these researchers identified was the need not to wait until patients need a last resort and have a BMI > 40 with major life threatening complications to perform surgery. Rather, Carmody et al., suggest that patients be treated earlier, before co-morbidities develop to decrease the patient’s perioperative risk and increase his or her postoperative weight loss.

The study consisted of 1465 participants who were divided into two separate groups. Group 1 consisted of individuals who had BMI greater than or equal to 35 with major co-morbidities. Group 2 consisted of individuals with a BMI greater than or equal
to 40 with minor co-morbidities such as degenerative joint disease, urinary stress incontinence, GERD, and hypercholesterolemia. All participants underwent a laparoscopic or open gastric bypass surgery. Comparisons between the two groups were made one year after surgery and measurements included total weight loss and BMI, “resolution of co-morbidities, complications and mortality” (Carmody et al., 2008, p. 513).

Findings of the study suggested that although patients with serious co-morbidities are at higher risk for and experience more postoperative complications than those who do not, surgery for this population is still beneficial. For instance, participants in group 1 lost less weight than participants in group 2, but still had success with resolving co-morbidities. For instance, 62.2% of those in group 1 no longer had hypertension one year after surgery and 74.9% of those who had diabetes mellitus no longer had DM one year following surgery (Carmody et al., 2008). In the end surgery did prove to be successful for both groups, but group 1 did have more problems than group 2. For instance, the occurrence of leaks, wound infections, and mortality were all higher for group 1 than for group two. Additionally, “Group 2 patients at 1 year demonstrated a lower BMI, greater percentage of EWL, and lower body weight” (Carmody et al., 2008, p. 514).

The researchers of this study suggest that surgery should be recommended before co-morbidities develop. A person who has a BMI of 35 will have fewer perioperative risks than someone with a BMI of 40. Therefore, surgery should be offered before reaching the more risky point if possible.

Psychological considerations. In general, the prevalence of psychiatric disorders is higher for the obese population than for the general population. In a study done by
Courcoulas et al. the prevalence of co-morbid psychiatric conditions was measured in a sample of individuals with morbid obesity seeking bariatric surgery. The researchers used a quantitative approach. In addition to gathering demographic and medical histories from participants, they used questionnaires before and after participants had bariatric surgery to formulate their results using statistical analysis. They sought to determine the prevalence of past and current psychiatric disorders in a specific population of individuals seeking bariatric surgery. In addition to this, they sought to identify a relationship between an increased BMI and increased psychological problems.

The researchers identified that there was a statistically significant relationship between psychiatric problems and morbid obesity. The sample of 289 mostly white, middle-aged women seeking surgery at an urban hospital answered questions from the Structured Clinical Interview for DSM-IV and the SCID –II to determine past and current Axis I and II diagnoses. They also answered questions from the Medical Outcomes Study 36-item Short-Form Health Survey. The most common current diagnosis was an anxiety disorder while the most common past diagnosis was major depression. Participants who had previously or currently qualified for a DSM-IV Axis I disorder (mood, substance, or eating disorder) generally had higher BMIs than participants who did not, and this was exemplified with low p values of 0.003 and 0.006 respectively (Courcoulas et al., 2007). The researchers concluded that “both axis I and axis II (personality disorders) psychopathology were associated with decreased functional health status, whereas axis I but not axis II, was associated with increased BMI” (Courcoulas et al., 2007, p. 330).

The results of this study indicate that the psychological component to health is just as important to evaluate as physical health is when working with an individual
preparing for bariatric surgery. Being aware of the individual’s past or current psychiatric conditions can guide an individualized and specific approach to preparation for surgery that factors in the individual’s past and current psychiatric needs.

Even though psychiatric disorders like depression and anxiety disorders are relatively common in individuals with obesity, people are rarely turned down for surgery based on this factor alone. Byrne et al. wanted to know how many applicants who applied for gastric bypass surgery would be rejected based on their responses to a psychiatric evaluation. The researchers also wanted to know the number of patients applying for gastric bypass surgery who were taking one or more psychotrophic drugs at the time of application. The researchers, working at a South Carolina hospital, divided applicants into two groups. One group of participants was ranked into one of three categories, A, B, and C. Those in Category A were those considered to have no psychological contraindication to surgery. Those in category B were those considered in need of psychologic or psychiatric treatment before they would be cleared for surgery. Those in category C, were considered to have a psychological contraindication to the gastric bypass surgery. The second group of participants applying for gastric bypass surgery were asked about their use of psychotropic drugs to treat psychological conditions.

The findings of this research study were positive in terms of the acceptance rate of applicants for gastric bypass surgery. For instance, “The overwhelming majority of gastric bypass applicants (n=366; 81.5%) had no psychological contraindications to surgery and were considered psychologically appropriate for immediate surgery” (Byrne et al., 2005, p. 525). This means that 81.5% of the 449 applicants who applied for surgery were accepted. This does not mean that they did not have co-morbid psychological
conditions, but that these conditions were not severe enough to be considered a major obstacle to postoperative compliance and success. For those not in category a, 71 or 15.8% of the 449 people were considered to need psychologic or psychiatric guidance, before they would be allowed to have the surgery. The reasons for deferment from most to least common were major depressive disorder, binge eating disorder, anxiety disorders, and substance abuse. Only 12 individuals were rejected based on having a psychological condition that was severe enough to affect postoperative success and outcomes. Seven of the twelve were psychologically contraindicated for surgery based the presence of a psychosis/thought disorder, while the other five were not deemed capable of providing informed consent (Byrne et al., 2005).

The researchers in this study were making recommendations for gastric bypass surgery based on perceived mental health of applicants. The applicants were placed into the different categories based on a self-report measure created by the researchers themselves that evaluated several areas of psychological health. This was completed about two weeks prior to having a clinical interview with a clinical psychology intern, postdoctoral psychology fellow or the supervising psychologist. Based on information obtained in the self-report and revealed during interviews, and information from the patient’s chart, a DSM-IV diagnosis was assigned (Byrne et al., 2005).

The second sample of individuals in this study consisted of 153 individuals. The researchers determined that nearly half, 47.7%, “reported using at least 1 psychotrophic medication at the time of their surgical evaluation (526). There was a racial discrepancy noted. There were more participants who were Caucasian than African American taking psychotropic drugs. Also of the 47.7% of those currently on a psychotropic drug, 87.7%
were on a antidepressant, and 9.6% on anti-anxiety meds, and 2.7% were on mood stabilizers. The findings of this research provide a hopeful message to individuals seeking bariatric surgery who have a psychiatric illness (Byrne et al., 2005).

Comfort with the healthcare system. For many individuals who are overweight or obese, interactions with the health care community can be very challenging, on both a physical and emotional level. A lack of accommodations for people of larger size in doctor’s offices can be a very real problem that causes the patient embarrassment and discomfort. It is not uncommon that this patient population feels that they are not respected or treated the same as patients who are not overweight. This can lead to reluctance to seek health care and a worsening of physical health (Brzezinski, 2008).

In one qualitative study, eight adult women were asked to tell their stories about how their experiences with physicians and nurses were impacted by their physical size. Four common themes emerged. First of all, participants identified a feeling of literally not “fitting” into the health care environment (Merrill & Grasby, 2008, p. 143). This was evidenced by stories from the women about how they could not fit into the gowns given to them in the doctor’s offices or about how one woman had to wait for half an hour while the nurse tried to find a larger blood pressure cuff. Another common theme was a feeling of not being treated like a human being. These women essentially felt they were being treated as lesser people because of their weight. Accounts told by the women included having a physician compare one of the women to a whale and a pervasive feeling that physicians were not seeing them as multidimensional people, but as just overweight bodies. The third theme identified was a feeling of dismissal. This was characterized by reports of feeling that every problem was blamed on their weight. The
women reported accounts of having the physician tell them to lose weight and that their problem would resolve, without considering any other underlying factors. Lastly, perseverance and a “don’t give up” attitude was observed among the eight participants (Merrill & Grasby, 2008, p. 144). This was evidenced by participant reports of trying several different options for weight loss including dieting, exercising, fasting, and consultation for surgery. They also continued to seek change and medical help despite a feeling that they were being judged and personally blamed for the state of their physical health.

This study was conducted by Merrill and Grasby (2008) in an urban city in Western Texas. Information was gathered through in-depth interviews. The methodology employed was a combination of Heideggerian hermeneutics, storytelling, and feminist theory. The information provided in this study provides excellent insight into the lived experience of overweight women and their experiences in healthcare. It indicates that accommodation or a lack thereof and the quality of communication between nurse, physician, and patient impacts the overall perception of the experience for the patient. The researchers point out that therapeutic communication and compassion from physicians and nurses working with people with morbid obesity is key to creating a non-threatening, non-judgmental, and respecting environment. The only drawback to this study is that the sample consisted of all white women and does not account for differences based on race or ethnicity.

_Medical exam._ Once a patient has been approved for bariatric surgery, there are specific medical and nursing interventions that need to occur. Interventions differ depending on what stage of the process the patient is in. For instance, prior to surgery it is
the obligation of the physician to discuss the causes and health risks of morbid obesity with the patient as well as to provide educational materials about the procedure and what changes the patient needs to make preoperatively (NGC, 2008). Patients are asked to quit smoking and to receive nutritional counseling (Ide et al., 2008). Additionally, the physician will need to obtain a thorough medical history from the patient, perform a physical exam, and order laboratory tests if the patient has a specific condition such as diabetes that requires special monitoring and control. All of this will be done prior to surgery. After surgery physicians are required to have follow-up appointments with patients to monitor and evaluate the patient’s health status and quality of life following surgery (NGC, 2008).

*Standard diagnostic workup prior to surgery.* Once a person is determined to be a candidate for a bariatric procedure based on the physical and psychological health requirements, several diagnostic tests are performed before the operation occurs. In addition to the in depth history and physical that the physician performs, all patients who are going to have a bariatric procedure should be screened for dyslipidemia and diabetes mellitus. This is done by having a fasting lipid panel done (Thompson Reuters, 2009). Additional tests that the physician might want to do include a complete blood count panel and tests that might rule out other disorders as the cause or contributing factors to the patient’s obesity. For instance a thyroid stimulating hormone (TSH) test can determine if the person has hypothyroidism contributing to his or her morbid obesity. Other disorders like polycystic ovarian syndrome (PCOS) can be ruled out by doing a total testosterone test. Cushing’s disease can be ruled out or confirmed by urine and serum cortisol levels (Thompson Reuters, 2009). Not all of these labs necessarily have to be done, but they
might prove beneficial in some cases where an additional illness is suspected. These tests can be used to identify conditions that might complicate the overall treatment and will require special monitoring and consideration.

*Preparation and expectations.* It is safe to assume that having a surgery that essentially reduces the size of one’s stomach will have an impact on a person’s life. For many people having a bariatric surgery such as roux-en-y gastric bypass or lap banding is a challenging, yet liberating experience that improves both psychological and physical health. However, it is not a single event, but rather a process that begins with the recognition that there is a problem and ends with a lifetime commitment to permanent lifestyle changes. Exactly how and in what ways the surgical procedure changes a person’s life is best understood by communicating with those who have experienced it first hand.

Ogden and Clementi (2006) conducted a qualitative research study in which 16 participants who had undergone a gastric bypass or lap band procedure were interviewed. During the interviews participants were asked about their personal history with obesity, the reasons prompting them to seek bariatric surgery, the impact of the surgery on physical and mental health, and the impact of the surgery on weight loss. While naturally there was variation in what participants reported, there were several common experiences shared by the majority of the participants.

Most participants attributed their problem with obesity to biological rather than psychological factors. This is in contrast to the common assumption that individuals with obesity are overweight because they lack dietary control. Interestingly enough, participants did report a lack of control of their body weight, but not because of reasons
that they necessarily attributed to their own behaviors. They reported lack a lack of control despite a sincere and long-lasting effort to control it with traditional methods including dieting, weight loss programs, behavior modification techniques, and therapy (Ogden & Clementi, 2006).

Most participants expressed that their decision to have bariatric surgery was motivated by either a worsening of another condition such as diabetes or hypertension or a general unhappiness with their body image and poor self-esteem. Almost every participant reported that the first six weeks following the surgery was the most difficult in terms of adjusting to the shock of the procedure. Many reported struggling with eating less and eating without experiencing discomfort. The postoperative process involved learning how to interpret true hunger from appetite and recognizing a full sensation from an overfull sensation (Ogden & Clementi, 2006).

An important finding of the study was that despite initial adjustment problems the majority of the participants reported an increased sense of control over their bodies. The researchers identified an interesting paradox. By taking control away from the patient and physically limiting the amount and types of food that the person was capable of eating, the surgery actually yielded a greater sense of control to participants over their bodies that they previously perceived as lacking. Most participants reported greater self-confidence and a positive change in their relationship with food. Food became less about fulfilling a psychological drive and more about the purely biological need for nourishment.

The research by Ogden and colleague strengthens the science of nursing in preparing individuals contemplating bariatric surgery about the changes that they can
expect following surgery. It also indicates that support groups in which individuals speak about their experience before and after surgery can be beneficial. Through talking about what their experiences were, individuals considering the surgery can hear first hand accounts of both the positive and negative aspects of having a major surgery. It also provides insight into the importance of being well informed ahead of time of what to expect and how to cope with the many changes that occur following surgery.

*The Role of the Nurse*

*Interventions.* Nurses have equally important, but different roles and perform different interventions depending on if the patient is presurgical, intraoperative or postoperative. Preoperative nurses are primarily responsible for verifying patient information and performing a preoperative assessment. They have the patient get into a hospital gown, review the patient’s information and start an IV all while assessing the patient’s general state (Ide et al., 2008). It is then the responsibility of the circulating nurse to verify and cross check that the patient’s identification band, chart, and name on the OR schedule are all the same. The circulating nurse does a preoperative physical assessment in which specific attention is given to “any preexisting comorbid conditions and factors that will affect positioning and perioperative care. . .” (Ide et al. 2008, p. 42). The circulating nurse asks about the patient’s psychological status, assesses skin integrity, and reports to the physician any concerns the patient has and any recent labs that have been done. Lastly, the nurse verbally goes through the procedure with the patient and answers any questions.

*Considerations After Surgery*

Despite the fact that in the case of treating morbid obesity, a surgical procedure instead of a medication is the best source of treatment, this does not mean that
medications should not be considered when working with a person with morbid obesity. Patients undergoing RYGB in particular will need to be informed of how the changes that are made in their digestive tract during surgery will not only alter their absorption of nutrients, but their ability to absorb medications as well.

_Intraoperative nursing care._ Intraoperative nurses perform different interventions than are done by the nurses the patients encounter before surgery. Intraoperative nurses’ tasks are focused on preventing complications involving the respiratory, cardiovascular, neurological, and musculoskeletal systems. They work in conjunction with the physician and anesthesiologist. These interventions include obtaining a surgical bed that will accommodate the patient’s size and weight, positioning the patient so that weight is distributed evenly and not putting excessive stress on a specific joint or area, positioning the patient so that he or she can breathe without experiencing difficulty to maintain a patent airway, and applying ted hose and sequential compression devices so that blood clots do not form during surgery (Ide et al., 2008). They are in charge of making sure that the proper equipment for resuscitation is present, inserting a urinary catheter if necessary, and monitoring vital signs (Ide et al., 2008).

_Post operative nursing care._ Once the patient has left the Post Anesthesia Care Unit the medical-surgical nurses continue to assess and monitor for any late complications of surgery. They assess vital signs and monitor especially for fever, rapid heart rate, low blood pressure, and hypoxia (Ide et al., 2008). During the postoperative period, nurses have an important role in discharge teaching and inform the patient of conditions that require that they call a physician, such as leg pain, shortness of breath, and chest pain (Ide et al., 2008).
Vitamin supplementation. Following an RYGB procedure, patients are particularly prone to deficiencies of the fat-soluble vitamins, A, D, E, and K. This is because the procedure changes the anatomy of their digestive tract so it no longer has the same absorption capabilities as it did prior to surgery (Miller, 2006). This has a positive effect when it comes to weight loss, but a negative effect on vitamin absorption. Deficiencies of these vitamins can contribute to the development of certain complications which include trouble seeing in the dark, poor wound healing, easy bruising, or uncontrolled bleeding (ASBS, 2008). By taking multivitamins such as One A Day or Centrum on a daily basis, which are usually provided in capsule or chewable tablet forms, patients are provided with both the water-soluble and fat-soluble vitamins that their bodies need to function and remain healthy. Patients should be aware that missing a dose is generally not harmful, but that there may be adverse effects such as bloody diarrhea or severe abdominal cramping and that these symptoms should be reported to their physician if experienced (Thompson Reuters, 2009).

In addition to being susceptible to fat-soluble vitamin deficiencies, those who have had a RYGB procedure are also prone to iron, folate, vitamin B12 and calcium deficiencies (Miller & Smith, 2006). When patients are not receiving enough iron in their diet, they can develop a condition called anemia. This essentially means that the person has an inadequate number of circulating red blood cells or that the red blood cells cannot carry as much oxygen as they should. This can cause fatigue and increase one’s susceptibility to illness.

When the stomach is made smaller in the RYGB procedure, it affects the amount of hydrochloric acid that is produced in the stomach. This in turn affects the absorption of
both iron and calcium (Miller & Smith, 2006). Iron supplements like Slow Fe and Ferro Sequels can be taken to prevent iron deficiency and subsequent problems like anemia. Like multivitamins, they are available orally in tablet, chewable tablet, capsule, and liquid forms. Iron supplements should be taken daily. The patient should notify his or her physician if chest pain, bloody diarrhea, or fever develops (Thompson Reuters, 2009).

Folate is another vitamin that is impacted by the RYGB procedure. Unlike iron and calcium which are absorbed in the stomach, folate is produced in the small intestine of the body (Davis’s Lab & Diagnostic Tests, 2009). It has an important function in the formation of red blood cells. Because the RYGB causes a portion of the SI to be bypassed, creation and distribution of folate to the liver where it is stored is decreased. This folate deficiency can result in anemia. This can be treated with a regular multivitamin, since most multivitamins have folate in them.

Calcium is a mineral that is very important in bone development and strength. It is also important in normal functioning of the neurological and musculoskeletal systems. A calcium deficiency can contribute to the development of the bone disease osteoporosis (Miller & Smith, 2006). Therefore it is important that following RYGB patients also take a calcium supplement in addition to the other supplements they are taking (ASMBS, 2005). There are many different kinds of calcium supplements, but one of the most commonly prescribed following bariatric surgery is calcium citrate, which is the same as Citracal. This can be taken orally and will help prevent osteoporosis and provide extra vitamin D (Thompson Reuters, 2009).

Vitamin B12 is an important water soluble vitamin that helps create red blood cells and DNA (Davis’s Lab & Diagnostic Tests, 2009). Its absorption is dependent on a
protein secreted by stomach cells called intrinsic factor. When the stomach is stapled in RYGB, the amount of intrinsic factor available is decreased. Consequently, the absorption of vitamin B12 also decreases. As with iron and folate deficiencies, a vitamin B12 deficiency may also lead to anemia. To prevent or treat vitamin B12 deficiency, a patient is often put on a medication called Cyanocobalamin. This medication can be taken orally, but sometimes has to be given by way of injection to make sure enough of it is absorbed in a person who has had a RYGB.

Clearly, there are many nutritional considerations after bariatric surgery that require monitoring and treatment. In order to avoid the complications that any of the above stated deficiencies can cause, the ASMBS has reported that “life long supplements of multivitamins, vitamin B12, iron and calcium are mandatory following this procedure” (ASMBS, 2005, p. 7). By taking the vitamins and minerals that are suggested, individuals who have had bariatric surgery are less likely to have complications related to malnutrition.

*Medication considerations.* Another consideration that individuals who have had gastric bypass surgery need to keep in mind is what kind of medications they are still able to take. Similar to how dietary vitamins will not be absorbed the same way after surgery as previously, neither will certain medications. Because the duodenum is almost completely bypassed in the roux-en-y procedure, a significant portion of the absorption surface is no longer being used. This means that medication that requires a longer period of time to be absorbed may not have the opportunity to do so and will not have its desired effects (Miller & Smith, 2006). It is recommended that patients who have had RYGB not take medications that are long acting or extended release because they will most likely be
ineffective (Ide et al., 2008). Additionally, because the size of their stomach has been decreased, gastric bypass patients are asked to crush medications that they need to take or take them in liquid form so that they do not get stuck in the pouch (Ide et al., 2008). This can be very uncomfortable and prevent the medication from working as it should. After surgery, patients are advised not to take non-steroidal anti-inflammatory drugs or NSAIDs, because these drugs can cause ulcerations of the stomach (Miller & Smith, 2006).

**Standard treatment and considerations.** Following bariatric surgery, patients are monitored for weight loss or gain, nutrient deficiencies, complications, psychological adjustments, and any existing co-morbid conditions (Ide et al., 2008). Ideally patients are followed for the rest of their lives on their progress and state of health, but careful monitoring is the most crucial in the first two years following surgery. Initially, some amount of nutrient deficiency is expected within the first three months after RYGB surgery but is expected to be back up to normal levels after this period (ASMBS, 2008). Patients should expect that they will have lifetime multivitamin, calcium, iron, and vitamin B12 treatment. Typically patients reach their maximum level of weight loss within a year and half to two years following their bariatric surgery (ASMBS, 2005). Women who have had bariatric surgery can still have children, but it is not recommended that they get pregnant during the period of rapid weight loss. Those who do get pregnant following gastric bypass will have to be monitored and follow special guidelines during their pregnancy (Ide et al., 2008).

**Important dietary changes and restrictions.** The most important dietary changes that individuals who undergo any bariatric procedure make is eliminating fatty and
sugary foods from their diets. If they do not do this, they can experience a phenomenon called dumping syndrome in which rapid emptying of the gastric pouch occurs. This leads to episodes of sweating, rapid heart rate, nausea, diarrhea, and cramping lasting up to an hour (ASBS, 2008). Around 85% of people who have had RYGB will have this unpleasant experience at least once (ASBS, 2008).

Patients who have had RYGB are encouraged to carefully monitor their diet and to consume food high in protein. This means eating food such as “fish, dairy products, meat, beans, legumes, and soy” (ASBS, 2008, p. 5). They can still have small amounts of carbohydrates and fats, but fresh fruits and vegetables are preferred. Instead of eating three large meals a day, these patients eat several small meals a day. This is because the amount of food that the gastric pouch can hold is about an ounce (ASBS, 2008). They should make sure to drink plenty of fluids so that dehydration doesn’t occur. They are also encouraged to avoid carbonated beverages because they can be irritating to the gastric pouch.

*Physical activity.* Even though patients have had surgery that will help them lose weight, it will only be successful as long as they do their share of the work. This means that in addition to eating small, healthy meals, they should be physically active as well. Weight loss may come off fast initially, but it can also be regained if the person does not maintain dietary and physical discipline. ASMBS recommends that patients make exercise a part of their daily activity because it is one of the most important factors contributing to weight loss maintenance following surgery (2008). Patients are encouraged to walk every day, increasing the distance each day. They can do other exercises such as bike riding or swimming if approved by their physician. As they get
further out from their surgery, they should introduce mild to moderate weight training and perform sit-ups. It is important that patients remember to stay hydrated and that exercise may be uncomfortable but it should never be painful (ASBS, 2008). By doing these activities, patients lose fat mass and gain muscle mass. They may also contribute to increased mental health and self-confidence.

Support. Individuals who have had gastric bypass surgery typically begin to lose weight rapidly during the first six months following the procedure. After that period, however, while most people continue to lose weight, it does not occur at the same rate as previously. Bariatric Centers of Excellence often require, in addition to nutrition and psychiatric counseling, that patients participate in a support group before and sometimes even after surgery. Buzdon, Lien, Reinhardt and Song (2008) conducted a quantitative research study in which they sought to answer the question: Does participating in more than five support group sessions, compared to those who attend five or fewer, impact the rate and overall amount of weight lost one year after surgery?

In their retrospective study, 78 consecutive gastric bypass patients who went through the same established bariatric program for an RYGB were divided into two groups. Group A (28 individuals) consisted of individuals who attended more than five support group meetings. Group B (50 individuals) consisted of individuals who attended five or fewer support meetings. The researchers then reviewed the patients' charts and evaluated the rate and amount of weight lost for each of the two groups up to one year post-surgery. The researchers hypothesized that participants who went to more than five support group sessions would have lost more weight than those who did not.
All participants went through a preparation program in which they met with physicians, nurses, nutritionists, and six months of counseling. They also watched an information video, and were required to attend monthly support meetings before, but not after surgery, although it was recommended. Major differences in the two groups in terms of the amount of weight lost were considered to be statistically significant until the 9 month and 12 month follow up visits. Previous to these follow up appointments, participants generally were losing the same amount of weight at the same rate. The researchers concluded, "Patients who attended > 5 support group meetings had an average of 55.5% excess weight loss at 12 months compared with 47.1% excess weight loss in patients who attended ≤5 support group meetings" (Buzdon et al., 2008, p. 102).

Overall, the important implication that this study offers is that encouraging patients to continue to attend support group meetings may ultimately help the patients achieve optimal weight loss. Continuing to attend support groups following surgery may help prevent discouragement after the six month point when the rate of weight loss tends to slow for most people. This not only provides an outlet for the expression of emotions and concerns, but also continuing education about the surgery and what life is like following surgery.

The study is both interesting and encouraging, but it does have some flaws and more research in this area would be valuable in providing more information on this topic. One problem the researchers had was that as time from surgery increased, more people dropped out from the study. Another issue is that because the study did not have an experimental design, the relationship between weight loss and support group attendance was not proved to be causal, only correlational. The study was retrospective and did not
randomly assign individuals to groups ahead of time, but assigned them to groups depending on prior attendance in support group sessions. Support groups were often of larger sizes, between 15-20, which is larger than the optimal size, and no recordings of what questions were asked by whom and who responded were kept track of. This was done to encourage participation, but the problem that was created is that there was no proof that participants actually interacted during these sessions, only that they attended.

*Conclusion*

There is an almost overwhelming amount of research literature available regarding obesity and the physical impacts it has on an individual’s health. Unfortunately, there is not nearly as much research about the psychological and day-to-day lived experiences of obesity. While perhaps physical problems may be more obvious, it is necessary not to neglect the other dimensions of a person’s health and overall well-being. Every person has physical, psychological, social, and spiritual dimensions that interact with one another to create a unique individual. When physicians and nurses only consider the physical aspect of a health problem or concern presented to them, they are not seeing the entire picture. More research about psychological impacts of morbid obesity and what the daily lived experiences are for people with morbid obesity will provide powerful insight for healthcare professionals that may alter the approach to caring for these individuals and foster a greater sense of empathy and compassion.
CHAPTER III

Methodology

A challenge for nurses working with patients who have obesity can be a lack of empathy for and understanding of the patient they are working with. Nurses may find it challenging to put aside snap judgments about the patient’s physical appearance, and instead attempt to understand the situation from the patient’s background and perspective. However, being able to do put aside personal biases is very important in forming trusting, empathic relationships with patients. There is no better way to understand what the patient is feelings, thinking, and experiencing than to directly ask about it which is what phenomenological research is concerned with. In its simplest definition it “is the study of human experience and of the ways things present themselves to us in and through such experience (Sokolowski, 2000, p. 3). Research about the lived experience of obesity can offer insight into the daily challenges that obesity has on an individual and possibly provide useful information about how to provide compassionate, respectful care to this specific patient population.

History of Phenomenology

Phenomenology began as a philosophical movement in the late 19th century and early 20th centuries. Edmund Husserl, a philosopher and mathematician, is considered to be the founder of the phenomenological movement. The sum of his writings and descriptions of his phenomenological philosophy is complex and goes beyond the scope of this paper, but his emphasis on the significance of human experience, intention, and reflection does not.
Husserl believed that when seeking meaning from experiences, a scientific, systematic approach was ineffective. He believed that by trying to make sense of the world by gathering data and consequently making assumptions from that data was too narrow. He believed that presuppositions about an experience actually limited the data that could be derived from that experience. Rather he emphasized that through personal detachment and reflection on the experience one could understand the factors that made up the experience and what was "essential and necessary" to these experiences (Sawiki, 2005). Husserl called his method "phenomenological reduction" and this was the path to ascertaining meaning (Korab-Karpowicz, 2005). This is what this student researcher is attempting to accomplish through interactions with participants who have had bariatric surgery. When Husserl referred to intentionality, however, he meant it as it "applies to the theory of knowledge, not to the theory of human action" (Sokolowski, 2000, p. 8). It refers not to the intention of doing something, for instance, but rather to the intentionality of finding meaning in experience (Sokolowski, 2000).

While Husserl is credited with founding the phenomenological movement, there are several other individuals who contributed to the development of the field. Martin Heidegger, for instance, was a philosopher who is associated with ontological phenomenology, a branch of Husserl's original phenomenology. Heidegger sought to answer the question "what is the meaning of being?" (Ebersole, 2007). He was interested in how moods and emotions impacted interpretation of experience. Toward the end of his life Heidegger was concerned with how technology impacted and possibly dehumanized society especially in times of warfare (Ebersole, 2007).
Jean Paul Sartre was another phenomenologist who derived his philosophy from Husserl’s. Sartre was an existential phenomenologist, writing in the pre-World War II era. In his book *Being and Nothingness*, he explored his perceptions on these two topics specifically, and his writing was considered radical and progressive for its time. Sartre was interested in self-control, and his “readers were brought to recognize that their lives were more under their own control than they had ever suspected” (Macann, 1993, p. 157).

He believed that “to understand an individual means to put oneself in his or her position, to understand his or her life ‘from within’, in terms of the basic chores that have governed the life in question” (Macann, 1993, p.157).

The method of phenomenology as it applies to this thesis is a holistic approach in which information about individuals and their life experience with a specific concern is gathered in context of their physical, social, spiritual, and psychological dimensions. This type of research provides in-depth, rich, and meaningful insights into peoples’ life experiences. It provides a deep, rather than superficial understanding of an experience and allows researchers to make connections and consider variables that may not be obvious from a more distanced perspective (Fain, 2004). It is a qualitative research approach, meaning that in this method researchers seek to understand and find *the meaning* of a specific human experience. They gather information about the lived experience of a phenomenon from individuals who are living or who have lived the experience.

*Data Collection*

Researchers doing phenomenological research studies typically gather data through in-depth interviews with participants or read written accounts from the
participant about their experience. The researcher tries to approach the research with no expectations about what he or she will hear from the individual so as not to introduce personal bias (Fain, 2004). Interviews with study participants are usually either recorded or videotaped and then typed out word for word in an organized document. The researcher may also keep a journal of the interviews that includes the researcher’s perspective or thoughts about information divulged during interviews (Fain, 2004).

**Phenomenology and Obesity**

This research project was an attempt to answer the question: what is the lived experience of a person with obesity and how does it change following bariatric surgery? Phenomenology was the methodology selected to answer this question because employing it allowed this researcher to gather detailed information about participants’ experiences with bariatric surgery within the holistic context of their lives. Data yielded detailed accounts of what living with obesity is like and how it affects all aspects of a person’s life, and how all aspects of a person’s life are impacted or not impacted by a weight loss surgery. Data collection involved in-depth interviews occurring between this researcher and the participants and lasting between 45 minutes to 1 hour. Participants provided information about their history with obesity prior to surgery, psychological history, social history, as well as the differences in their lives post-surgery. This researcher then used the information provided to write an account of what the experience meant to each of the participants and the significance of its contribution to already existing literature. This was done through typing up transcripts of the recorded interviews and then reading them and analyzing the content of what was said with a preceptor.
Participants

Participants in this study included adult women who had undergone bariatric surgery and who were willing to provide information to this researcher about their life experiences with obesity before surgery and the changes they experienced following surgery. Participants were initially contacted by this researcher through electronic mail, telephone, or both means of communication depending on circumstances. Participants were all individuals referred to this researcher by Dr. Joni Walton or Dr. Brian O’Byrne as individuals likely to be willing to share their experiences. Three women who had had bariatric surgery were interviewed for this study. Additionally, the Surgical/Orthopedic Program Coordinator of a hospital that routinely performed bariatric procedures was also interviewed for her insight on Bariatric Centers of Excellence and successful bariatric programs.

Setting

Data was collected through interviews conducted at various times and places according to participant preference. The first participant was interviewed in her work office, and the interview lasted 45 minutes. The second participant was a person from out of state, and therefore the interview with her was conducted over the phone and lasted 40 minutes. Interviews occurred at mutually agreed upon times and places. During interviews participants were asked questions such as the following: What was a typical day like for you before you had bariatric surgery? How has your life changed since the surgery? What was the most difficult part of being obese for you? What is the most challenging part of your life now?
Confidentiality

Before divulging any personal information to this researcher, participants were asked to sign an informed consent form stating that they understood that they were being asked to participate in a research study, that they could back out of it at any time, and that they could call the researcher if they have any concerns or questions. Participant confidentiality was ensured through careful actions taken by this student researcher. Documents and notes regarding discussions between the participant and researcher that occurred at interviews remained in a locked cabinet accessible only to the researcher. Any electronic data was kept in a locked computer file, which could only be opened with a password known to this researcher. Participants were provided pseudonyms so that their anonymity would be maintained during data analysis and in the final paper. Participants were informed that this study was approved by the Carroll College Institutional Review Board.

Analysis of Data Collection

The information collected from participants was analyzed using Giorgi’s method. Giorgi’s method is a type of analysis used in qualitative, phenomenological studies involving between 2-10 participants who have been interviewed or who have provided a written narrative of their experience. The method consists of several steps that are designed to aid the researcher in analyzing and interpreting all the data that is present without skipping over anything. Similar to other data analysis methods, to be able to get the most out of this method researchers must read and reread or listen and re-listen to the information provided in interviews. This is an important part of the process that allows
the researcher to become "immersed in the participant’s descriptions to identify the themes, essences, or meaning structures of the lived experience" (Fain, 2004, p. 229).

The first step in Giorgi’s method involves reading or listening to the entire account of the participant’s experience from beginning to end “to obtain a sense of the whole” (Fain, 2004, p. 230). Then the researcher repeats this step with the intent to derive meaning, themes, or shifts in thought during the interview. After this, the researcher tries to relate meaningful information to other pieces of information divulged by the participant. These relationships are then further analyzed and considered in light of the experience as a whole. The researcher then attempts to “extrapolate the essence of the experience for each participant (Giorgi, 2004, p. 230). Lastly, the researcher produces a written description of the meaning of the experience to the participant and the meaningful variables and factors that contributed to the overall experience.

Research Reliability

Honesty and guidance are two important factors in ensuring that reliable research has been done. In the case of this thesis, all interview transcripts were reviewed and analyzed by this researcher and Dr. Joni Walton together. Analysis was done conjointly so that in cases where this researcher needed more information from a participant, she could be guided into what follow-up questions to ask so that truthful, honest reporting could be done.

Limitations

The sample size for this study was small and results obtained from these particular people are not applicable to the population as a whole of women who have had bariatric surgery. Nevertheless a small sample size does not detract from the reality and
personal meaning of the experiences of these individuals. Another limitation of this study is the fact that despite genuine attempts to avoid introducing bias into encounters with participants, interviewer bias was unintentionally introduced in terms of phrasing of questions and in verbalized responses to what participants said. For instance instead of asking “how were your spiritual needs met?” this interviewer asked instead how religion played a part in a participant’s post-surgical experience.

This researcher brought her own biases in terms of religious influences and health habits. This researcher is a practicing member of the Roman Catholic faith. She also is related to a general surgeon who performs bariatric surgeries. This researcher worked for a physician who performs bariatric surgeries, and through interactions with patients has come to generalizations about obesity and bariatric patients that were difficult to put out of mind when approaching this project.

**Conclusion**

The data collected from personal interviews were typed, and the information derived was added to this paper and to the literature on obesity as a whole. This paper was not an attempt to find a solution to obesity, but rather an attempt to gain a comprehensive understanding of the life experience of obesity and how surgical intervention changes one’s life experience.
CHAPTER IV

Results

The purpose of this thesis was to examine the physical, social, and psychological effects that morbid obesity has on an individual and how having such a procedure as bariatric surgery creates both challenges and improvements. After performing and analyzing research, and through in-depth interviews with four women who had undergone either a roux-en-y gastric bypass procedure or a gastric lap banding procedure to facilitate weight loss, the following themes were identified: (a) The Beginning of Obesity as a Problem, (b) Dieting, Losing Weight, and Regaining Weight, (c) Experiencing Social Stigma, (d) Withholding Disclosure, (e) Enhancing Self Esteem, (f) Battling Depression, (g) Enjoying Food in Smaller Quantities, and (h) Recognizing Sustained Weight Loss as a Process. These themes will be discussed and validated using quotes from the participants who are identified with pseudonyms.

The Beginning of Obesity as a Problem

While the timing of when obesity became a health concern for each of these individual women varied, there was a point in each of their lives when they came to the realization they had a health problem. For two of the participants in this study, being overweight was something that began in childhood. One participant stated, “I was always the heaviest person in my whole class boys and girls from kindergarten on ... it’s always been an issue.” The other participant could narrow it down to a specific summer when she was either six or seven years old when she lived with her grandparents. During this time “my grandmother called my mom and told my mom that none of my clothes fit, and when I ended up getting back from that trip, um, on the train, my mother cried, and I
thought she was crying because she was happy to see me.” However, Amanda later realized that her mother was actually crying because of the weight she’d gained.

For the other two participants, obesity was not a health concern for them until later in life following the birth of their children. Patty stated, “I’d been very thin my whole life growing up... Then with each child I just started putting on weight.” Similarly, Sarah reported that she was never overweight prior to adulthood. It was with the birth of her third and fourth children that added significant weight gain:

When the weight started creeping on a little bit and, uh, so I never lost baby weight from those last 2 babies, and then I don’t even know what happened; you know, I just got lazy; I think and I just started putting on the weight, I’m not sure exactly. It just was all of a sudden there.

Regardless of the timing, the reality was the same: their weight was something that they noticed made them look different. And whether it was something that had been with them since they were children or acquired as an adult, it was a health risk and concern worth addressing.

_Dieting, Losing Weight, and Regaining Weight_

Each participant reported having difficulty maintaining weight loss despite repeated attempts using various weight loss programs. The participants reported being in a cycle in which they would start a dieting program, lose weight, and once they were off the diet would regain the weight. The cycle would continue after they regained the weight and tried to be successful with a new diet. Patty stated, “I was very good at losing weight, um, and very good at finding it again is what I say. So I could always take it off with all the different programs but I couldn’t keep it off.” Debra who had been trying to lose
weight and keep it off for “all my adult life” said, “I had tried Weight Watchers, Slim for Life...Atkins Diet, you know, um, South Beach, you know, anything, any commercial program that was out there I ‘m sure I’ve done it.”

Sarah who had two roux en y gastric bypass procedures 10 years apart recognized the same pattern in herself stating that “I did notice one of the things when I started dieting before and after my first surgery; the minute I started trying to lose weight, that’s when I started gaining weight.” So it wasn’t that weight loss wasn’t possible for each of these women; rather it was maintaining the weight loss that was the problem.

Experiencing Social Stigma

While not all participants stated they felt they were treated differently due to their physical appearance, social interactions were still challenging. For Sarah she felt that it was a blatant judgmental attitude that other people were giving off when she was around: “You know, people treated me different. They looked at me different going into clothing stores. You know, they just treat you different; they’re rude to you.” Amanda, on the other hand, felt that rather than feeling as if she was treated poorly in social encounters because of how she looked she felt as though she was not acknowledged. “It’s more that you’re invisible. People don’t interact with you or engage you in the same way, um, when you’re overweight, than when you’re heavy, so you just don’t really get attention.”

Conversely, for Debra, she didn’t feel that she was treated differently by others because of her appearance. When asked if she thought she was treated differently, she replied: “Never. Maybe little kids joking, you know, but. that was pretty rare, but no, I mean, I just didn’t let it bother me. You know, I was a social bee; I did everything. You know what I mean?” Debra acknowledged that she has been lucky in that regard: “I know
that’s been a big problem for a lot of people but that has not been a problem, never been an issue for me.”

**Withholding Disclosure**

For various reasons two participants decided to keep their decision to undergo weight loss surgery primarily to themselves, to their spouses, and to close friends only. For the two participants who had repeat surgeries for repair, Sarah for a second gastric bypass, and Patty for a second lap band surgery, they did not disclose to many people outside of close friends and family that they had surgery:

I had the support, like I said, of my husband; I didn’t really tell people at church and that. They just noticed that I started losing weight, and I didn’t really tell them this time either. There has been, there was one of my friends that when I told her, she was a little bit weird about it, but you know, she’s still at least my friend but, uh, no the church, um, I just felt good about my decision.

After her first bypass, Sarah stated, “I had a lot of friends who got very rude with me; they did not like the fact that I was losing weight.” So for her second time around she was reluctant to tell people about it, especially because she felt people were judging her for it. “I didn’t really want to tell everybody, you know, because I’ve had people that have said, oh, you did it the easy way and I just think you’ve got to be kidding me.” For Patty part of her decision was based on her status in her job:

I didn’t tell my coworkers and I’m a supervisor; I didn’t tell any of my employees I was doing it. My immediate supervisor knew and was very supportive of it, um, my immediate family knew, and, um, a sister who was overweight and they were very supportive.
For these two women, bariatric surgery was something they needed to do for themselves, not for the approval or disapproval of other people.

Enhancing Self Esteem

While problems with low self-esteem were not reported by all four participants, they all reported having higher self-esteem and being happier in their lives postoperatively. For a couple of participants, contributing factors to lowered self-esteem included disliking themselves and past struggles.

Disliking self: For Sarah disliking herself manifested itself through isolating behavior. “I just hated myself and did not want to, you know, I just got to the point where I didn’t want to leave the house... Uh, it was just, it’s a very emotional depressing thing.” Similarly for Patty, “It’s just I didn’t like myself, I didn’t like the way I felt, I didn’t like the way I looked, I hated to go shopping for clothes, just all of it.”

For Amanda, self-esteem issues went back to insecurities from elementary school and childhood and feeling as if she stood out:

I mean, it’s really hard, and especially, you know, I’m 55 years old, I mean, I was always the largest person in my class and when you’re growing up, you know, as a kid, you don’t ever want to stand out; you don’t want to be different, so it does affect you. And the interesting thing, even in spite of my weight, I mean, I, you know, got a college education, had a pretty successful career even at my all-time-high weight; you know, I was a bureau chief with the department of public health and managed the certification bureau... .

She found that despite insecurity regarding her own weight she was a very accomplished person.
Past struggles. For Patty, past struggles with weight loss and maintenance were geared toward eating habits.

I was a stress eater. Um, and I was an eater that when I was bored or when I was depressed, um, I would just, and once I started eating I just kept going, I never felt full. And I never got to the point that I was miserable until it was way down the road. So, I had lots of stashes of food, um, junk food, ice cream, candy, comfort food, I like crunchy, I like salty, I couldn’t not buy them. I could never get past that barrier. Um, I’d say I was buying them for my kids but I ate them. And I was a closet eater, I hid them; I brought them out for me. so yeah, I had a real problem with overeating.

For Sarah, embarrassing experiences were a struggle to her self-esteem and overall health. She recalled one particular instance:

I had a little girl ask me one time when I was sitting in one of those plastic seats if, um, I was stuck, because she could see my body coming through the little holes, and that was, and that was mortifying.

Present feelings. All the women reported a sense of improved self-esteem and of feeling genuinely happy with their decisions to undergo bariatric surgical procedures:

I just think I’m maybe a little bit more self-confident, um, maybe, if that, just healthier, I move around more, I have more energy, I’m off of medications . . . I’ve even said if I had to have it every 3 months, I’d do it every three months. It wasn’t a big deal for me.
And for Amanda,

It’s been one of the best decisions and the best things I’ve ever done for myself. . .

I just feel really lucky that I’ve been as successful as I have been, pretty much,
you know, doing it mostly on my own. I mean it’s just a wonderful feeling not
being morbidly obese. And being able to wear clothes, and shop, and you’re
treated differently.

Simply stated for Patty, “I’m just, I’m happy again.” And for Sarah, “I just feel a lot
better about myself and I don’t have that weight on me.” She even went as far as to say
the following: “I would do it again in a heartbeat.”

Fortunately for all of these women, weight loss surgery was something they found
to be very beneficial for their overall self-esteem and self-image. It has helped them to be
healthier, happier individuals.

*Support systems.* An important factor for each participant in this study was having
a support person throughout the process. Whether it was a best friend or life partner or
other resource, they all have utilized relationships with meaningful people in their lives to
transition through the process and incorporate the needed lifestyle modifications. For
Debra social support was something she identified as being very important for her when
asked about who was supportive of her:

My husband was very supportive. My family was supportive; um, I have a group
of friends called the YaYas; they were all supportive, they all were supportive, I
mean, I had more support than the average person I would say; I think that’s
crucial.
And Amanda stated, “I did this on my own. Literally. I mean I searched the internet, you know, found Dr. Kuri, you know, and just made the decision to do it.” She still identified her personal trainer as being someone who was an important influence on her postoperatively:

The personal trainer that I worked with, she ended up being probably a major support, so reaching out to her and getting started on exercise, and, you know, when you work with somebody for 2-3 years twice a week, we really developed a wonderful relationship; she was the one that really ended up being my, my major support.

Another source of support for Amanda was her sister who had a lap band surgery the same weekend with Amanda.

We were going through it together, so she and I really supported one another...we did. You know, my sister and I have had, you know, she’s, this lap band surgery actually brought us closer together, so that was really a nice thing, because we would probably go sometimes a year or more and and not have any contact with one another, and so the lap band really brought us together, and gave us something to work on.

Sarah identified her husband as her main support person with whom she could work on making healthy lifestyle changes not just as an individual but as part of a couple as well. In terms of incorporating exercise, “You know, we like going and doing different things, so we’ve been hiking, and then I ride my bike a lot,” and in terms of eating, “My husband and I have both started a new program where we’re getting into the more organic foods
and stuff like that, and so, we’re kind of working on it that way, watch our eating that way.”

Patty reported feeling as if she was surrounded by a lot of support, including her immediate family and friends, and exercise physiologist:

My immediate family knew and, um, a sister who was overweight, and they were very supportive. As it’s gone on, people have become more supportive in how are you doing this and me telling them and then us doing it together because they’ve gone and done it as well. So it developed more and more support systems.

_Battling Depression_

Every participant in this study is currently on an antidepressant. On the other hand, she was not necessarily taking an antidepressant to address issues directly related to her struggle with obesity. Three of the women reported having been on antidepressants for 20 or more years for various reasons. However, each woman expressed that no matter what the specific reason or reasons for being on the antidepressant that she felt it made a positive impact on her life. Patty, however, did feel that many of her depressive feelings came from her insecurities with her weight:

Um, probably a good, I’m trying to think...how old is... probably a good twenty years. A long time. And they’ve worked for me, helped me get through. I used to just want to stay in bed and eat and watch TV and not do anything else. Because I think the majority of my depression was geared at my weight. I really do.

Sarah recognized that she has a family history of depression, and being on an antidepressant helps her from becoming “a recluse.” She said:
When I was heavier, I got so I, like I said, I wouldn’t even come out of the house. I was just really turning into a recluse, but I’ve taken Prozac ever since I was in high school; if I go off of it, I can feel it immediately, and, uh, I’ve never been on a real high dose, but just enough to kind of help me.

And for Amanda and Debra, antidepressants have helped them cope with specific situations and life events. Amanda stated:

I just kind of accept that I think I’m the type of person that’s just gonna do better on an antidepressant. I don’t know; it’s kind of weird, it’s like, and especially when you’ve gone through bad things... I feel like I do better with it, even though I feel great, I’m doing great; I just leave well enough alone and, you know, just take a low dose and that’s the only pill I take.

Similarly for Debra, “I have depression. Um. Situational. And I’ve been, I’ve been in therapy probably... I’ve had a counselor of some sort which I still see on a monthly basis, since about 1987.”

Enjoying Food in Smaller Quantities

Listening to the band. Every participant noted that listening to what her body, or in the cases of the participants who had lap band procedures, listening to what the surgical band was “telling” her was an important factor in altering eating habits. Due to the fact that the size of the stomach is smaller postoperatively than it was before, eating habits and the amount of food that could comfortably be ingested were decreased.

Naturally there is an adjustment period when the postoperative bariatric patient has to learn his or her new physiological boundaries. And when too much food is taken in, it can literally make the person vomit because there is more food in it than it can handle. After
her lap band surgery Amanda described that there was an adjustment period when she learned she really did have to listen to her band: “I was throwing up, and that’s what happens with the lap band when you don’t listen to the band.” Part of this process is also recognizing that within the initial few months after surgery, the appetite is generally diminished, but eventually will come back. When it does and the patient can tolerate more food, it is still just as important to “listen” to what the body is saying.

Sarah reported, “One of the things I noticed with both surgeries is you want to eat more than you know you can, and you try to eat too fast and that’s not a good thing. It makes you real sick.” Other participants noted liking that this happened because it was a negative reinforcement. Patty said: “Occasionally I’ve gone and thrown up. That it hurts so bad and I feel so uncomfortable that you throw it up and so that’s been the negative reinforcement to say don’t do that again.” Because of the unpleasant experience of vomiting, the women had motivation to limit their intake of food to prevent this. Debra was disappointed that she didn’t experience dumping syndrome after her surgery, because she was hoping that it would help her restrict food intake:

I have a great appetite for anything, you know what I mean. And even now, the surgery doesn’t fix that; I am not blessed with having like a dumping syndrome. You know, I can, I can eat full meals. You know, I am to the point now this far out that I really have to struggle to maintain my diet. See I knew that in my head, but you know the reality of that is probably the most difficult. And that I can eat as much sugar as I want to and I don’t dump. I really wanted a built-in behavior modification, you know what I mean, and I wasn’t, I didn’t get that, but you know be careful what you wish for.
Dietary changes. One part of learning to incorporate dietary changes is to literally slow down the rate at which one eats food. Patty found that for her slowing down the eating process helped her to identify her limits:

So, just the trial and error, and being a nurse, and I don’t mind that people know that I was a nurse, um, eating slowly, chewing slowly. We are so used to just shoving it in when you get a minute, um, that, that taking time to eat. And so I found that, I literally would take a bite, very small portions, I cut them small, lay my fork down in between every bite and that helped me learn to slow down to eat.

For Sarah, she has incorporated healthier foods into her diet:

Um, we’re getting so we eat a lot of fish, lots of vegetables, lots of fruit, we’re trying to cut out; we don’t do much starch anymore. If I do then it’s whole wheat; um, I do a lot of oatmeal for breakfast and, uh, let’s see, what else, I try not to eat after 5:00 in the evening. I try not to snack on anything, so if I’m going to eat a meal, we usually have a protein, a vegetable, and a fruit. Very rarely do we have starch.

Food intolerances. Three of the participants in the study reported that there are certain foods that they do not tolerate well since having had bariatric surgery. For Amanda: “It’s very hard for me to eat salad; high fiber foods are very very difficult because they’ll plug up the band.”

Foods that are healthy and nutritious such as salads and fruit are difficult for her to eat so she is challenged in maintaining a balanced diet:
I eat almost no fruits and vegetables, so I don’t have, it’s been really hard, to have a real healthy balanced diet, and then the vegetables that you do eat, they tend, they have to be soft. I can eat broccoli, and green beans and peas, squash, you know, I can do a little bit of asparagus, especially the tips, and you have to chew, really, really well.

Within the early months after her surgery, Patty also had trouble with certain foods, “I found I couldn’t eat breads, soft breads at all; they would just clump up get stuck and I was really miserable.” But now that she is a couple of years out of her surgery, she reported:

What I’ve really learned is there isn’t really anything I cannot eat. I take a bite of what I want, but it’s the portion control. Because I found through all my different efforts, if you say to me, you can’t have that, that kills me, and I will find a way that I’ll have it. I’ll make myself sick; I’ll do whatever. So I choose, I mean I know that I should eat my protein first and then I need to look at vegetables and I need to eat the healthy stuff, but there is nothing that I don’t taste that I want to taste, but I do start with my portion of protein first, um, and the nice thing is I truly feel full.

And for Sarah, who had a bypass, there are foods that she still cannot eat much of without getting sick:

I pretty much eat what I want. The only thing I don’t tolerate well is ice cream and milk. I don’t do that at all. I can have a little. You know, if I have any ice cream, I might have just like a ¼ of a cup and that’s about it, and then I’m sick, and so I really try to watch the sugar, because that really makes me sick.
Drinking with meals. After having bariatric surgery, patients are discouraged from drinking liquids with meals. Liquids move the food through the stomach faster, which in the case of someone who is trying to eat restricted amounts of food is not necessarily a good thing because it could allow him or her to eat more than necessary. Therefore prior to surgery this was something Patty was worried about, but it turned out that it was not as serious as she thought it would be: “When they tell you that you can’t drink anything when you eat, I had always been a person that drank a lot with my meals, and I was really worried about that. Um, that ended up not being a big issue.” For Debra, though, the first time she had bariatric surgery, she had a hard time not drinking with meals: “The first time, the hardest lifestyle change was not being able to drink with my meals. . . . That, that was really hard for me, but I still don’t drink with meals, just because I can’t. It’s almost physically impossible.”

Recognizing Sustained Weight Loss as a Process

Each participant recognized that the surgery for weight loss was only part of a greater process that does not end, but rather requires life-long dedication to maintaining physical and emotional health and well-being. Amanda said: “And you know that’s the thing about the band; it’s, it’s a process.” Only with the understanding that the surgery in itself is not going to fix everything can optimal success be achieved. Each of the women followed was on a similar path or process that led her to where she is today.

Accepting defeat. The process of achieving sustained weight loss was begun before the women even had the surgery. It began with trying to diet and make lifestyle changes on their own and accepting the fact that this was not a possibility for them. For Debra, when asked about what was the hardest part of making the decision to have
surgery, she replied: “The reality that I wasn’t able to do it myself.” There came a point when the participants realized that they could not do it on their own and that in order to attain their goal they were going to need more help than a diet could provide. For Sarah, a diagnosis of thyroid cancer and gaining 80 pounds related to this disease is what prompted her to have a second bypass: “I wish I could have done it on my own, without going and having the surgery, but I just, you know, and part of that, like I said, was my thyroid problem because once they got me squared away with that, man, you know it’s been really good.”

Therefore admitting that they could not do it on their own was an important motivating factor in considering bariatric surgery: “I could always take it off with all the different programs, but I couldn’t keep it off.”

*Viewing surgery as a tool.* Another part of the overall process was having the correct perception of what the surgery was: a tool to success, not necessarily success itself. Each of the participants knew enough about the surgical procedures and lifestyle changes that were being asked of her to know that bariatric surgery is part of a bigger picture. For Amanda, “The surgery is just putting the tool in, and then you’ve got to get that tool tweaked.” While the surgical procedure aids in weight loss “It’s a tool, it’s a three-prong tool; one is the surgery, the second is diet, and the third is exercise.” Since the surgery is a tool rather than a “fix-it,” the expectations that each participant had were based on her understanding that she was still accountable for incorporating healthy lifestyle choices.

*Recovering from surgery.* The surgery itself was not described by any of the participants as being a stressful or overwhelming experience. In fact in terms of the
challenges that the process of weight loss involves, they described it as a relatively easy part of the process. For Patty, “the surgery itself was very, very easy for me. . . Laparoscopic surgery was really no big deal for me, and I was in and out very quickly, um, didn’t even spend the night, came back to work, did that on a Friday and came back to work on Monday.” Debra reported a similar experience: “I sailed through it because I was just so motivated. . . Within a week I was walking 3 miles a day.” Amanda was on the beach the next day following her lap band surgery.

*Giving up pop.* Another part of this experience in addition to changing food habits was changing drinking habits as well. With both laparoscopic lap band procedures and roux-en-y gastric bypass procedures, drinking carbonated beverages such as soda is contraindicated, because it can erode the band and stretch out the stomach pouch. For three of the women, it ended up being a challenge giving up soda, and a couple have fallen back into drinking it. For Sarah, when she was asked about what she found to be the most challenging part of the whole weight loss surgery experience, she replied that it was “my pop. I drink water all the time now, with those Crystal Light, but the soda was the hardest thing for me. Everything else wasn’t really that hard.” She went on to say that it continued to be a temptation for her, especially when out with people who are drinking soda. “I knew that if I chose to do this again, I would never get another pop, and there are some times when I’m at a restaurant and my husband gets his diet coke and I’m just sitting there going ooh that would taste so good, but I don’t.”

For Amanda, she finds drinking pop to be an unpleasant experience, but continues to drink it for the energy the caffeine in it provides her:
With the band you’re not supposed to have carbonated, but I do have 1 diet
Mountain Dew a day. It takes me hours to drink it. It’s uncomfortable, it’s not
really pleasant, but I don’t drink coffee, so it’s really the only little bit of caffeine
that I get.

And for Patty it was having become comfortable enough with her new body to
relax the rules she had been vigilantly keeping herself to. She stated: “I’ve slipped back
and I’ve started drinking pop, that I still am gonna have all those challenges, but I need to
try to get back to the reasons why and reincorporate them.”

_Incorporating exercise._ All of the participants reported that exercise has become
an important part of their lives, although challenges in maintaining a routine vary
according to time of year or even the business of any particular week. Patty
acknowledged:

To say that I am successfully getting to the gym three times a week and doing
some weights and some aerobic, I’m still struggling with that. That’s a forever. So
it, um, I do better with that in the winter really, when there is nothing else to do in
the evenings. I’m not a real winter outdoor person, so I do that fairly well.
Summer I’ve not made it to the gym as much, but I’m doing my outdoor
gardening, walking, playing with the grandkids.

Amanda reported that she was very dedicated to working out when she worked with a
personal trainer, but since her trainer moved away she has fallen out of that habit. She
stated:

I ended up working with a personal trainer, here in town, and she came, we started
here at the house. You know, I got a nautilus machine, and an exercise bike and
all that. Within probably a month or six weeks, we were back at the Life Fitness Center and, boy, I’ll tell you, she really, I worked with her for probably 2+ years, and, um, we worked at Crossroads together and life fitness, and then she started a pilates studio, and so now I’ve stopped exercising... .

And for Debra exercise is part of her life but in terms of how frequently she exercises, she stated:

   It depends on the week. Um, I always try to do something, um, 3-5 days a week .Some weeks it’s three, some weeks it’s more, but, um, I like to walk, I go to zoomba class, we have a Wii Fitness here at home.

There was a general understanding, though, that exercise was an expected and important part of the process .Sarah stated: “I know that I need to keep myself active.”

   Improving health. After their surgeries and when they began to lose weight, the women noticed an improvement in their health, and in some cases resolution of previous comorbidites. For instance, Patty stated: “I was having a lot of trouble with my knees and arthritis. My knee pain’s gone away. So getting that weight off my knees has been huge. Um, I was borderline diabetic, you know. I’m not , I’m not dealing with any of those issues. I sleep better .I, I went into this because I wanted to have more energy to play with my grandkids, and I can get out and run and play with them now.” Debra also had a similar experience: “I had hypertension. I was on, um, an ACE inhibitor and a diuretic, and, um, I had high cholesterol, hyperlipidemia, and I was on a high cholesterol medication. And I also had sleep apnea.” All of her comorbid conditions such as the hypertension and being borderline type II diabetic resolved except for her cholesterol levels, for which she believes she most likely has a genetic predisposition.
Encountering a plateau. While the rate at which weight is lost varies among individuals and among procedures, in the months following any kind of weight loss surgery, individuals’ weight typically declines consistently. However, after a period of time, it is not uncommon for weight to stabilize at a certain point regardless of whether the person wants it to or not. This plateauing of weight was a challenge for all participants. While they noted they were at a much healthier body weight than they once were, they were challenged in getting to and sustaining their weight at their most desired level. Keeping weight off was easier than it had been preoperatively, but was still an issue that needed to be kept in mind. Patty said: “I’m just, I’m 2 ½ years out on my surgery, and I’ve lost the eighty pounds. Lost eighty, I’m playing with 10. So the biggest thing is that I’ve been successful. You know, I’m playing with 10 pounds, but I haven’t put eighty and more back on.” Debra, who preoperatively weighed greater than 250 pounds, stated:

It’s been a struggle because there have been times when I’ve gotten as high as like 178 and I just have to really, you know, I need to get my groove on and get back on track, you know…but, you know, I would love to finally be between 155 and 165, but I’m not right now.

Even though the surgery assists in losing weight, it is not necessarily what is going to keep weight from coming back on, but rather it is a combination of the physical restrictions created by the procedure and the individual’s own hard work. Amanda stated: “Well, first of all you’re losing weight, so as you lose weight everything gets smaller, including your insides, and then all of a sudden, you can eat more, the hunger
starts to come back, your weight loss will plateau.” Consequently, part of the challenge postoperatively is to recognize the plateau and maintain the weight at this level.

Supporting others. Three of the women reported being a support person for other individuals considering bariatric surgery at one point or another. For instance, Amanda, who chose to have her surgery down in Mexico, accompanied two of her friends to Mexico so that they could also have lap bands. Similarly, Patty has supported and continues to support, one of her friends who is struggling postoperatively with adjusting to life with a lap band.

For Debra, having had gastric bypass surgery has helped her to be a resource on a professional level. She said that continuing to go to support group sessions even now several years after her surgery has benefited her most in that “I think it benefits me the most because, um, it helped me to be a resource.” In her job as a nurse manager she receives calls almost daily requesting her insight on bariatric surgery for prospective, interested patients from physicians working in her hospital and is in the process of becoming certified as a group leader.
CHAPTER V

Discussion

The decision to undergo weight loss surgery is not one to be made without much consideration and education. More than anything, the individual has to have the personal discipline and the commitment to incorporate a multitude of lifestyle changes if he or she wishes to see successful, long term management of weight loss. Incorporating new eating habits, exercise routines, and diets are just a few of the tasks that are required and that pose daily challenges to the individual.

In the course of writing this paper, it became evident that to say an individual will make a “lifestyle change” is easy, but in reality it is the opposite and requires an extraordinary amount of discipline and resolve. It is not just about changing the kinds of food eaten, but literally the amount. It is about making conscious, healthy decisions every day even if they do not always feel natural or easy to do. It is about not breaking “the rules” following bariatric surgery even when there is no one around to enforce them.

The most satisfying result of this research was finding that each of the four women interviewed was genuinely happy in her life following her bariatric surgery. Whatever worries or concerns and unhappiness she had regarding her weight before surgery were greatly decreased. While they all reported individual challenges, they all were very happy with their decision to undergo bariatric surgery. They acknowledged that the surgery does not fix everything and that every day they have to make healthy decisions to maintain their weight loss.

Current research regarding this topic is of the view that overall it is a very safe and effective procedure for people who are well informed, well prepared, and who are
committed to implementing change. A special emphasis is placed on patient education of the procedure itself, the risk factors involved, and what to expect in the short term following surgery as well as the long term.

Recommendations:

Follow-up. Preparing for bariatric surgery and recovery is only part of a larger, lifelong process. Following a bariatric procedure, patients initially have follow-up appointments within the first 2-3 weeks following surgery and then an appointment every 3 months throughout the first year, but this does vary among individual physicians and patients respectively (Clark et.al, 2006). Clark et.al conducted research on clinical studies about bariatric surgery, and with their own expert knowledge at the Mayo Clinic stated that “comprehensive longitudinal care of patients is critical after bariatric surgery” (2006, p. 34). Follow-up care by a primary physician is important not just in the following weeks after surgery, but yearly check-ups are recommended as well. This is especially important for patients who have had a roux-en-y gastric bypass, because of the potential for nutritional deficiencies and associated complications such as vitamin B12 deficiency, calcium deficiency, as well as complications from an expanding pouch, development of abdominal adhesions and hernias that threaten the integrity of the surgery (Clark et al., 2006).

Physical activity. While maintaining a regular exercise routine is difficult for many people, the research on health for the general population as well as for the bariatric population is almost unanimous on its implications for physical and mental health. An important fact to remember is that no one following bariatric surgery is expected to be perfect in his or her exercise routine. Rather, it is more important to start more slowly,
with realistic, achievable goals and work on incorporating more exercise gradually over time. Additionally, bariatric patients need to be doing something for exercise that they enjoy so that exercise reinforces rather than hinders their effort to sustain weight loss.

Psychological follow-up. For the majority of bariatric surgery patients, there is a reported increase in self-esteem and psychosocial health. For instance:

In a study of 69 patients undergoing bariatric surgery, researchers used 4 scales with clinical cutoff scores for depression, anxiety, relationships, and binge eating to classify patients as having “great psychosocial stress” or “little or no psychosocial stress” Ten months after surgery, the prevalence of great psychosocial stress had decreased from 70% to 12%. Patients also reported clinical improvement in quality of life and well-being associated with weight loss. (Clark et.al, 2006, p. 42)

Unfortunately, in some studies not everyone reports improved self-esteem. Clark et al. identified another study in which “in a study of 157 patients who underwent bariatric operations, most experienced improvements in mental health, but 3 committed suicide, and 2 died of complications from alcohol abuse” (2006, p. 43). While there is no information available regarding the mental health of these specific individuals, these findings emphasize the importance of presurgical screening for depression or mood disorders and teaching regarding what the patient can expect physically and psychologically after surgery.

Areas of Needed Research for the Future

Sexual abuse. While the Clark et al. study did refer to a study correlating a history of sexual abuse with bariatric surgery, there is not a great deal of available research regarding this problem in the current literature. It would be interesting to explore what
the strength of this correlation is if it truly does exist and to study special considerations and interventions for this specific subpopulation of bariatric surgical patients.

*Factors of regaining.* Another area that is explored in the current literature is addressing the number of people for whom surgery is not successful in the long term. While this is certainly variable among individuals and the different surgical procedures, it still highlights an important issue. What is lacking is current research that identifies successful interventions. Often it is attributed to patient non-compliance with the post-surgical diet, exercise, and overall lifestyle changes that are taught and the patient is prepared for preoperatively. However, research that goes beyond this assumption and dives into possible psychosocial, physiological, spiritual, and other contributing factors reported by patients could prove to be highly beneficial in aiding this specific patient population in achieving a sustained weight loss following surgery. In a study conducted by Berry, Canetti, and Elizur, the authors explored how emotional eating (EE) and having a "neurotic predisposition" contribute to outcomes of patients who underwent a vertical banded gastroplasty (n=44) and laparoscopic adjustable banding (n=7) in comparison to a group of individuals who did dieting only. While surgical patients did not undergo one of the procedures discussed in this paper (roux-en-y gastric bypass), the findings of this study are still relevant. The authors reported:

In both the dieting and in the surgery groups, individuals high on EE remained heavier than their counterparts even when the dramatic weight loss of surgery overshadowed other variables. This focus on EE is in line with psychosomatic theories of obesity which assume that for some obese individuals eating constitutes a refuge from external and internal pressures, as well as a mean to.
regulate emotions, and a mean for consolation and compensation. (Berry et. al, 2009, pp.114-115)

This does not mean that a person with obesity who is considering bariatric surgery will be unsuccessful at losing weight if he or she has problems with emotional eating. However, what it does imply is that these individuals, depending on other factors such as overall self-esteem and need for control, may need additional psychological, nutritional, and educational support before and after surgery. Research that identifies factors and intervention strategies for emotional eaters could be helpful in identifying these individuals and aiding them before they have surgery in changing these behaviors, which are often unconscious.

In conclusion, there are many benefits to bariatric surgery. But this is not to say that it is the right solution for everybody. Many people are capable of dieting, losing weight, and keeping it off for years all on their own. For those who cannot do this, regardless of the reason or reasons, bariatric surgery can be a very liberating and life changing experience. It can not only impact a person’s physical body image and self esteem, but enhance quality of life and overall happiness as well.
References


http://www.regent.edu/acad/schcom/rojc/mdic/martin1.html


http://www.iep.utm.edu/heidegge/


